

**Discussion** To the best of our knowledge, this study is the first to explore specific clinical management outcomes in patients with PC need in the ED. It has highlighted the challenges faced in identifying and appropriately managing this cohort, early in their journey within the acute medical system. Areas for improvement include identification of these patients and careful clarification of their goals and wishes, and assessment and management of pain and other symptoms in the ED.

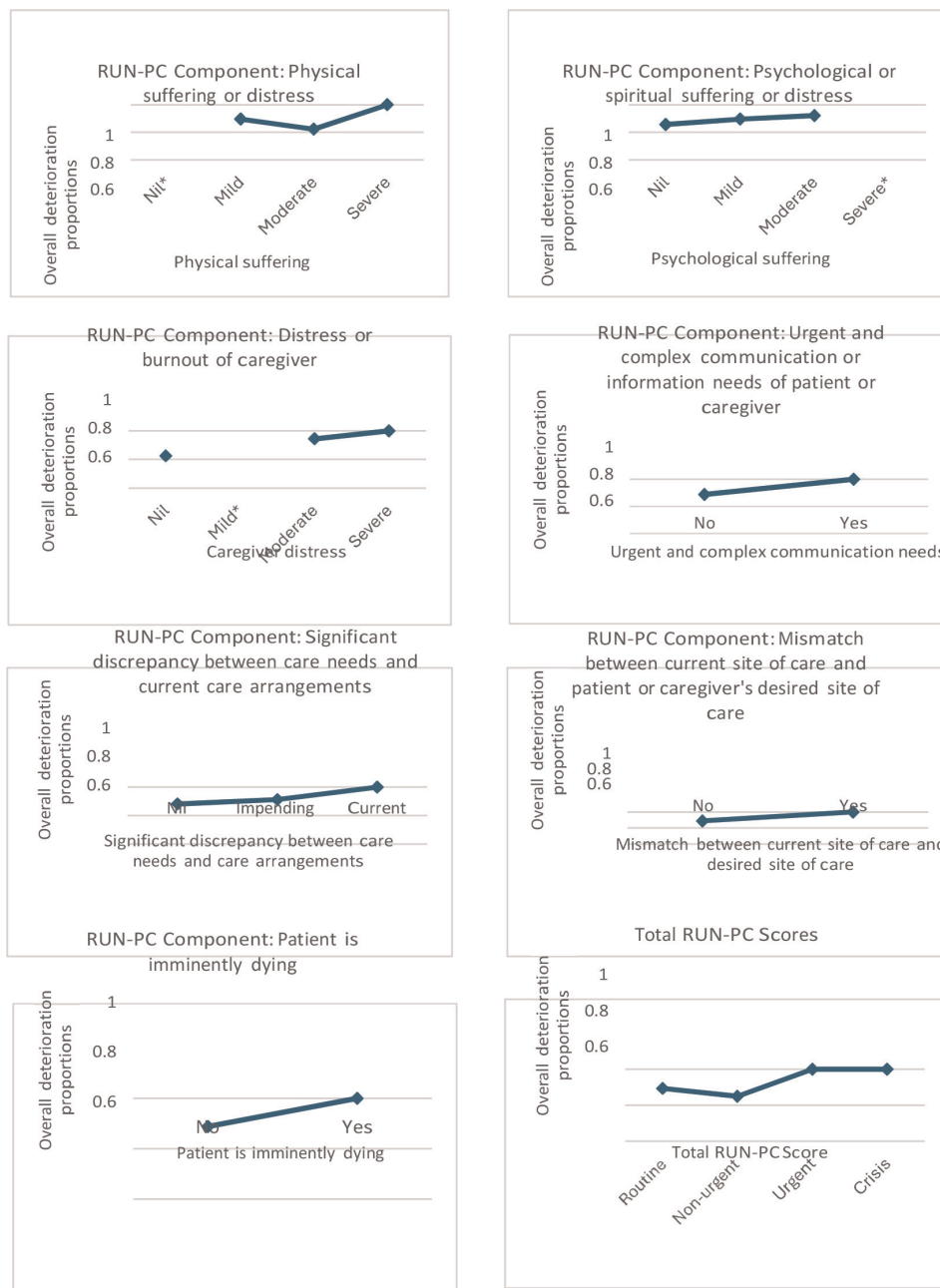
**Conclusion** A significant proportion of patients presenting to ED have palliative care need. Novel initiatives are required to improve the identification of these patients and subsequent clinician response.

**OP-3 RUN-PC TRIAGE TOOL IN SPECIALIST COMMUNITY PALLIATIVE CARE – A RETROSPECTIVE OBSERVATIONAL STUDY**

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**Background** Our specialist community palliative care service is a multidisciplinary service providing 24-hour care in the greater Newcastle area of New South Wales. With COVID-19 pandemic impacting our service, a triage tool become



**Abstract OP-3 Figure 1** Proportion of patients with overall deterioration in each RUN-PC component and total score category. (n = 90)

necessary to guide resource allocation. RUN-PC Triage Tool was identified as a validated triage tool during our scoping exercise. Therefore, an implementation pilot was conducted to evaluate the RUN-PC Triage Tool in our community palliative care setting.<sup>1</sup>

**Objective** To identify whether initial assessment occurring within the RUN-PC Triage Tool recommended timeframes impacts clinical deterioration risk, and to explore relationships between RUN-PC Triage Tool component scores and clinical deterioration.

