

with higher IL-16 levels, although insignificant ($p=0.241$; p for interaction= 0.020). Morphine tended to provide a better analgesic effect than oxycodone in patients with the rs4778889 TT genotype and the rs17809012 AG/GG genotype ($n=45$), while a trend toward a better analgesic effect of oxycodone was observed in patients with other genotype combinations of the SNPs ($n=93$) ($p=0.001$ for interaction).

Discussion Our study suggests that IL-16 blood levels and polymorphism (rs4778889) may be useful as a possible biomarker for oxycodone selection. Only patients with IL-16 (rs4778889) TT and CCL11(rs17809012) AG/GG SNPs responded well to morphine, but only about 30% clinically (Japanese), suggesting that oxycodone may be superior for about 70% of patients. Combining these with IL-16 concentrations would further increase accuracy. It is hoped that a larger sample size will lead to the realization of personalized medicine for pain relief in the future through the revalidation of biomarker such as IL-16 identified in this study.

REFERENCES

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HARNESSING THE NEW NATIONAL PALLIATIVE CARE STANDARDS FOR ACCREDITATION EVIDENCE!

SHOWCASING THE UPDATED NATIONAL PALLIATIVE CARE STANDARDS FOR SPECIALIST PALLIATIVE CARE PROVIDERS 5.1 ED. (2024) AND THE SIMPLIFIED PALLIATIVE CARE SELF ASSESSMENT (PACSA) CHECKLISTS TO SUPPORT CONTINUOUS QUALITY IMPROVEMENT. HEAR HOW OTHERS ARE USING THE STANDARDS IN PRACTICE

Chelsea Menchin. *Palliative Care Australia, Canberra, Australia*

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Palliative Care Australia has been developing standards for more than 15 years to support the specialist palliative care sector to deliver high quality palliative care. A limited scope review conducted in 2023, led to two updates of the Quality Improvement Suite:

1. the introduction of the National Palliative Care Standards for Specialist Palliative Care Providers 5.1 ed. (2024) and
2. a series of downloadable checklist packs that support self-assessment against the revised Standards for clinical and service leadership teams.

The presenter aims to share with the audience the updates to the National Palliative Care Standards and how these were determined.

Utilising the newly launched PaCSA Checklist Packs (for self-assessment), the poster presenter will speak about the evidence collection that can be harnessed through this process to contribute to mandatory accreditation processes with the National Safety and Quality Health Service (NSQHS) Standards, the National Safety and Quality Primary and Community Healthcare Standards, and a range of other relevant Standards and Frameworks as they become available, such as the new Aged Care Standards.

Participants will be able to engage with the new National Palliative Care Standards for Specialist Palliative Care Providers 5.1 Ed. in new and more meaningful ways. The self assessment tools have been simplified to enable practical, timely responses to continuous quality improvement efforts, within the clinical setting and for professional development and service improvement innovations.

Continuous Quality Improvement, while a must within the health system, is often required to be addressed in clinical hours. PCA has listened to the needs of the sector and has established a program that fits within a variety of team or sole clinician settings, and has all the congruencies between other Standards and Frameworks mapped for you, to assist services to meet their QI requirements both within and outside the palliative care specialisation.

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DOES VOLUNTARY ASSISTED DYING IMPACT QUALITY PALLIATIVE CARE? A RETROSPECTIVE MIXED-METHOD STUDY

^{1,2}Natasha Michael, ¹Lucy Kernick, ^{3,4}David Jones, ^{1,2}David Kissane. ¹University of Notre Dame, Australia, Australia; ²Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Australia; ³Anscombe Bioethics Centre, UK; ⁴St Mary's University, Twickenham, UK

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Objectives We aimed to explore the relationship between the pursuit of Voluntary Assisted Dying (VAD) and the delivery of quality palliative care in an Australian state where VAD was newly available

Methods We adopted a retrospective convergent mixed-methods design to gather and interpret data from records of 141 patients who expressed an interest in and did or did not pursue VAD over two years. Findings were correlated against quality domains.

Results The mean patient age was 72.4 years, with the majority male, married/partnered, with a cancer diagnosis and identifying with no religion. A third had depression, anxiety or such symptoms, half were in the deteriorating phase, two thirds required help with self-care and 83.7% reported moderate/severe symptoms. Patients sought VAD because of a desire for autonomy (68.1%), actual suffering (57.4%) [existential more than physical], fear of future suffering (51.1%) and social concerns (22.0%). VAD enquiries impacted multiple quality domains, both enhancing or impeding whole person care, family caregiving and the palliative care team. Open communication promoted adherence to therapeutic options and whole person care and allowed for timely access to palliative care. Patients sought VAD over palliative care as a solution to suffering, with the withholding of information impacting therapeutic relationships. Our analysis ascertained that patients could fall into one of three categories: those open to exploring palliative care, those who were ambivalent about palliative care and VAD and those who were committed to pursuing VAD, regardless of palliative care involvement. Exploration of the fears, uncertainties, suffering and needs of these patients and families are critical clinical tasks. Palliative care practitioners are challenged to be companions to patients on each path, regardless of outcome.

Conclusions As legislation is expanded across jurisdictions, palliative care is challenged to accompany patients on their chosen path. Studies are necessary to explore how to ensure the quality of palliative care remains enhanced in those who