

Abstract OP-15 Table 6 Factors associated with having an EPOA[†]

| Characteristic | Odds Ratio | 95% CI [‡] | p-value |
|------------------------------------|------------|---------------------|---------|
| Age (Years) | | | |
| <65 [§] | 1 | | |
| ≥65 | 1.34 | 0.79–2.40 | 0.3 |
| Sex | | | |
| Female [§] | 1 | | |
| Male | 1.18 | 0.79–1.77 | 0.4 |
| Geography | | | |
| City [§] | 1 | | |
| Regional | 0.53 | 0.29–0.90 | 0.024* |
| Remote | 0.46 | 0.07–1.67 | 0.3 |
| Relationship Status | | | |
| Never Married [§] | 1 | | |
| Partnered | 1.00 | 0.47–2.30 | >0.9 |
| Separated | 0.80 | 0.35–1.93 | 0.6 |
| Religion | | | |
| Other [§] | 1 | | |
| Christian | 0.84 | 0.56–1.25 | 0.4 |
| Pre-referral Hospitalisation | | | |
| No [§] | 1 | | |
| Yes | 0.75 | 0.48–1.20 | 0.2 |
| Parenthood Status | | | |
| Non-Parent [§] | 1 | | |
| Parent | 1.18 | 0.58–2.67 | 0.7 |
| Palliative Care Phase | | | |
| Stable [§] | 1 | | |
| Unstable, Deteriorating & Terminal | 0.58 | 0.38–0.87 | 0.009* |
| AKPS | | | |
| <50 [§] | 1 | | |
| ≥50 | 1.09 | 0.70–1.73 | 0.7 |
| RUG-ADL | | | |
| <14 [§] | 1 | | |
| ≥14 | 0.68 | 0.4–1.10 | 0.12 |

[†]Binary logistic regression[‡]Confidence interval**Abstract OP-15 Table 7** Factors associated with having an AHD[†]

| Characteristic | Odds Ratio | 95% CI [‡] | p-value |
|------------------------------|------------|---------------------|---------|
| Age (Years) | | | |
| <65 [§] | 1 | | |
| ≥65 | 2.23 | 1.01–5.92 | 0.070 |
| Sex | | | |
| Female [§] | 1 | | |
| Male | 0.78 | 0.46–1.31 | 0.3 |
| Geography | | | |
| City [§] | 1 | | |
| Regional | 1.17 | 0.61–2.12 | 0.6 |
| Remote | 0.54 | 0.03–2.78 | 0.6 |
| Relationship Status | | | |
| Never Married [§] | 1 | | |
| Partnered | 1.21 | 0.46–4.20 | 0.7 |
| Separated | 0.90 | 0.30–3.30 | 0.9 |
| Religion | | | |
| Other [§] | 1 | | |
| Christian | 1.48 | 0.86–2.61 | 0.2 |
| Pre-referral Hospitalisation | | | |
| No [§] | 1 | | |

| | | | |
|------------------------------------|------|-----------|-------|
| Yes | 1.05 | 0.57–2.03 | 0.9 |
| Parenthood Status | | | |
| Non-Parent [§] | 1 | | |
| Parent | 0.85 | 0.37–2.30 | 0.7 |
| Palliative Care Phase | | | |
| Stable [§] | 1 | | |
| Unstable, Deteriorating & Terminal | 0.63 | 0.37–1.09 | 0.095 |
| AKPS | | | |
| <50 [§] | 1 | | |
| ≥50 | 0.87 | 0.50–1.56 | 0.6 |
| RUG-ADL | | | |
| <14 [§] | 1 | | |
| ≥14 | 0.64 | 0.31–1.21 | 0.2 |

[†]Binary logistic regression[‡]Confidence interval[§]Reference group

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OP-16

AMBULANCE TRANSPORT TO HOSPITAL IN PATIENTS WITH A PALLIATIVE AMBULANCE MANAGEMENT PLAN (AMP)

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Background Many palliative patients prefer to receive care at home rather than attend hospital (Evans *et al.*, 2006). Most community palliative care services are unable to provide 24-hour in-person care, therefore ambulance services are often called to assess palliative patients in acute situations. Palliative ambulance management plans (AMPs) are documents created in collaboration with patients and their families. These documents assist ambulance personnel in the acute care of patients with life-limiting illness by outlining the patient's goals of care regarding transport to hospital versus best supportive care at home, and by providing guidance on the provision of symptom management at home.

Objectives The aims of this study were to assess whether patients' AMP goals of care regarding transport to hospital were being followed, to describe the common indications for ambulance attendances and transport to hospital in patients with AMPs, and to identify outcomes for the patients who were transported to hospital.

Method This was a retrospective study describing the use of AMPs in the Hutt Valley region, New Zealand. Patients in the Hutt Valley health district with an AMP created between

January 1st and December 31st 2022 inclusive were included (table 1). Patients were followed until death or 12 months after implementation of their AMP. Data was collected from the Wellington Free Ambulance and Capital, Coast and Hutt electronic databases.