**Methods** A retrospective observational study of community palliative care referrals from May 2021 to November 2021 at Calvary Mater Newcastle Community Palliative Care Service. Data was extracted from the electronic medical records and patients were dichotomised into two groups for analysis based on whether the initial assessment occurred within or outside the RUN-PC recommended response time (Group 1 and Group 2 respectively). Clinical deterioration was defined using five Palliative Care Outcomes Collaboration (PCOC) assessment tools as – a) an increase of score  $\geq 1$  in SAS, PSS and RUG-ADL; b) a decrease of score of  $\geq 10$  in AKPS; c) an adverse change of phase; or d) an emergency department presentation prior to initial assessment. The relationship between RUN-PC Triage Tool component scores and overall deterioration was explored visually.

**Results** A total of 337 referrals were reviewed, and 161 were excluded, primarily due to having no initial assessment ( $n = 83$ ). At baseline, Group 2 patients had significantly higher RUN-PC, PSS and SAS difficulty sleeping scores and were younger. There were also no patients in terminal phase at triage in both groups. Among the 176 patients included, there were no statistically significant differences in the overall clinical deterioration between the two groups using Fisher's exact test ( $p = 0.132$ ), with 89.1% in Group 1 and 80% in Group 2 experiencing deterioration (table 1). Among the 101 patients in Group 1, the proportion of overall clinical deterioration increased as the RUN-PC score increased in all individual RUN-PC Triage Tool components and in total RUN-PC scores, but this was not statistically examined (figure 1).

**Discussion** Although our findings suggest that implementation of this triage tool did not impact the deterioration outcome used in this study, the predictive value of RUN-PC components was observed. As a tertiary specialist palliative care service, it is likely that referrals were occasionally responded to without formal triage assessment and interventions were often implemented at triage for patients with acute distress. Our research during the COVID-19 pandemic provides further support for the implementation of clinical screening tools within a wider quality improvement framework. Further research could consider outcomes beyond deterioration and patients' and carers' experiences.

**Abstract OP-3 Table 1** Overall deterioration of group 1 and group 2

	Overall deterioration	No overall deterioration
Group 1, $n = 101$ (within recommended time)	90 (89.1%)	11 (10.9%)
Group 2, $n = 75$ (outside recommended time)	60 (80.0%)	15 (20.0%)
Fisher's exact test ( $p$ -value)		0.132

## REFERENCE

- Russell B, Philip J, Wawryk O, Vogrin S, Burchell J, Collins A, *et al.* Validation of the responding to urgency of need in palliative care (RUN-PC) triage tool. *Palliative Medicine* 2021;**35**(4):759–67.

Table 1 shows the overall deterioration between triage and initial assessment time points in Group 1 (seen within the recommended time) and Group 2 (seen outside the recommended time).

Figure 1 illustrates a positive trend towards higher baseline RUN-PC scores falling into increasing symptom severity categories.

OP-4

## CHARACTERISTICS OF PRIMARY BRAIN TUMOUR PATIENTS RECEIVING END-OF-LIFE CARE IN A QUATERNARY CANCER CARE HOSPITAL

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**Background** Patients with primary brain tumours experience challenging symptoms and benefit from timely specialist palliative care referral.<sup>1</sup> Prognosis is poor, particularly for high grade gliomas.<sup>1</sup> This study, the first of its kind to the author's knowledge, aims to assess the clinical characteristics, reasons for and timing of referral, symptom burden, multidisciplinary interventions and end-of-life medication utilisation in patients with primary brain tumours referred to palliative care who received end-of-life care in a quaternary cancer care hospital. This study also aims to explore the psychosocial impacts of primary brain cancer on patients and their carers.

**Methods** A retrospective review was conducted of patients with primary brain tumours referred to a palliative care service who died in a quaternary cancer care hospital between the period of March 2022 and May 2024 (at the time of submission). Data was collected from electronic medical records and paper medication charts with focus on the inpatient hospital admission where end-of-life care was provided. Descriptive statistics and thematic analysis were used to analyse preliminary clinical data.

**Results** At the time of submission, 13 patients met the inclusion criteria. At initial diagnosis, 11 patients had glioblastoma multiforme, one patient had grade II astrocytoma (grade III on subsequent recurrences) and one patient had stage III anaplastic oligodendroglioma. All patients were male. Median age at the time of death was 57 (range 35–81). Mean survival from the time of diagnosis was 11 months (range 2–24) for the patients with glioblastoma multiforme, whilst the two patients with lower grade tumours had survival times of 150 and 251 months. The reasons prompting final hospital admission were multifactorial, with functional decline the most common ( $N=9$ ). Patients were known to palliative care (either community or inpatient services) for a mean of six months (range 1 day–23 months) prior to death. Patients were usually referred to palliative care for management of physical symptoms ( $N=11$ ). At the time of inpatient palliative care referral, the median patient Australia-modified Karnofsky Performance Status was 30 (range 20–40). Progressive drowsiness, functional decline and gait disturbance were noted in all patients. Other frequently reported symptoms were fatigue ( $N=11$ ), delirium ( $N=8$ ), agitation/restlessness ( $N=8$ ), constipation ( $N=8$ ), headache ( $N=7$ ), nausea ( $N=5$ ) and seizures ( $N=5$ ). Regular opioids and benzodiazepines were used in all patients