

community or hospital-based palliative medicine services, and opportunities for future service development.

**Methods** This study is currently in progress. It follows a qualitative study design, using a phenomenological approach to data collection and analysis. The study is set within RACFs in metropolitan Melbourne. GPs responsible for providing end-of-life care to patients within RACFs are to be recruited, and will each participate in a semi-structured interview. Interviews will be audio-recorded, transcribed and coded using NVivo. Data analysis will be conducted iteratively through a constant, comparative approach until thematic saturation is achieved.

**Findings** Recruitment and data collection are currently underway and will be completed by July. Preliminary findings will be presented.

**Implications** It is expected that findings from this research will highlight the current experiences of Australian GPs delivering end-of-life care to older Australians living in RACFs. Results will illustrate the ways in which GPs interact with various services, including community and hospital palliative care teams in order to provide quality end-of-life care within RACFs. Study findings may also indicate opportunities for service optimisation, with a view to cultivating high quality and effective palliative care services for Australia's ageing population in future.

## REFERENCES

- Herrmann A, Carey ML, Zucca AC, Boyd LAP, Roberts BJ. Australian GPs' perceptions of barriers and enablers to best practice palliative care: a qualitative study. *BMC Palliative Care*. 2019;18(1):90.
- Australian Institute of Health and Welfare. Interfaces between aged care and health systems in Australia—where do older Australians die? Canberra: AIHW; 2021.
- Reed RL. Models of general practitioner services in residential aged care facilities. *Aust Fam Physician*. 2015;44(4):176–9.
- NSW Ministry of Health. End of Life and Palliative Care Framework 2019–2024, North Sydney: 2019.

### OP-42 INCIDENCE AND OUTCOMES OF FALLS IN AN INPATIENT PALLIATIVE CARE UNIT: A SINGLE-CENTRE RETROSPECTIVE STUDY

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**Background** Falls are the leading cause of hospitalisation and death due to injuries in Australia. Amongst hospitalised patients, falls are the most common safety incident and cause substantial concern among staff and families. Current Best Practice Guidelines for preventing falls in older people in Australian hospitals do not specifically address falls in palliative care settings. Identifying and managing falls risk in palliative care is crucial for maintaining healthcare standards and ensuring patient safety and quality of life.

**Objectives** The primary aim of this study was to determine the incidence of falls in an inpatient palliative care unit over a one-year period. Secondary aims included determining the outcomes of falls, characteristics of patients with falls, and the fall prevention interventions utilised.

**Methods** This retrospective cohort study examined falls by palliative care patients admitted to a 40 bed metropolitan palliative care inpatient unit (IPU) over a 12-month period. Falls were identified using the online incident reporting system and

patient characteristics, falls risk assessment and prevention measures was obtained through the electronic patient records.

**Results** A total of 525 individual patients were admitted to the IPU for 613 episodes of care, representing 10,536 bed days. There were 61 falls by 51 individual patients, yielding an incidence of 9.7 and the rate of falls was 5.8 falls per 1000 bed days for all admitted patients.

Falls occurred throughout the day, with more falls between midnight and 08:00. Most falls (93%) were unwitnessed. Half of the falls resulted in no injury, while the most common injuries were skin tears/abrasions and haematomas. Serious injuries such as fractures occurred in 1.6% of falls. Of the patients who fell, 41% died within one week post-fall.

Falls risk assessment was completed for 97% of patients at the time of the fall. Fall mitigation strategies were in place for 93% of falls, including bed rails, alarms, increased observation, education, assistance with toileting, and grip socks. Six falls (10%) involved patient refusal of fall mitigation strategies.

**Discussion** The fall rate in the IPU was 5.8 falls per 1000 bed days, the lowest reported for inpatient palliative care units. Compared to similar studies, this study had a large sample size and provided comprehensive data on falls incidence, prevalence, and rates. Most falls did not result in serious injury, and falls prevention strategies were widely implemented. However, the refusal of mitigation measures by some patients highlights the need for interventions that respect patient autonomy and dignity.

**Conclusion** This study provides valuable insights into falls in inpatient palliative care units, reporting an incidence of 9.7% and a rate of 5.8 falls per 1000 bed days. Falls prevention strategies must balance patient autonomy with safety and quality of life. Further research is needed to assess the effectiveness of interventions and gather patient and staff perspectives on falls prevention in palliative care settings.

### OP-43 LIVER SUPPORTIVE CARE – AN EMBEDDED SERVICE FOR CIRRHOTIC LIVER DISEASE AND HCC

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'Liver Supportive Care' is a multidisciplinary approach that integrates palliative care into the multidisciplinary team involved in the management of chronic liver disease, in order to improve the care of patients with chronic, end-stage liver disease with palliative care needs.

There is a growing body of evidence to support the integration of palliative care for patients with the growing burden of chronic liver disease and related complications, in particular patients with End Stage Liver Disease. Available evidence dictates that integration of health specialties with palliative care is associated with improved health outcomes including improved quality of life, quality of life care, decreased rates of depression, improved understanding of illness and improved patient satisfaction.<sup>1-3</sup>

We describe a new, embedded model of care at St George Hospital, Sydney. Patients who meet referral criteria (based on modified-SPICT criteria) with cirrhotic liver disease and/or HCC without curative intent, are referred to the Liver Supportive Care service. This encompasses a co-located clinic each week, with a Multi-Disciplinary team approach involving a

Palliative Care Physician (0.4FTE), Hepatologist, CNCs, Dietician and Social Worker. There is also a ward consult service which sees patients known to the service and accepts new referrals, who can then be followed up in the Outpatient Clinic on discharge. The service aims to manage symptoms of end stage liver disease, which are numerous and severe<sup>3</sup> and then seamlessly transfer patients to the community team for end of life care. Preliminary statistics show that over the 14 months from February 2023 to April 2024, we received 87 referrals to the service. There were 134 inpatient occasions of service, and 201 outpatient occasions of service.