Results 111 patients were included in this study. The majority of patients (74%) had a primary diagnosis of cancer. 67 ambulance attendances were observed across 46 patients, and 40% resulted in transport to hospital (n=27). 69% of patients' goals of care were for 'symptom control at home'. Goals of care were followed in 76% of all ambulance attendances. Of the 27 transports to hospital, 44% were inconsistent with the patient's goals of care (n=12). The most common reason for transport to hospital against goals of care was 'family's wishes' (n=5). The most common indications for an ambulance attendance were pain (28%) and breathlessness (15%). Infection was the most common indication for transport to hospital (22%), and the most common indication for ambulance attendance in patients who were transported to hospital against their goals of care. 59% of patients transported to hospital were discharged home. Of the 5 transports to hospital that resulted in death, only one was inconsistent with the patient's goals of care.

Discussion Although uncontrolled symptoms were the most common indications for an ambulance attendance, most of these attendances did not result in transport to hospital. AMPs provide ambulance personnel with the ability to both recognise a patient's wishes to remain at home where possible and provide care that can enable this. It is encouraging that the majority of patients received care consistent with their goals of care. We acknowledge that these directives may be appropriately overridden in circumstances where a hospital admission is expected to be beneficial (Robinson et al., 2015), however our study suggests that these decisions may be influenced by family rather than the patient themselves. Further research into ambulance personnel perspectives on AMPs would be valuable.

Abstract OP-16 Table 1 Ambulance attendance and hospital transport data

| Indications for ambulance attendance | Number of attendances (percentage) | Number of attendances resulting in transport to hospital | Number of transports against goals of care |
|--------------------------------------|------------------------------------|--|--|
| Pain | 18 (26.9%) | 3 | 1 |
| Breathlessness | 10 (14.9%) | 4 | 2 |
| Nausea/vomiting | 1 (1.5%) | 1 | 0 |
| Confusion/agitation | 5 (7.5%) | 1 | 0 |
| Infection | 6 (9.0%) | 6 | 3 |
| Fall/trauma | 3 (4.5%) | 2 | 1 |
| Cardiac issue | 2 (3.0%) | 1 | 1 |
| Respiratory | 3 (4.5%) | 3 | 0 |
| Gastrointestinal issue | 2 (3.0%) | 2 | 2 |
| Urinary issue | 1 (1.5%) | 1 | 0 |
| Neurological | 1 (1.5%) | 1 | 0 |
| Mental health | 2 (3.0%) | 0 | 0 |
| Other | 5 (7.5%) | 2 | 2 |
| Deceased | 7 (10.4%) | 0 | 0 |
| Non-emergent | 1 (1.5%) | 0 | 0 |
| Total | 67 | 27 | 12 |

OP-17 RESPONDING TO PSYCHOLOGICAL/SPIRITUAL DISTRESS EXPERIENCED BY PALLIATIVE CARE INPATIENTS AT A COMPREHENSIVE CANCER CENTRE

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Background and Objectives Patients at the end of life often experience psychological and/or spiritual distress. This study explored the involvement of psychosocial and spiritual care teams in the care of palliative care inpatients at the Peter MacCallum Cancer Centre (PMCC) in Melbourne, Australia.

Methods Medical records of palliative care inpatients at PMCC during 2022 were reviewed to extract their demographic and clinical details; Palliative Care Problem Severity Score – Psychological/Spiritual (PCPSS-PS); referral to and contact with Clinical Psychology (CP), Consultation-Liaison Psychiatry (CL), Social Work (SW) or Spiritual Care (SC) teams. Data analysis utilised descriptive statistics.

Results Palliative care teams cared for 766 patients (47% female) over 1017 admissions (median age 65 years, IQR 52–75). Death occurred in 42% of admissions. A history of mental illness was documented in 16%, although 27% had been in contact with CP and/or CL teams prior to admission.

Psychological/spiritual distress was rated as mild (47%) or moderate (22%) during most admissions. Severe distress was rare (1%).

Referrals were made to at least one psychosocial or spiritual care team during most admissions (69%): CP (11%), CL (11%), SW (58%) and/or SC (28%). Contact with at least one psychosocial/spiritual care team occurred during most admissions (85%): CP (8%), CL (12%), SW (56%) and/or SC (75%).

Discussion and Implications Significant psychological/spiritual distress is uncommon among palliative care inpatients at PMCC. Despite this, contact with at least one psychosocial/spiritual care team occurred during most admissions.

OP-18 UNDERSTANDING PEACEFUL DYING AMONG CANADA'S ELDERLY

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Background Death is a universal phenomenon that is an intrinsic part of the human experience and a cornerstone of clinical science, yet little is known about how Canadians experience death.¹⁻³ We examined novel data from the Canadian Longitudinal Study on Aging to describe peace with dying among older Canadians and examine correlates.⁴

Methods We conducted a secondary analysis of decedent interview data from the Canadian Longitudinal Study on Aging (CLSA) in Canada. Next of kin and proxies of deceased CLSA participants were interviewed and reported on the End-of-Life (EoL) experiences of participants who died between January 2012 to March 2022. We examined EoL characteristics, including the location of death, cause of death, arrangements for health care decision making, and arrangements for end-of-life care decision making and their association with dying peacefully. Regression methods identified the association