

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.