

of open communication and to establish a psychologically safe space. Key elements of mindfulness, such as non-attachment, equanimity and non-reactivity, are referenced and modelled during class discussions, as these have been observed to be particularly relevant to the field of palliative care, where burn-out and empathy fatigue can be particularly challenging and intimidating to new hires.

Summary of Results The feedback received from our new hires was overwhelmingly positive in favour of the group-based training format. Cultivating a safe space wherein new nurses could bring their doubts and queries was a clear positive point, with some stating that it was less stressful than having to report all activities to a single mentor. Multiple new hires reported that the prospect of having a safe space to return to regularly, during the transition from supervised to independent practice, was validating and reassuring.

Discussion and Conclusion The group-based discussion uses tools similar to those employed in group therapy. It has proven useful in allowing individuals to better reflect on their learning and to process issues specific to palliative care, such as transference from a grieving caregiver or empathy fatigue.

Take-Home Message The challenges of home hospice care are manifold, and the training of new staff must include holistic development of the person alongside their clinical skills. Employing a group-based format cultivates a strong sense of belonging and trust that facilitates reflective and collaborative learning. Creating a workplace culture that normalises staff learning from each other, given the heterogeneity of our training backgrounds and experiences, improves the tendency for prosocial thinking and behaviours and fosters open communication and interpersonal respect at work.

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BLOOD TRANSFUSION DEPENDENCE & FUTILITY – A CASE DISCUSSION

Jason Tay, Singapore General Hospital, Singapore, Singapore

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Introduction The decision to deliver transfusions to patients who are receiving palliative care is complex, where they may be of variable benefit especially towards the end of life. We describe a case of a gentleman with metastatic castrate resistant prostate cancer presenting with non-resolving active bleeding gastrointestinal tract, and discuss the ethical considerations attached to the issue of continued blood transfusions in the palliative setting.

Case Report Mr W is a 67-year-old Chinese male with CRPC that progressed despite anti-androgen therapy, bilateral orchidectomy and radiotherapy. He presented with melena and a haemoglobin level of 3.9g/dL. He was started on proton-pump inhibitors and red blood cells transfusions. He remained comfortable throughout his admission. His condition was complicated by a NSTEMI, urinary tract infection and acute kidney injury. He was reviewed by Cardiology who deemed him not a suitable candidate for cardiac interventions nor anti platelet therapy in view of his active BGIT.

His echocardiography revealed a reduced ejection fraction of 37%; he developed fluid overload and required intravenous diuresis. He was assessed to be a high risk for esophagogastro-duodenoscopy considering his NSTEMI. He remained ambivalent when broached about continuation of blood transfusions, while his family felt that withholding transfusions was akin to ‘giving up’. Mr W continued to have daily melena and was

MEDICAL INDICATIONS	PATIENT PREFERENCES
<p>Beneficence and Nonmaleficence</p> <ul style="list-style-type: none"> • What is the patient’s medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided? 	<p>Respect for Patient Autonomy</p> <ul style="list-style-type: none"> • Is the patient mentally capable and legally competent? Is there evidence of capacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information, and given consent? • If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? • Has the patient expressed prior preferences (eg, advance directives)? • Is the patient unwilling or unable to cooperate with medical treatment? If so, why? • In sum, is the patient’s right to choose being respected to the extent possible in ethics and law?
QUALITY OF LIFE	CONTEXTUAL FEATURES
<p>Beneficence, Nonmaleficence, and Respect for Patient Autonomy</p> <ul style="list-style-type: none"> • What are the prospects, with or without treatment, for a return to normal life? • What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? • Are there biases that might prejudice the provider’s evaluation of the patient’s quality of life? • Is the patient’s present or future condition such that his or her continued life might be judged as undesirable? • Is there any plan and rationale to forgo treatment? • Are there plans for comfort and palliative care? 	<p>Loyalty and Fairness</p> <ul style="list-style-type: none"> • Are there family issues that might influence treatment decisions? • Are there provider (physician, nurse) issues that might influence treatment decisions? • Are there financial and economic factors? • Are there religious or cultural factors? • Are there limits on confidentiality? • Are there problems of allocation of resources? • How does the law affect treatment decisions? • Is clinical research or teaching involved? • Is there any conflict of interest on the part of the providers or the institution?

Abstract P-51 Figure 1

supported with blood transfusions every other day, to pace with family members to come to acceptance. Eventually they were agreeable with the medical recommendation to discontinue further blood transfusions and he was discharged back home with home hospice support.

Discussion This case raises the ethical dilemma of blood transfusions despite medical futility, while balancing the family's maintenance of hope. The Jonsen's Four Box Method (figure 1)¹ enables physicians to navigate a holistic approach.

