

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

1. Valery PC, Powell E, Moses N, Volk ML, McPhail SM, Clark PJ, Martin J. Systematic review: unmet supportive care needs in people diagnosed with chronic liver disease. *BMJ Open* 2015;5(4):e007451. <https://doi.org/10.1136/bmjopen-2014-007451>

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.