

P-39 INTEGRATING PATIENT-REPORTED OUTCOME MEASURES INTO SUPPORTIVE AND PALLIATIVE CARE TO FACILITATE HIGH-QUALITY PATIENT-CENTRED SUPPORTIVE CARE

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Background Patient-reported outcome measures [PROMS] are validated surveys which can enhance decision-making and guide clinicians to address patients' most pressing concerns. Increasing in use since the turn of the century, PROMS are employed to gauge patients' clinical outcomes including symptoms, health-related quality-of-life and functional status. In Australia, although PROMS have been widely used in community and inpatient settings as part of national dataset collection, they have had only limited utility in tertiary hospital palliative care outpatient clinical services. Given the rise of telehealth implementation in the COVID-19 pandemic environment, alongside increases in digital health tools in recent years, PROMS applied to virtual supportive and palliative care clinics may not only facilitate better understanding of patients' needs and improve communication but also provide a self-reporting approach to detect evolving issues between clinic appointments. This implementation project invited clinicians, patients, and family members with palliative care experience to co-design the implementation paradigm of an electronic PROM (ePROM) tool for use by oncology patients attending palliative care virtual clinics.

Aim To identify barriers and expectations of clinicians and consumers in introducing an e-PROM system into clinical settings and inform an implementation strategy.

Methods Convenience sampling and mixed data collection were applied. Focus group interviews with clinicians and verbal surveys with consumers were conducted. Both clinicians and consumers were sampled from Monash Health services. Focus group interviews were transcribed verbatim and analysed using thematic analysis. Descriptive statistics and content analysis were used to analyse the verbal survey. The Consolidated Framework for Implementation Research guided the identification of key theme and code categories, as well as outline the implementation strategy.

Results Nine clinicians and 14 consumers participated. Qualitative data of both target groups was found to be saturated. While all participants expressed a readiness to use e-PROMs, barriers associated with clinical resources, such as a lack of administrative/clinical liaison support as well as patients' characteristics, such as age, language, and technical literacy were identified. Developing a procedural guideline that delineates the process, purpose and goal of e-PROM usage and identifying a clinical liaison role are significant for the implementation phase.

Conclusion Ensuring the involvement of clinicians and consumers is critical in developing approaches to address identified barriers for ePROMs. Considering participants as 'quasi-researchers' is impactful in co-ordinating/providing/delivering a safe and consumer-focused ePROM implementation. The findings of this research will facilitate a feasible ePROMS paradigm for use by oncology patients attending palliative care virtual clinics, with the potential of improved patient-centred care in the age of digital health tools.

P-40 A SURVEY EXPLORING CURRENT PRACTICE IN OPIOID PRESCRIBING FOR CANCER PAIN BY PALLIATIVE CARE, MEDICAL ONCOLOGY AND GENERAL PRACTICE SPECIALISTS IN AUSTRALIA AND NEW ZEALAND

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Background Pain is common amongst cancer patients and is often undertreated. Over the past 30 years the use of opioids has proven an effective treatment, with multiple evidence-based guidelines available. Increasingly, barriers to prescribing opioids have been described both internationally and within Australia and New Zealand, including the supply, availability and access to various opioids.

Objectives This study aimed to describe current practice in opioid prescribing for cancer pain by Palliative Care, Medical Oncology and General Practice clinicians in Australia and New Zealand; identify factors that influence prescribing of opioids; and explore how supply issues have impacted opioid prescribing.

Methods Invitations were circulated via peak bodies to participate in a cross-sectional survey administered online (Qualtrics).

Results 114 doctors responded to the survey (85 Australia, 29 New Zealand). 100 worked in Palliative care, 5 in Medical Oncology, and 13 in General Practice. Morphine and oxycodone were the most commonly prescribed long-acting opioids for cancer pain in both Australia and New Zealand. The most common reasons for selection were availability, cost, and alignment with colleagues' practice. Most clinicians rarely used weak opioids in the management of cancer pain. There was a high level of experience and self-reported knowledge in prescribing opioids. Factors influencing opioid prescribing included current restrictions in prescribing (85.8%), and potential side effects (82.1%), while only around 25% of clinicians were concerned about addiction or about professional/legal repercussions. When selecting background opioids the patient-factors considered were: mechanism of pain (91.5%), renal function (92.5%) and routes of medication available (92.5%), with the least important factors being marketing (0%) and stigma regarding opioids (31.1%). The most likely factors to trigger opioid rotation were intolerable side effects (100%), inadequate analgesia (99%), and mode of delivery (98.1%). When rotating opioids for cancer pain, most clinicians relied on their own knowledge (91.4%) and/or sought advice from colleagues (54.8%), while only 27.9% sought advice from pharmacists. The most frequently used guidelines were the Palliative Care Formulary, ANZCA opioid calculator and local guidelines. 74.8% of Australian clinicians reported that the supply/availability of opioids impacted their practice last year (2023). Of those, 92.2% report having to choose a less preferred opioid option. Hydromorphone (both long and short-acting) was the most commonly reported medication impacted by availability. Clinicians described wanting to use hydromorphone as a rotation option due to its effectiveness, potency, and particularly for use in patients with renal impairment. Almost all Australian clinicians agreed stronger government policy is needed for consistent opioid supply.

