

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
<b>Total</b>	<b>67</b>	<b>27</b>	<b>12</b>

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

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10.1136/spcare-2024-ANZSPM.17

**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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10.1136/spcare-2024-ANZSPM.18

**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.<sup>1-3</sup> We examined novel data from the Canadian Longitudinal Study on Aging to describe peace with dying among older Canadians and examine correlates.<sup>4</sup>

**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

between demographic and EoL characteristics in experiencing peace with dying.

**Results** There were 3,672 total deceased participants at the CLSA and 1,287 had completed a decedent questionnaire. Sampled decedents (55.3%) were 75 years old or older at death, 62.0% were male, 62.7% were married, and 39.7% died of cancer. Next of kins reported that 66.0% of the deceased experienced peace with dying, 7.0% were 'somewhat' at peace with dying, and 17% did not experience peace with dying. A peaceful death was more likely if the deceased was older (75+; OR 1.55; CI 1.04–2.30), widowed (OR 1.53; CI 1.12–2.10), died of cancer (OR 1.71; CI 1.27–2.30), died in hospice/palliative care (OR 1.67; CI 1.19–2.37) and having an appointed EoL decision making power of attorney (OR 1.80; CI 1.39–2.33).

**Conclusions** Many older Canadian do not experience peace with dying which underscores the greater public need and demand for health system focus on improving the quality of death.<sup>5 6</sup> Our findings support the presumption of effectiveness for end-of-life programs as well as programs that include advanced planning regarding wishes and decision making as potentially modifiable factors to support quality of death. A person's experience with close family member death, predictability of course of illness, and strength of close social bonds are less modifiable factors that can support how end of life programs are designed and targeted.

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OP-19

### A STUDY INTO THE BENEFIT OF 'STANDARD PALLIATIVE CARE' ON SYMPTOM CONTROL IN RANDOMISED CONTROLLED TRIALS

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10.1136/spcare-2024-ANZSPM.19

**Background** Measuring and assessing the impact of palliative care is a challenge faced by researchers and clinicians. Despite established standards, assessing the benefit of palliative care remains challenging due to its subjective nature, diverse care models and frailty of patients.

This study evaluates the benefit of palliative care, when delivered within a standard approach in the context of randomised controlled trials (RCTs), by assessing its impact on symptoms and quality of life using the change in Total

Symptom Distress Score (TSDS) of the Edmonton Symptom Assessment Scale (ESAS) as an indicator of improvement.

**Objective** The primary objective was to determine if standard palliative care delivered within a RCT led to an improvement in TSDS that was either statistically and/or clinically significant.

**Methods** A literature review identified five RCTs conducted on patients actively receiving palliative care, with ESAS measured on two occasions within a 4-week period. A meta-analysis was conducted to look at the Mean Differences (MD) and Standardized Mean Differences (SMD) in TSDS in the identified RCTs.

The magnitude in reduction of TSDS can be determined to be clinically relevant by considering the Minimal Clinically Important Difference (MCID). Based on work by Hui et al., an improvement of at least 5.7 was considered to be clinically significant.

**Results** The five trials included 274 patients receiving palliative care in the United States of America, Australia, and Poland. All trials involved patients with advanced cancer.

The analysis found a statistically significant improvement in the TSDS of the palliative care arms over a 2- 4-week period. The SMD of the TSDS showed statistically significant improvement at Day 14 (SMD -0.59, 95% CI: -0.84, -0.34), as well as at Day 28 (SMD -0.49, 95% CI: -0.75, -0.22) when compared to baseline. The MD analysis supported these findings, with statistically significant improvement at Day 14 (MD -5.80, 95% CI: -8.53, -3.07), and at Day 28 (MD -6.64, 95% CI: -11.27, -2.01). Standard palliative care was also found to deliver clinically significant improvements in TSDS in these RCTs.

**Discussion** The results of the meta-analysis provide evidence of the benefits of palliative care in improving patient outcomes over a 2–4-week period in a RCT setting. Our findings replicate evidence that participation in RCTs may be beneficial compared to non-participation. A review of the examined trials however, noted a heterogeneity in the definition of 'standard palliative care'. This study therefore observes that the results might not be replicable in standard practice outside of RCTs. The intensity of patient contact in the RCTs analysed here exceeds the frequency of contact in published studies of 'real world' palliative care, which could contribute to the improvement in symptoms observed in this paper. Future trials should aim to clearly define the standard of palliative care applied. This would render RCTs more useful to clinicians who are looking to integrate trial findings into real-world palliative care models.

OP-20

### CARE PLUS: A MODEL TO ADDRESS BARRIERS TO EARLY PALLIATIVE CARE INTEGRATION IN THE CARE OF PEOPLE WITH ADVANCED CANCER

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10.1136/spcare-2024-ANZSPM.20

**Background** Despite mature evidence of the benefits of early palliative integration into the care of people with cancer, in Australia, referral to palliative care remains variable and often late, if at all. A series of barriers including uncertainty around timing of referral, fear and stigma of palliative care and