68 patients had a diagnosis of HCC (with or without pre-existing cirrhotic liver disease), 20 had non-malignant cirrhotic liver disease, and 2 had cholangiocarcinoma. At time of submission, 41 patients had died and 10 had been discharged (1 due to successful transplantation). Of those who died, the mean time of referral to death was 72 days (range 3 – 322 days) with the majority (90.3%) expected and appropriately planned for. Just under half of the deaths occurred in a Palliative Care Unit, and 41.4% were known to the Community Palliative Care Team prior to death. Only 2 patients died without an Advance Care Plan in place, both of whom were referred at the beginning of the service.

## REFERENCES

1. Temel J S *et al.* Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal*. 2010.
2. Hui, D & Bruera, E. Models of integration of oncology and palliative care. *Annals of Palliative Medicine*. 2015.
3. Potosek MD *et al.* Integration of palliative care in end stage liver disease and liver transplantation. *Journal of Palliative Medicine*. 2014.

OP-44

## CARE PLUS – INTEGRATING EARLY PALLIATIVE CARE WITH MULTIPLE MYELOMA

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**Background** Patients with haematological malignancy frequently do not access palliative care, moreover, for those who do, access is frequently late in the illness.

**Aims** To understand the implementation of early palliative care integration for people with multiple myeloma across four cancer treatment centres in Victorian and South Australia.

**Methods** A stepped wedge, multi-site implementation clinical trial testing usual care (control) versus Care Plus (early palliative care integration as practice change) following the Consolidated Framework of Implementation Research. Care Plus (early palliative care) was introduced at a standardised point(s) in the illness, either at time of diagnosis or time of first relapse of multiple myeloma. Qualitative interviews with health professionals, patients and families were conducted to explore the implementation processes of Planning, Engagement, Practice Change and Evaluation across hospital sites. Interview transcripts were thematically analysed by making codes and categories with emerging themes. Consolidated criteria for Reporting Qualitative research guidelines were used to maintain rigour.

**Results** Nineteen semi-structured interviews via zoom referred to the care of people with multiple myeloma. These interviews involved haematologists (n=4), palliative care physicians (n=8), clinical nurses (n=3) and patients (n=4). Patients and

clinicians reported satisfaction with the implementation of Care Plus. Major themes included (1) benefits of standardised points for referral to early palliative care, (2) development of strategies for introducing early palliative care to patients and carers; (3) enhanced collaborative practice between haematology and palliative care teams; and (4) the time and value of exploring goals and planning for the future available with early palliative care including asymptomatic patients.

**Conclusions** Care Plus facilitated enhanced access to palliative care for patients with multiple myeloma including at time of diagnosis. For haematology clinicians this Care Plus model appeared to provide an opportunity to ‘re-imagine’ how palliative care may be delivered and the role it plays in patient care.

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OP-45

## TOOLS THAT CAN ASSIST IDENTIFYING THE MOST SUITABLE PATIENTS FOR BEST SUPPORTIVE CARE AND AVOIDING POOR DIALYSIS OUTCOMES

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**Aim** We investigated two prognostic tools, the Supportive and Palliative Care Indicators Tool (SPICT) and the Surprise Question (SQ) that may assist decision making on initiating chronic dialysis vs Best Supportive Care.

**Background** Older age, frailty and comorbidities negatively impact on dialysis outcomes. There is increasing concern that the burden and complications of dialysis may harm both quality-of-life and longevity in patients with limited life-expectancy. The SPICT has been validated for prognostication for the final year-of-life. The SQ, ‘Would I be surprised if this patient died in the next 12 months?’ If SQ positive, then the clinician is not surprised if the patient dies within 12 months. We applied both tools retrospectively on patients commencing dialysis to examine their potential to assist the decision-making around dialysis initiation, versus a Best Supportive Care without dialysis.

**Methods** A single centre retrospective cohort pilot study of consecutive dialysis patients from two periods January-February 2023 & August-September 2023 to study two separate groups one aimed at 12 months and the other at 6 months respectively following initiation of chronic dialysis. Demographics, SPICT criteria, SQ along with outcome measures including tertiary hospital admissions, dialysis complications and mortality to date were collected from their hospital e-medical file.

**Results** There were a total of 23 patients with mean age was 67.5 ± 12.3 years, 83% male. There were 52% SPICT positive (n=12) and 43% of patients were SQ-positive (n=10). SPICT-positive patients had more hospital presentations in both 6 month (2.4 vs 1.1, p=0.002) and 12 month (5.6 vs 1.7, p=0.0001) groups. SPICT-positivity was associated with dialysis complications with a relative risk ratio of 14.4x (95% CI 1.4 – 150.8).

By comparison, SQ-positivity had less statistically significant results but did trend in the same direction with more hospital