

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.

This project is funded by Cancer Australia, National Pancreatic Cancer Roadmap – Delivery of early implementation priorities.

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.

The year prior to CSCS (2019) there were 21 ward deaths under cardiology with 24% (5/21) receiving CPR (mean age 85yrs (76–92yr)), 76% had documented ceilings of care and 66% were known to the palliative care service prior to death. Three years after CSCS began (2023), 8% (3/37) received CPR with the mean age of 63yrs (range 57–69yrs) All inpatients over the age of 75 years had documented ceilings of care, and 84% were known to CSCS or Palliative care prior to death.

Discussion The introduction of a community based CSCS has lead to a nearly 4 fold increase in cardiology inpatient referrals to CSCS/palliative care. The majority of these referrals were not previously known to CSCS and most had ceilings of care documented. When reviewing cardiology ward deaths pre and post CSCS, there was less CPR attempted, more ceilings of care documented and more CSCS/palliative care involvement prior to death following the introduction of CSCS.

OP-48

LIVER SUPPORTIVE CARE – UTILISATION OF PALLIATIVE CARE AND CARE COORDINATION TO IMPROVE OUTCOMES FOR LIVER DISEASE PATIENTS

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Background Advanced liver disease (ALD) poses significant challenges, including high symptom burden, frequent hospital readmissions, and complex care needs for patients. Traditional models delay palliative care until end-of-life stages or End-Stage Liver Disease (ESLD), often missing opportunities for earlier intervention, holistic approach to care and ‘unmet needs’ that could improve patient outcomes (Valery et al., 2015).

Aim The Liver Supportive Care program aimed to enhance the quality of life and health outcomes for patients with ALD with early integration of palliative care to manage symptoms, reducing hospital readmissions, and providing comprehensive, patient-centred care through a multidisciplinary approach.

Methods Patients were identified from the Royal North Shore Hospital (RNSH) liver clinic or during hospital admissions for decompensated liver episodes. Eligible patients, meeting the SPICt criteria, were enrolled in the Liver Supportive Care program. The program included:

- Early integration of palliative care
- Regular follow-up via telehealth consultations
- Weekly multidisciplinary team meetings (MDMs) involving hepatologists, nurses, dietitians, psychologists, and palliative care specialists to develop individualized patient care plans
- Patient reported outcome measures (PROMs) and quality of life assessments prior to palliative care reviews to tailor interventions

Results Since June 2023, the program has reduced 30-day readmissions from 42% to 12.12% and 90-day readmissions from 50% to 15.15%. With a clear discharge follow-up pathway, the program has reduced the average length of stay in hospital from 16.1 days (statewide) to approximately 4.6 days (within RNSH). Additionally, 48% of patients received early palliative care reviews, with 25% referred to community palliative care for ongoing management. Of the 18% of patients

that have deceased since being on the program, 50% of the patients were known to community palliative care teams and care was escalated to a palliative care unit for End-of-Life care (EOLC) or to an acute hospital for management of reversible causes. The program has achieved significant cost savings and improved patient outcomes by reducing readmission rates and improved linkage to community services, as appropriate.

Conclusion The Liver Supportive Care program demonstrates that early integration of palliative care and a multidisciplinary approach significantly improve health outcomes and reduce hospital readmissions for ALD patients. Its sustainable, scalable model offers a valuable framework for transforming chronic disease management, ensuring comprehensive and compassionate care that aligns with patient needs and healthcare efficiency.

REFERENCE

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Poster Presentations

P-1

WHAT ARE THE ELEMENTS OF A PALLIATIVE CARE INTERVENTION THAT HAVE A POSITIVE INFLUENCE ON OUTCOMES FOR PEOPLE WITH ADVANCED HEART FAILURE? DESIGNING THE IDEAL MODEL OF CARE

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People with advanced heart failure experience a poor quality of life, marked symptom burden and high mortality. With the increasing burden of disease, an aging population and limits to the availability of specialist palliative care teams to provide the necessary delivery of care, alternative models of care need to be considered.

We undertook a Systematic Review of the literature to inform the development of a Model of Care that could improve the care for people with advanced heart failure at the end of their lives, and to support the delivery of generalist palliative care for this vulnerable group of people.

Randomised controlled trials with keywords heart failure and palliative care were reviewed. Twenty-one papers were included. Salient features of care that were associated with improved quality of life and symptoms and a reduction in unplanned hospital admission include early follow-up from discharge, the intensity of the initial follow-up, coordination of care, clear communication and consistency of clinician input.

The barriers to enacting an effective palliative care approach include system issues, patient, and clinician factors.

Using Participatory Action Research and co-design between palliative care, cardiology and consumers, we are implementing a care package for people with advanced heart failure who have unmet needs. Critical to the success of this program will be identifying patients with unmet need and supporting the cardiology team to develop confidence and competence in initiating difficult conversations with people with advanced heart failure. The model of care and preliminary results will be presented at the conference.