

the differences between participants who considered MAiD but did not undergo the procedure and those who underwent a MAiD.

Methods We conducted a secondary analysis of decedent interview data from the Canadian Longitudinal Study on Aging (CLSA) in Canada. Next of kin and proxies of deceased CLSA participants were interviewed about end-of-life characteristics and MAiD considerations for participants who died between June 6, 2016, and March 15, 2022. We examined clinical and demographic characteristics and their association with considering MAiD compared to receiving MAiD. We conducted a descriptive analysis comparing non-MAiD deaths to MAiD-related deaths. Regression methods identified the association between demographic and EoL characteristics factors with consideration and reception of MAiD.

Results There was a total of 981 deceased participants with a completed decedent interview. Approximately 25.4% considered MAiD and 6.7% experienced MAiD. In both groups, most participants were male, married, and died of cancer. Considering MAiD was more likely if individuals died in hospice or palliative care (OR 1.73; CI 1.12–2.67), had health care or end-of-life arrangements (OR 1.75; CI 1.15–2.76), and experienced peace with dying (OR 1.87; CI 1.23–2.92). For those who had a MAiD, they were less likely receive palliative care, but had a better overall quality of death and dying experience. Individuals considering MAiD reported dying in place (64.7 vs 56.3; SD: 0.75) and peace with dying (78.3 vs 63.7; SD 0.77) more frequently than those who did not consider MAiD.

Discussion Given that more than a quarter of older adults are considering MAiD, honest and informed conversations between health care providers and patients regarding MAiD need to become a part of the EoL care planning process.⁴ Palliative care settings may offer effective symptom management and psychosocial support that may alleviate the need for MAiD. Considering MAiD as an end-of-life care pathway, even if not received, enhances the overall quality of the dying experience, by providing autonomy during the end-of-life decision-making process contributing to a positive death experience.^{5 6}

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P-5 PALLIATIVE SEDATION IN ADULTS ADMITTED IN A HOSPICE SETTING

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Introduction Palliative sedation(PS) is the monitored use of medications intended to induce a state of decreased or absent

awareness (unconsciousness) at the end of life(EOL) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health-care providers.^{1 2}

A hospice is a place designed to provide palliative care and emotional support to the terminally ill in homelike setting so that quality of life is maintained and family members and active participants in care. The hospice of this study is in Hyderabad and of 22 beds under Pain Relief and Palliative Care Society (PRPCS).

Aim To evaluate demographics, diagnosis, symptom needing PS, medications used and outcomes.

Methods Retrospective case-sheet study of a time period of 6 months (1/5/2023 to 30/11/2023)

Results During this time period, total 516 patients were admitted (with readmission); of which 16(3.1%) patients got palliative sedation. 8(50%) of 16 patients were having severe refractory dyspnoea, 6(37.5%) of them were with terminal restlessness, 2(12.5%) of them were with refractory pain. Out of 16 patients 2(12.5%) were admitted with non-cancer diagnosis. Only 1 patient discharged, 15(93.75%) of them passed away, all of them were peaceful death. Medications used will be discussed.

Conclusions A hospice relieves the burden of otherwise intractable suffering in EOL by means palliative sedation.

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P-6 DEMENTIA PALLIATIVE CARE IN AGED RESIDENTIAL CARE: A UNIQUE GRIEF

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Context Those living with dementia who require the specialist care environment of Aged Residential care find themselves facing loss, clinical challenges and relational complexities. Their reality results in a very unique grief. It is one that requires time and clinical acumen to help navigate. This presentation will explore both the complex and complicated grief associated with progressing dementia, and how our GP/NP shared care model with a team dedicated clinically to Aged Care alone can make a difference.

Objective To highlight the challenges of those living with dementia and emphasize the pivotal role the primary care provider has in patient outcomes and family grief experience during the disease and after their death. Using practitioners that focus only on Aged Residential Care, the palliative lense is stronger and addressed much earlier.

Discussion The dementia experience is one often mentioned but not talked about enough across all sectors of health. Navigating the significant and recurrent losses with the disease progression, with A known terminal end but unpredictable symptoms, palliative care provided in Aged Residential Care needs a specialist approach on a daily basis. Our model of care utilizes GPs and NPs who work primarily in Aged Care. This means we have been able to grow the palliative care support given across the trajectory of the dementia process. A comprehensive palliative care approach is required, but often