

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 severe³ 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.

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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

presentations in both the 6 month (2.4 vs 1.4, p value 0.35), and 12 month groups (4.6 vs 1.8, p value 0.07). Similarly, SQ positivity was associated with a relative risk ratio of 5x (95% CI 0.8 – 30.5) but did not reach statistical significance. All deaths were SPICT positive and SQ positive (n=2) with \geq 20% annualised mortality predicted by both tools.

Conclusions Positivity with both tools suggested poorer dialysis outcomes and predicted higher mortality. SPICT appeared better than SQ in terms of predicting complications arising from dialysis. The SPICT tool prognostication may assist with patient selection and shared decision making regarding chronic dialysis vs supportive care in end-stage renal failure.

OP-46 GUIDANCE TO BEST CARE: DEVELOPING A PATHWAY TO EARLY PALLIATIVE CARE FOR PEOPLE WITH PANCREATIC CANCER IN AUSTRALIA

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Background Pancreatic cancer is known for its late symptom onset, high pain burden and low survival rates. The management of pancreatic cancer requires a holistic approach to improve patient outcomes. The development of a clear referral pathway for early palliative care is crucial to improve the experience of patients with pancreatic cancer and their families.

Aim To develop an evidence-based and community-informed pathway, with associated clinical guidance and implementation plans, for early access to palliative care for people with pancreatic cancer.

Method The pathway development involved a longitudinal iterative approach. Literature reviews were conducted alongside extensive stakeholder and expert consultation with individuals (n=84) from all states and territories in Australia. A range of groups were represented including clinicians, consumers, peak body organisations, culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander communities. A deliberative dialogue approach was adopted to review existing evidence and was complemented by lived and clinical experience to shape the outcomes.

Results The referral pathway to early palliative care for people with pancreatic cancer was developed based on evidence and recommended best practice. It highlights the:

- referral to be triggered by diagnosis of unresectable disease for all patients
- importance of presence of palliative care representation at cancer multidisciplinary meetings
- role of cancer care coordinators to facilitate patient identification and referral to palliative care at any time according to needs, including prior to multidisciplinary meeting
- importance of screening for pain at each patient contact

- language around introducing early palliative care to patients to overcome barriers and fears
- role of outpatient consultation including by telehealth for people having anti-cancer treatment
- opportunity for stable patients to continue with anti-cancer care only after tasks of palliative care are assessed/addressed, with the understanding that the patient can link back into palliative care at future point when needs escalate
- smooth transition to community and inpatient palliative care as end of life nears.

Conclusion The National Pancreatic Cancer Roadmap, developed by Cancer Australia, set out work to establish standardised care pathway to early palliative care for people with pancreatic cancer, with accompanying clinical guidance at key stages of the pathway. The implementation of this pathway is the next step to provide equitable care and improve the experience of people affected by pancreatic cancer.

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OP-47 THE IMPACT OF AN EMBEDDED CARDIAC SUPPORTIVE CARE SERVICE ON ADMITTED CARDIOLOGY INPATIENTS IN A TERTIARY METROPOLITAN HOSPITAL – A SINGLE SITE OBSERVATIONAL STUDY AND DEATH REVIEW

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Background The National Heart Foundation and the Cardiac Society of Australia and New Zealand recommended referral to palliative care for all patients with advanced heart failure in 2018.

In 2020, a Cardiac Supportive care Service (CSCS) was developed, pairing a palliative medicine physician and a cardiology nurse practitioner to provide home based community visits to patients with heart failure. Patients were then reviewed on subsequent inpatient admissions. This embedded care model promotes bidirectional learning, trust and possible ‘fringe benefits’ to all patients with heart failure. This study aims to explore the impact of an CSCS on numbers of inpatient referrals, to describe this patient cohort and conduct a death review for cardiology inpatients pre and post the CSCS. **Methods** All inpatient referrals were prospectively collected for 12 months and compared to historical referral data. Demographics, previous referral to CSCS and rates of ceilings of care documentation and separations were collected.

All deaths admitted under the Cardiology Service in the year pre and 3 years post were reviewed. Deaths in the intensive care unit or cardiac catheter lab and perioperative deaths were excluded. Ceilings of care, delivery of cardiopulmonary resuscitation (CPR) and involvement with palliative care during the admission were recorded.

Results From June 2023- May 2024 there were 122 inpatient referrals to the CSCS. Compared an annual average of 34 referrals to palliative care (2010- 2020) and 56 in the first 12 months of CSCS. Mean age 83 years (37–102yr), 56% male and 22% (27/122) were known to the community CSCS prior. Ceilings of care were documented during the admission in 95%(116/122) and 26% (32/122) died during the admission.