

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.

#### REFERENCES

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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

interruptions and stress in the schedules of home care nurses. Further research is warranted to evaluate the long-term impact of this medical innovation on patient outcomes and nurse satisfaction.

**P-9** **COMET PROJECT – INCREASING RESEARCH CAPABILITY AND ACCESS TO CLINICAL TRIALS FOR COMMUNITY-BASED PALLIATIVE CARE PATIENTS AND SERVICES**

<sup>1,2</sup>Lucy Demediuk. <sup>1</sup>Peter Maccallum Cancer Centre, Melbourne, Australia; <sup>2</sup>Alfred Health, Melbourne, Australia

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**Background** Despite caring for large numbers of people, the community palliative care sector is underrepresented in clinical research. People receiving community palliative care are frequently older, have significant needs for symptom relief and supportive care, find travel to treatment centres burdensome and are not being served by current systems of clinical trial delivery. However, when given the opportunity many community dwelling patients are highly engaged with clinical trials. Increasing access to clinical trials and research informed care has important outcomes both for the immediate care experiences of patients, and also for the improved care of future patients.

**Objectives** COMET (Community Supportive Care Trials Program) Program is a 3-year implementation program that commenced in 2022 to build a sustainable research and clinical trial program for patients and staff in community palliative care services in Victoria.

**Methods** The COMET project has adopted a multidimensional implementation approach informed by the RE-AIM (Reach Effectiveness Adoption Implementation Maintenance) implementation framework to build a sustainable research and clinical trial program for patients and staff. Key strategies adopted include:

- Research capacity building via education, training and provision of resources to community palliative care staff
- Development of a network of providers involved in clinical research, linking community palliative care services with clinical trials groups, and with other engaged community providers
- Establishing systems of eligible patient identification using existing data collection and service delivery structures
- Establishing systems of seamless referral to trial centres
- Creating accessible clinical trials, including in-home assessments and intervention

**Results** To date, the COMET project has successfully engaged with three metropolitan and two regional community palliative care services with plans to build further relationships in 2024. Successful implementation strategies have included: staff education workshops, distribution of resources with resulting increased research activity in the sector evident by patient identification, regular introduction to research by clinical staff and preliminary development of 'home grown' research ideas.

From a baseline of zero, since implementation of COMET staff have identified 124 potential patients for referral to clinical trials centre. Of these, 63 patients have been referred for consideration of eligibility. In total, through the project 13 patients have been part of a supportive care clinical trial.

A clinical trial of acupuncture for advanced cancer pain has been developed and will be run in 2024, it is an accessible trial for patients as some assessments and intervention will be offered in their homes.

**Conclusions** COMET is an implementation project still ongoing, that has already demonstrated effective strategies for improving staff and patient engagement with research in the community palliative sector in Victoria. Successful outcomes include increased research capability, patient clinical trial participation and established relationships between service providers. The success of this provides a framework and platform for wider implementation to better meet the unmet needs of the Australian community palliative care population.

**P-10** **A PILOT STUDY COMPARING THE DOSES OF END OF LIFE MEDICATIONS IN THE LAST 48 HOURS OF LIFE IN PATIENTS WITH CANCER IN THE ADOLESCENT AND YOUNG ADULT HOSPICE AND IN THE NEARBY ADULT PALLIATIVE CARE UNIT**

<sup>1,2,3</sup>Abigail Franklin\*, <sup>1</sup>John Coen. <sup>1</sup>Northern Sydney Local Health District, Manly, Australia; <sup>2</sup>Macquarie University, Sydney, Australia; <sup>3</sup>HammondCare, Sydney, Australia

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**Background and Objective** Anecdotal experience of palliative medicine physicians suggests that adolescent and young adult patients with cancer require higher doses of end-of-life medications, in comparison with older adults with cancer. This has been difficult to quantify given the paucity of specialist AYAH hospices. This information could aid in resource management for staff and medications.

This pilot study aimed to quantify the doses of end-of-life medications given over the last 48 hours of life in patients with cancer at the Adolescent and Young Adult Hospice (AYAH) in Manly, NSW and adults with cancer in the nearby located adult palliative care unit (PCU) at Mona Vale Hospital.

**Methods** A retrospective analysis of eMR (electronic medical records) medication charts was performed. Inclusion criteria were all patients who had died from cancer at AYAH since opening in February 2023. An equal number of the most recent patients to die at PCU from cancer were included.

Exclusion criteria were no diagnosis of cancer, died in the community, inpatient for under 48 hours. This identified 7 AYAH patients and 7 PCU patients.

Demographics including age, sex, diagnosis, renal function and liver function (LFT) were recorded. The total doses of the following medications were calculated and compared:

- Opioids (converted to morphine equivalents using MDCalc opioid conversion)
- Benzodiazepines (which were converted into oral midazolam equivalents using ClinCalc)
- Levomepromazine
- Phenobarbitone
- Dexamethasone
- Gabapentinoids (converted using a ratio of gabapentin: pregabalin 6:1)
- Lidocaine
- Ketamine

Average doses over the last 48 hours of life were calculated and compared.