

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 kin 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.^{5 6} 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.

REFERENCES

1. Ko E, Kwak J, Nelson-Becker H. What constitutes a good and bad death?: Perspectives of homeless older adults. *Death Studies*. 2015;**39**:422–32.
2. Georges JJ, Onwuteaka-Philipsen BD, van der Heide A, van der Wal G, van der Maas PJ. Symptoms, treatment and 'dying peacefully' in terminally ill cancer patients: a prospective study. *Support Care Cancer*. 2005;**13**:160–8.
3. Teno JM, Freedman V. A., Kasper, J. D., Gozalo P., Mor, V. Is care for the dying improving in the United States? *Journal of palliative medicine*. 2015;**18**:662–6.
4. Van Soest-Poortvliet MC, van der Steen JT, Zimmerman S, Cohen LW, Munn J, Achterberg WP, et al. Measuring the quality of dying and quality of care when dying in long-term care settings: a qualitative content analysis of available instruments. *J Pain Symptom Manage*. 2011;**42**:852–63.
5. De Roo ML, van der Steen, J. T., Galindo Garre, F., Van Den Noortgate, N., Onwuteaka-Philipsen, B. D., Deliens, L., EURO IMPACT. When do people with dementia die peacefully? An analysis of data collected prospectively in long-term care settings. *Palliative Medicine*. 2014;**28**:210–9.
6. Diaconu V, Ouellette, N., Camarda, C. G., Bourbeau, R. Insight on 'typical' longevity: An analysis of the modal lifespan by leading causes of death in Canada. *Demographic Research*. 2016; **35**:471–504.

OP-19

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

¹Aanjane Weerasinghe*, ²Taylan Gurgenci, ³Janet Hardy, ⁴Phillip Good. ¹Mater Health Services, St Vincent's Private Hospital, Brisbane, Australia; ²Mater Research Institute – University of Queensland, Brisbane, Australia; ³Mater Research Institute-University of Queensland, Brisbane, Australia; ⁴Mater Health Services, Mater Research Institute-University of Queensland, St Vincent's Private Hospital, Brisbane, Australia

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.

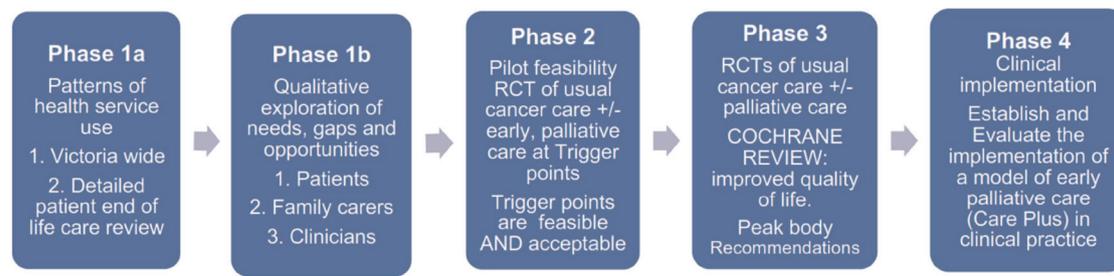
OP-20

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

^{1,2}Jennifer Philip, ¹Dalini Selvam*, ^{1,2}Farwa Rizvi, ^{1,2}Kylee Bellingham, ^{1,3}Brian Le. ¹The University of Melbourne, Parkville, Australia; ²St. Vincent's Hospital, Fitzroy, Australia; ³The Royal Melbourne Hospital, Parkville, Australia

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



Abstract OP-20 Figure 1 MRC framework process for complex interventions

variability of access impede translation of this evidence into practice.

Aim To describe the elements of Care Plus, an intervention designed to specifically address the barriers of early palliative care integration with oncology as a standard of care.

Methods Based on the Medical Research Council framework (figure 1) for the development and evaluation of complex interventions, data was collated from: phase 1 qualitative studies exploring patient, family and health professional views of palliative care, as well as statewide health service data mapping patterns of care; phase 2 pilot feasibility trials; and phase 3 randomised controlled trials to inform the Care Plus intervention. The intervention was then introduced as part of an implementation study across 4 hospitals in two Australian states.

