

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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PALLIATIVE SEDATION IN ADULTS ADMITTED IN A HOSPICE SETTING

Ritabrata Bandyopadhyay*, Gayatri Palat. *MNJIORCC, Hyderabad, India*

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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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DEMENTIA PALLIATIVE CARE IN AGED RESIDENTIAL CARE: A UNIQUE GRIEF

Anneke Barkwith*. *Hub Aged Care, Wellington, New Zealand*

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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

do not meet the referral criteria for a specialist palliative care service.

I would present on the shared care GP-NP clinic we have established, specializing in Aged Residential Care. With our daily practice dealing with dementia using a palliative care lense, we can improve patient outcomes and family experience. .

Summary This presentation will talk directly to advancing palliative care practice outside of the hospice setting, to improve the outcomes for the patients and populations we serve. It will be thought provoking and motivating to encourage a desire to grow our practice.

P-7 DEVELOPMENT OF A BEREAVEMENT SUPPORT MODEL AT AUSTIN HEALTH

Sarah Charlton*. *Austin Health, Heidelberg, Australia*

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Bereavement support encompasses the experience of family members and friends on a continuum, including the anticipatory, expectant, death and post-death periods. It is an essential element of high-quality end of life care (DHHS, 2016). Austin Health cares for approximately 1400 people per year who die as inpatients. We thank the North and West Palliative Care Consortium for funding this initiative.

We have developed an evidence-based bereavement support model to ensure a systematic approach to identifying and supporting the bereavement of families and carers of Austin Health patients. The model has a focus on sustainable bereavement support utilising existing resources (including community palliative care services when available) and targeting clinical resources to those in most need. The model includes a bereavement risk assessment tool, consumer resources, and the use of the validated Brief Grief Questionnaire (Shear et al., 2005). Consumers were an integral part of the steering committee.

Prior to death, the Bereavement Risk Assessment tool identifies factors contributing to both resilience and risk (based on Neimeyer et al., 2012). At the time of death, the patient's next of kin is allocated to either 'universal' or 'specialist' follow-up. Usual psychosocial assessment and care is provided at all times.

All next of kin are sent a bereavement card, hand-written and posted by volunteers, with information on supports available.

The specialist stream adds a telephone call to the next of kin from a trained clinician (most commonly a social or spiritual care worker) at about 12 weeks post death. At this point, the Bereavement Risk Assessment is repeated.

If ongoing risk of complicated grief is identified, a further telephone call is undertaken at 6 months. The Brief Grief Questionnaire is then used to formally screen for complicated grief. Usual psychosocial care is provided at both these time points, but if more support is required then the person is advised to seek external supports as appropriate, for example via their general practitioner.

The model has been implemented on the Palliative Care Unit and is being scaled up across the hospital. It has been well received by staff and bereaved families.

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P-8 IMPLEMENTATION OF A RAPID RESPONSE TEAM IN HOME PALLIATIVE CARE TO REDUCE INTERRUPTIONS IN HOME VISITS BY HOME CARE NURSES

Winnie Choo*, Poh Heng Chong, Zhi Zheng Yeo, Miao Lan, Xu Fen, Jodie Sin, Tan Joo Eng. *HCA Hospice Care, Singapore, Singapore*

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Background HCA Hospice (HCA) is Singapore's largest home hospice care provider, serving 3,600 patients annually. Patients with life-limiting illnesses with an estimated prognosis of less than a year are either seen in a day-care center, or visited at home at regular intervals by nurses, doctors, medical social workers and allied health workers.

The nurses are contactable by external stakeholders such as family members or other healthcare workers by phone during office hours on weekdays from 8.30am to 5.30pm. Phone calls after office hours are received by a call team of a nurse and doctor. The daily duties of a palliative home care nurse during office hours include calling patients to check symptom control, scheduling their visits and multi-disciplinary meetings. During home visits, they take history from the patient and family, perform physical examinations, perform procedures like the changing of feeding tubes and hold conversations with patients and other stakeholders.

Incoming calls during office hours were postulated to cause interruption and disruption to their work, leading to distraction, inefficiency, burnout and staff attrition. A team of four nurses and one doctor were assigned to be first responders to incoming phone calls to the home care nurses. This team receives phone calls that were diverted from the nurses. Phone calls from 30 home care nurses were diverted to the triage nurse team during office hours. The team was equipped with the necessary skills and knowledge to assess and address patient needs over the phone. Call diversion protocols were established to ensure timely and appropriate routing of calls to the triage team. If clinically warranted, the team would make video consultations or make home visits to the patient to manage the patients. Prior to this survey, the effectiveness of this system and its impact on the home care nurses was not studied.

Method Call logs and case notes between Nov 2023 – Apr 2024 are analysed to describe the frequency of calls and the outcomes following MediHELP support. Nursing staff were surveyed about their experience of work having diverted their calls. Qualitative and quantitative data are integrated to produce findings.

Results Preliminary data analysis found a reduction in the number of interruptions and stress experienced by home care nurses following the rapid response team's implementation. It remains to be seen if this system allows home care nurses to allocate more time and attention to direct patient care.

Conclusion The introduction of a rapid response team in a palliative home care service was effective in reducing