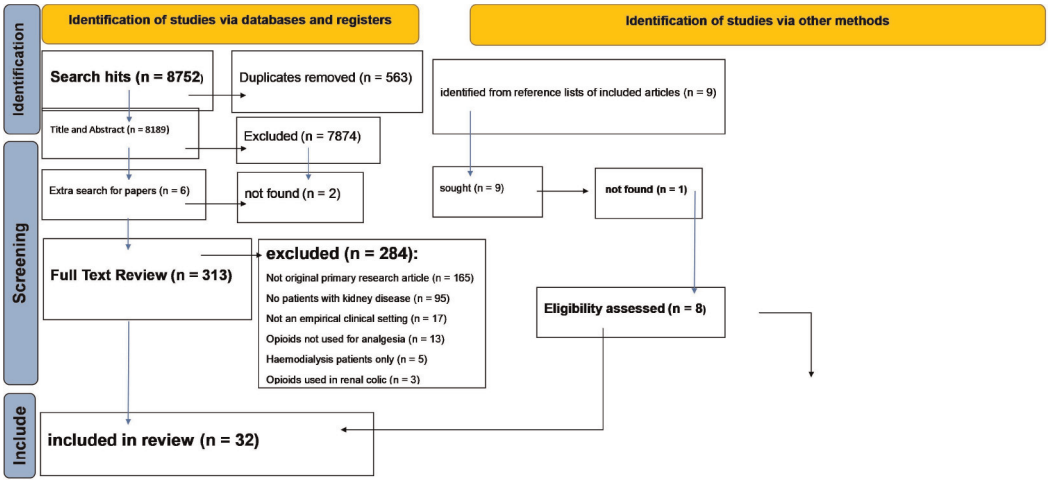

Abstract P-44 Figure 1

outcomes associated with the use of different opioids and opioid doses in kidney disease are warranted.

P-45 TAKE HEART – LESSONS LEARNT FROM DEVELOPING A CARDIAC SUPPORTIVE CARE SERVICE

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Background Guidelines published in 2018, from the National Heart Foundation and the Cardiac society of Australia and New Zealand, recommend early palliative care referral for patients with advanced heart failure.[1] However, there is a gap for this population accessing traditional palliative care services. A Cardiac Supportive Care Service (CSCS) was introduced at a tertiary metropolitan hospital in early 2020.

Population Patients with end-stage heart failure (ESHF) are eligible for referral to CSCS following a heart failure admission to the acute hospital or a positive result on the Supportive and Palliative Care Indicators (SPICT) tool for breathlessness or chest pain at rest or on minimal exertion or as a direct referral from a cardiologist.

Aims The CSCS aims to provide symptom assessment and management, provision of breathlessness action plans, and advance care planning discussions. Patients are offered a seamless transition to traditional community palliative care services and direct access to inpatient palliative care unit.

Model The integrated CSCS offered initial home visits from a palliative care physician and heart failure nurse practitioner. Follow up home visits conducted by the nurse practitioner, with the palliative care physician as required. Readmissions to an acute hospital occurred under the treating cardiologist, with the palliative care physician providing inpatient consultations. Admissions to the Palliative Care Unit for symptom management or end-of-life care occurred under the care of the palliative care physician. In 2023, the model was extended to include a monthly collocated clinic in the cardiology outpatients by the palliative care physician using the same referral criteria, with 2–3 monthly follow up visits.

Results and lessons learnt Over 225 new patients have been seen by the community and clinic CSCS. The service has strengthened the relationships between cardiology and palliative care. The following outlines some of the key learnings to be discussed.

1. Barriers and enablers to developing an embedded care service
2. Symptom burden, prognosis and the relationship to ejection fraction in ESHF
3. Impact of the CSCS on place of death and hospitalizations.
4. The use of opiates and benzodiazepines in cardiac breathlessness.
5. Fluid balance and use of diuretics on referral and when entering the terminal phase with ESHF
6. Challenges in advance care planning and deactivation of defibrillators
7. Flow on effects of embedded care service to cardiology inpatient referrals to CSCS and palliative care services and documentation of ceilings of care.

Conclusion The development of a CSCS has resulted in early provision of supportive care to patients with ESHF in line with the guidelines and has allowed seamless transition to traditional palliative care services. The bidirectional learning has increased the skill base of both cardiology and palliative care clinicians and has seen fringe benefits for all cardiology inpatients. The model has been replicated across the Local Health District and continues to grow.

REFERENCE

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P-46 SUPPORTIVE CARE SERVICE: A MULTIDISCIPLINARY APPROACH TO MANAGING CHRONIC ILLNESS IN THE LAST 24 MONTHS OF LIFE

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Background Approximately 70% of deaths in Australia are due to non-malignant illnesses, however, only 25% of these patients receive palliative care input according to Palliative Care Outcomes Collaborative data. This highlights a significant