



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.

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OP-21 INDICATORS OF PALLIATIVE CARE NEEDS AND OUTCOMES IN OLDER ADULTS ADMITTED TO HOSPITAL WITH HIP FRACTURES

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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

hospital was high quality, excepting notification of GP's. Few were referred to community palliative care post discharge, indicating needs may have been under recognised or unmet in the community. These results reflect challenges of accessing specialist palliative care in the aging frail population.

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OP-22

MEASURING THE TRUE COST OF INFORMAL CANCER CAREGIVING: DEVELOPMENT OF A CO-DESIGNED ECONOMIC ASSESSMENT TOOL

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Background Recognised as the 'foundation of the palliative care workforce', informal caregivers disproportionately carry the burden of caring for patients with cancer, providing an estimated 75–90% of home-based care.¹ Current economic evaluations of health services and interventions are based on the benefits to the formal healthcare system, while the financial impact on informal caregivers is routinely overlooked. This lack of a societal approach precludes a more nuanced understanding of the drivers of burden experienced by caregivers and does not account for direct or indirect costs borne by caregivers, such as the impact on employment. To date, no standardised instrument exists to understand the economic impact of informal caregiving for cancer patients at the end-of-life.

Aim

1. To co-design a questionnaire that comprehensively captures the resources incurred by caregivers for cancer patients at the end-of-life
2. To assess its feasibility, acceptability and face validity.

Methods This is a qualitative study conducted in three phases:

1. Semi-structured interviews conducted with caregivers to explore the depth and breadth of resources used in day-to-day life. Supported by economic theory, themes were grouped into direct and indirect costs and broader themes identified inductively according to the principles outlined by Braun and Clarke.²
2. Questionnaire design by a community advisory group (CAG) comprised of caregivers and community-based clinicians using the findings from phase one, previous literature and lived experience.
3. Questionnaire piloting and psychometric testing using cognitive-interviewing techniques to assess its feasibility, acceptability and face validity

Results For caregivers of someone with cancer who has accessed palliative care, direct cost categories include home environment, food, equipment, medications, transport, health-care, insurance and funeral and faith-based costs. Indirect cost categories include carer time, family and friend time, employment absenteeism and presenteeism, own health impacts, and

leisure or opportunity costs. These categories informed the final questionnaire content, which consists of eight domains with 36 questions that meaningfully capture the economic impact of informal caring for cancer patients at the end-of-life. The initial pilot results have found the tool to be feasible, acceptable and valid.

Conclusions/Discussion This tool has the potential to shape how we value informal caregivers by contributing data informed by a societal perspective to future economic evaluations for provision of care in the palliative and end-of-life phase.

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OP-23

THEMATIC ANALYSIS OF THE EXPERIENCES OF HOME HOSPICE PROFESSIONALS WHEN COMMUNICATING WITH YOUNG CHILDREN OF TERMINALLY ILL PATIENTS

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Background Assisting young children when a parent faces a life-limiting illness presents significant challenges. Healthcare professionals play a crucial role in engaging them, and yet the impact of such interactions on the professionals themselves and their perceived ability to offer support remains unclear. The impact on home hospice professionals is even less understood, and yet they are more likely to interact with these children during their visits. They recognize the need to communicate with these children and address their needs, despite the delicacy of broaching the topic and potential challenges. Understanding the home hospice professionals' concerns is essential to enhance their capacity to provide effective support.

Objectives This study aimed to examine the experience of home hospice professionals when supporting the young children of terminally ill patients. We sought to understand the emotional and psychological impact of doing this work, and describe sources of strength and coping strategies.

Methods Semi-structured, in-depth interviews were conducted with 16 home hospice professionals who had supported patients with young children at home: 4 Doctors, 6 Nurses and 6 Psychosocial Support Professionals. The latter group consisted of 3 Medical Social Workers, 2 Art Therapists and 1 Spiritual Care Counsellor. Verbatim transcripts of recorded interviews were analyzed thematically.

Results Three themes emerged. First, the multidisciplinary team was a pillar of support, with members performing distinct roles. Art therapists and Medical Social Workers primarily attended to the children, with doctors and nurses tending more to the patient. Members supported each other, and more experienced colleagues provided supervision/advice. Collaboration with other institutions such as schools was also useful.