Results The Care Plus intervention addresses the barriers to early palliative care by multiple strategies; (1) referrals were based on trigger points in the illness established in collaboration with referring clinicians; (2) the name Care Plus was used, and suggested language and training to support referrers to overcome stigma of palliative care; (3) Care Plus was positioned as ‘an extra layer of care’ and part of the routine high quality care pathway with an emphasis on family and carers; (4) efficient delivery of early palliative care at outpatient clinics alongside and integrated with regular cancer care delivery; (5) suggesting a ‘dose’ of a minimum number of consultations to address core palliative care tasks and establish relationships thereby facilitating future re-engagement when further complications or deterioration develops; and (6) timely case conference with usual General Practitioner, improving coordination and providing support to primary care.

Conclusion Through the incorporation of background evidence and engagement principles of implementation, Care Plus is an intervention designed to overcome the uncertainty and hesitation of introducing palliative care referral, and in turn, reduce the variation of timing and access to this form of care. The future integration of palliative care must now turn from demonstrating the benefits to the systematic implementation of models such as Care Plus, into real world practice.

Funding source NHMRC/MRFF Keeping Australians Out of Hospital Research Grant 1174028

* Presenting author

OP-21

INDICATORS OF PALLIATIVE CARE NEEDS AND OUTCOMES IN OLDER ADULTS ADMITTED TO HOSPITAL WITH HIP FRACTURES

¹Rachel Everitt, ¹Katherine Hauser*, ¹Samara Cua, ¹Marianne Wadsley, ²Catriona Parker, ^{1,2}Peter Poon. ¹Monash Health, Clayton, Australia; ²Monash University, Clayton, Australia

10.1136/spcare-2024-ANZSPM.21

Background Older patients admitted to hospital with traumatic hip fractures often have multiple co-morbidities and reported 30 day mortality of 8% and 12 month mortality of 25%.¹ This study aimed to investigate indicators of palliative care needs, frailty, referral to specialist palliative care and markers of quality end-of-life (EOL) care.

Methods Retrospective chart review of all patients aged >65 admitted to Monash Health with acute hip fracture between July 2022 and June 2023. Measures included demographics, Charlson Co-morbidity Index (CCI), Clinical Frailty Scale (CFS), Supportive and Palliative Care Indicators Tool (SPICT), advanced care directives and goals of care (GOC) documentation, referral to specialist palliative care and EOL care. Measures of quality of EOL care included appropriate GOC, prescribed pre-emptive medications and no inappropriate interventions. EOL medication doses (oral morphine equivalent dose [OMEDD] and midazolam) 2 days and 1 day prior to death were recorded.

Results 481 hip fracture admissions were reviewed. Patients had a median age of 83, 68% were female, 71% lived in private residence and 25% in residential aged care facilities (RACF) 77% spoke English as primary language. 26% were SPICT positive indicating palliative care needs, CFS mean was 4.9 (+1.6), indicating mild frailty and CCI mean was 5.4 (+2.2) indicating high risk for 1 year mortality. 13% had documented advanced care plans. Most patients (91%) had surgical management. Average length of stay was 10 days and majority were discharged to subacute (30%), rehabilitation (21%) or RACF (24%). 57% of those residing at home prior to admission returned home following subacute care. 30 day mortality was 7% and 12 month mortality at study end was 17%.

31 patients were referred to specialist care service, of whom 21 died and 6 were referred to a community palliative care service on discharge. Reasons for referral were EOL care (21%), symptom management (21%) and discharge planning (40%).

27 (5.6%) patients died during the acute admission and a further 5 (1%) died in subacute.

Of deaths in acute care the majority had palliative GOC (96%), families were informed (100%) and anticipatory medication prescribed (81%). Inappropriate interventions (antibiotics, ICU and blood products) were infrequent. Most died in acute ward (67%) and only 6 died in a palliative care unit. Mean doses of EOL medications 2 days before death were 56mg OMEDD and 11mg of midazolam. One day prior to death doses were 65mg OMEDD and 14mg midazolam. All families were informed of the death and GP’s were notified in 52%.

Discussion Older patients with hip fractures have frequent markers of palliative care needs and frailty. End-of-life care in