Conclusion Opioid prescribing for cancer pain was largely mechanistic, highly influenced by cost and availability of medications. Despite differences in the availability of opioids in

New Zealand and Australia, the most commonly prescribed options were similar. Opioid supply issues are impacting the evidence-based practice of experienced clinicians in Australia and New Zealand. Constructing stronger government policy is recommended for the ongoing safety and efficacy of cancer pain management.

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CALCIPHYLAXIS AND PALLIATIVE CARE. COMPLEX SYMPTOMS, TREATMENT SIDE EFFECTS AND CHOOSING THE OPTIMAL MODEL OF SUPPORTIVE CARE. A CASE STUDY AND DISCUSSION

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Calciophylaxis, or calcific uraemic arteriopathy (CUA), is a clinical syndrome usually associated with advanced renal disease, which is characterized by vascular calcification and the development of painful ischaemic ulcers. It is a rare disease, with an incidence of only 4.5 cases per 1000 patient-years on dialysis (Toussaint et al 2024). Diagnosis generally implies a poor prognosis, with an overall mortality of approximately 50 per cent at six months (McCarthy et al 2016). Calciophylaxis also causes significant symptom burden, with painful skin lesions requiring a specialised approach to analgesia. Treatments are limited and can result in adverse side effects. Despite its poor prognosis and significant symptom burden, only a minority of patients diagnosed with calciophylaxis are referred for specialist palliative care (Gaster et al 2021).

We present a case of a 53-year-old female with previous renal transplant, admitted to Monash Health, Melbourne with non-uraemic calciophylaxis. She was referred to our specialist palliative care consult service for management of complex disease and treatment-related symptoms. Ischaemic wound pain in calciophylaxis is well described, and our patient required multiple analgesic agents to achieve adequate pain relief. However, her most burdensome symptom was severe nausea and vomiting, which related to sodium thiosulfate infusions – one of few recognized treatments for the disease.

After failing first and second-line anti-emetics, a levomepromazine infusion enabled adequate tolerance of sodium thiosulfate treatment. She was transitioned from levomepromazine to intermittent doses of oral olanzapine, administered as pre-medication to therapy. Once she achieved a treatment response, she was discharged home, returning for maintenance therapy with intermittent sodium thiosulfate infusions administered as an outpatient, in a day-clinic infusion setting. At this time, her palliative care was transitioned to our Monash Hospital-in-the-Home Palliative Care (HITH PC) team. At the time of writing, sodium thiosulfate infusions have continued for over 6 months, with an enduring response, well tolerated with the above premedication regime.

Traditional community palliative care models were not well equipped to meet this patient's needs. Her uncertain prognosis, and active goals of care, precluded a solely symptom-based focus. Her medical complexity and the interplay between supportive and active care (with frequent nephrology intervention) also meant that consolidating treatment teams within the one health service offered the best continuity of care. Our HITH PC service provided a transformative model to deliver specialist palliative care interventions as required.

Our case highlights the role of specialist palliative care working in novel ways, alongside nephrologists in providing optimal symptom management to manage the complex symptom burden associated with calciophylaxis and its treatments.

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HITH PALLIATIVE CARE – BRIDGING GAPS BETWEEN TRADITIONAL COMMUNITY AND INPATIENT PALLIATIVE CARE MODELS

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Community palliative care (CPC) services provide a comprehensive service to many patients with life limiting conditions. Factors which may challenge traditional community models include responding to same-day requests for admissions, admitting clients who wish to pursue active treatment alongside symptom management and managing patients who have complex treatment plans whose care is still overseen by hospital-based specialists. Another recognised challenge is communication between hospital and community providers, particularly during acute admissions. This is important for optimal transition of care both on admission and when patients return home. In response to these challenges, Monash Health developed a Hospital-In-The-Home Palliative Care (HITH PC) service with dedicated palliative medicine specialist EFT and additional consult support from our RAPID palliative care team. This service aims to overcome deficiencies in traditional models, and support patients to receive specialist palliative care acutely in the community setting when desired.

Our HITH PC model provides outreach care to varied patient cohorts. Our largest cohort includes patients with recurrent pleural effusions and ascites, requiring frequent drainage via indwelling Rocket and PleurX drains. These patients receive regular visits from HITH nursing staff for drainage of pleural effusions and ascites, as well as specialist palliative care which is provided via a telehealth model. Many of these patients are jointly managed with CPC, and their care is discussed at a weekly HITH PC MDT. A second HITH PC model is delivering continuous subcutaneous infusions of palliative care medications when required for optimal symptom management or end of life care. This service supports patients to be discharged from hospital earlier, and avoids unnecessary ED and acute hospital presentations. Deteriorating RACF patients with unstable symptoms can be admitted same-day to our service for urgent assessment and initiation of care, whilst awaiting transition to traditional CPC models. HITH PC is also able to oversee complex cancer pain management, involving opioid rotations or titration guided by palliative medicine in a bed-substitution model of care.

A key initiative is our weekly HITH Palliative Care Multi-disciplinary Discussion Team Meeting (MDT). This meeting is attended by medical, nursing and allied health staff from Monash Health HITH and Palliative Care teams, as well as clinical representatives from our regional CPC services. It enables direct and regular discussion of joint clients, to optimise handover and ensure seamless transition of care between services. Having evolved during the COVID-19 pandemic, a period of transformation in community care provision, this meeting is now an established part of our usual care.