In Mr W's case, it was recommended that repeated blood transfusions be withheld. There were no alternative curative interventions for his active bleeding that could be taken upon safely, and the low chances of a spontaneous recovery weighed significantly less against the increasing harm of worsening fluid overload. He remained comfortable and symptom-derived benefits from transfusions were negligible; fatigue and reduced activity are nonspecific symptoms and are often considered insufficient reasons for transfusion. In addition, the presence of his life-limiting metastatic CRPC, ongoing functional decline, and infective complications already portends a poor prognosis. Further prolongation of hospitalisation with repeated intravenous cannulation was not in keeping with quality of life to him. Offering a trial of therapy, with clearly defined end-points, to demonstrate medical futility facilitates acceptance of the circumstance and aligns eventual goals of care. It is imperative that physicians provide families with accurate, current, and frequent prognostic estimates throughout the course of the illness. There is a need to address the emotional needs of the family to understand the problems from the family's perspective by being available, approachable, and compassionate.

REFERENCE

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END-OF-LIFE CARE QUALITY FOR VULNERABLE POPULATIONS IN AUSTRALIA: THE COMMUNITY PERSPECTIVE

Jessica Vereker, Catriona Parker, Peter Poon. *Monash University, Clayton, Australia*

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Background Vulnerable populations are highlighted across Australian national palliative care (PC) and end-of-life care (EOLC) documents to increase care equity and inclusivity; however, there are disparities in listed populations across these documents, and justification of inclusion is limited. This narrative review aims to describe current literature about the EOLC experiences of the vulnerable populations listed across these care-influencing documents from the community perspective (comprising the perspectives of decedents, family members and caregivers).

Methods Separate literature searches were conducted for the fifteen vulnerable populations identified across three key national EOLC documents (Palliative Care Standards 2018, the Australian Government Department of Health's 'Exploratory Analysis of Barriers to Palliative Care' and the National Consensus Statement on 'Essential Elements for Safe and High-Quality End-of-Life Care'). Eight vulnerable populations were included for discussion as their searches returned one or more relevant articles. As the literature was almost entirely descriptive, a concept-based approach was used to describe the

EOLC experiences of included populations. Concepts were synthesised from key and recurring topics throughout the literature.

Results Agency and communication were critical areas for improvement amongst all included vulnerable populations. Concepts identified for the eight vulnerable groups included were as follows: for people living in rural and remote settings, concepts included EOLC designed for metropolitan settings, limitations of local services and interventions in rural communities; for people with dementia concepts included comfort of people with dementia, carer experiences and access to PC; for people with culturally and linguistically diverse backgrounds concepts included culture and decision-making, balancing death taboo and advance care planning discussions and trust in the healthcare system; for people living in residential aged care facilities (RACFs) concepts included advanced care planning in RACFs, place of death preference vs reality and inclusivity of RACFs; for Aboriginal and Torres Strait Islander Peoples concepts included fear of relocation to receive EOLC, culturally competent communication and resources and access to services in the community; for people who identify as lesbian, gay, bisexual or transgender (LGBT) concepts included expressing sexuality and gender identity, social isolation of people who identify as LGBT and substitute decision-makers and legal rights for people who identify as LGBT; for people living with disabilities concepts included access to disability-inclusive services, discrimination by healthcare professionals and disability support workforce and family limitations; for people experiencing incarceration concepts included balancing risk vs humanity and entitlements and inaccessible agency.

Implications Although enablers were identified throughout the literature, there was a predominant focus on barriers and negative experiences, perhaps speaking to the cumulative narrative for vulnerable populations. Evidence describing the experiences of the community was limited, with many studies conducted over twenty years ago, which illustrates a significant literature gap. Further research describing community experiences of EOLC across a broader range of settings for all identified populations is needed to inform future EOLC initiatives and standards and may assist in determining an accepted set of vulnerable populations across guidelines.

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QUALITATIVE EXPLORATION OF GYNAECOLOGY ONCOLOGISTS' VIEWS AND UNDERSTANDING OF PALLIATIVE CARE

¹Carolyn Wicks, ²Heidi Gregory, ¹Farwa Rizvi, ³Adam Pendlebury. ¹St Vincent's Hospital Melbourne, Fitzroy, Australia; ²Austin Health, Heidelberg, Australia; ³Mercy Hospital for Women, Heidelberg, Australia

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Background Patients with advanced gynaecological cancers have high symptom burden and supportive care needs and have traditionally had little and delayed involvement with specialist palliative care.

Aim This qualitative study explores the views and experiences of consultant gynaecological-oncologists and their trainees in managing advanced gynaecological cancers, providing generalist palliative care (with a specific focus on symptom profile and end of life care), as well as reflecting on their interactions with palliative care services in an Australian healthcare setting.

Methodology All gynaecological-oncology specialists and fellows working and training in the state of Victoria, Australia