

between November 2022 and July 2023 were approached to participate in semi-structured, face-to-face interviews. A reflexive thematic analysis approach guided the data analysis.

Results Fifteen clinicians participated in the study. Four themes were derived from the qualitative data set – the evolution of the role of gynaecological-oncologist in advanced cancer from a more ‘holistic’ care provider to being ‘the surgical person or assessment decision maker’; the challenges of symptom management; the importance and challenges of difficult communication tasks, and how different models of care influenced the involvement of palliative care services.

Conclusion Both gynaecological-oncology specialists and fellows described a role for palliative care involvement in symptom management. They highlighted personal and institutional preferences for the management of all patients approaching end of life to be undertaken by specialist palliative care teams. Participants discussed the many communication tasks they undertook and how specific training could improve their skill-set in this area. Palliative care integration with gynaecological-oncology care is service dependent, which has implications for future service planning.

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PATIENT AND CAREGIVER PERSPECTIVES OF AN INTEGRATED SCLERODERMA AND PALLIATIVE CARE SERVICE: A QUALITATIVE STUDY

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Background St Vincent's Hospital Melbourne cares for the largest cohort of patients with scleroderma (also referred to as systemic sclerosis) in Australia, and physicians recognised potential unmet supportive and palliative care needs of patients and their caregivers. In response, a pilot integrated palliative care outpatient clinic (the Scleroderma Supportive Care Service (SSCS)) was commenced, collocated within the usual rheumatologist-run Scleroderma Clinic.

Aim This qualitative study explored patient and caregiver satisfaction of the SSCS. It aimed to identify what interventions were perceived as helpful and if further modification of the pilot clinic was needed.

Methodology Patients and their caregivers who attended at least one SSCS appointment were contacted post attendance and invited to participate in a semi-structured interview conducted via telephone. Interviews were audio recorded, transcribed and analysed. A reflexive thematic analysis approach guided the data analysis.

Results Twelve interviews were completed.

Five major themes described the data set:

1. **Communication Style.** Patients reported the palliative care physician was supportive, encouraging and empathetic. Difficult conversations were approached gently and respectfully and if requested, discontinued. The time and opportunity to explain their unique experiences and those of the caregiver was highly valued.
2. **Coping with scleroderma.** Many patients spoke of their resilience in the face of chronic disease and future uncertainty. Loss of function, loss of social agency and increasing dependency were spoken about with mixed feelings: patients described appreciation of the caregiver, finding joy in each day, and acceptance of a new normal.

Denial, sadness and grief associated with living with scleroderma were frequently expressed.

3. **Caregiving Role.** Caregivers reflected on their responsibility to provide practical care, medication and symptom management, and coordination of care. They described their desire to be involved in clinical discussions and highlighted the impact of the unpredictability of this chronic disease.
4. **Role of the SSCS.** Some patients and caregivers were confronted by the ‘palliative care’ label, yet this was balanced by the value gained from symptom management, disease explanation and future care discussions. Patients valued coordinated and specialist care from the inter-disciplinary clinic team who they voiced understood the complexity of their rare condition.
5. **Serious Illness Conversations.** There were diverging views regarding acceptance of discussions relating to the seriousness of the disease, prognosis, advance care planning and future care supports. Patients and caregivers varied from pragmatic acceptance, and being well prepared, to fearful denial of any future care discussion and a strong preference to avoid any discussion about any future, increased care needs.

Discussion This integrated inter-disciplinary palliative care clinic was found to be both acceptable and valued by patients and caregivers. Those interviewed emphasized they appreciated time to describe their experience, discuss their disease and explore symptom management. Future palliative care engagement should be sensitive to the diversity of responses to serious illness conversations, and further explore patient and caregiver perceptions of palliative care.

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CHALLENGES OF ACUTE TRANSITIONS FROM HOSPITAL TO HOME FOR END-OF-LIFE CARE (EOLC): LESSONS LEARNT FROM A COLLABORATIVE SPECIALIST PALLIATIVE CARE AND HOSPITAL-IN-THE-HOME (HITH) SERVICE PILOT

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Background Although population surveys suggest that 60–70% of Australians would prefer to die at home, only 14% of them achieve this. This is comparatively low compared to other developed countries. Home-based palliative care programs increase the chance of patients dying at home through models of care providing multidisciplinary support for a complex range of care needs at the end of life.¹

Aim To support more patients transitioning home for EOLC through the delivery of a specialist palliative care and HITH hybrid model.

Methods The collaborative program included a team of HITH doctors and nurses; palliative care physicians and clinical nurse consultants; and allied health practitioners including an occupational therapist, physiotherapist and social worker. Referral criteria encompass patients admitted to the inpatient palliative care ward at the Royal Melbourne Hospital who express a preference for home-based palliative care and have an

available caregiver. Upon admission to the program, patients received daily in-home nursing reviews supplemented by HITH medical consultations via telehealth. Palliative care physicians provided input through coordinated reviews at least weekly during admission, with increased frequency as warranted. Allied health support can be accessed depending on need and after-hours assistance was provided by HITH nursing and medical staff via telephone.

Findings Over the 9 months pilot phase, 10 referrals were made to the program and 4 patients were admitted. The patients who were referred all had a strong desire to return home for EOLC. Reasons for discordance between referrals and admissions to the pathway included rapid change in clinical status, change in discharge destination due to caregiver stress, and availability of alternative services to meet care needs. Of the admitted patients, one fulfilled their wish to die at home, one continued care at home with community supports, while two other patients had planned readmissions to the palliative care unit and managed to spend additional time at home aligned with their wishes.

Lessons Learnt The implementation of this pilot program has strengthened the relationship and collaboration between specialist palliative care and HITH services, which enabled support of patients with complex palliative care needs. There were several challenges including the uptake and integration within the broader service framework, partly due to limited awareness despite educational efforts targeted at inpatient services. Patient-related challenges included unstable symptoms and care needs, as well as rapid clinical fluctuations attributed to underlying disease progression, rendering program admission unfeasible on some occasions. Additional factors encompassed the limited availability and anxiety of caregivers in meeting the high care demands.

Future Directions The program remains ongoing, with a focus on continued education for hospital staff to enhance awareness of its availability. Referral sources have been expanded to include patients from other wards and an adjacent precinct cancer care hospital, and ongoing refinement of referral criteria is underway to optimize program efficacy.

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RECOMMENDATIONS FOR IMPROVING QUALITY AND COST OF CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESS

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It is evident that the cohort of patients who have a Life Limiting Illness (LLI) both globally, and in Australia, is significant.¹⁻⁴ It should go without saying that as our population's average age slowly rises, so too does this group of patients

whose medical needs and chronic conditions begin to mount. With such a significant collection of patients suffering with a Life-Limiting Illness, it is integral that our healthcare systems are aware of the best practise for how to manage such patients. Multiple rigorous studies have shown that the best practise for a patient with an LLI is a style of care that incorporates a palliative approach.⁵⁻⁹ This has proven to improve patients' quality of care and decrease cost of hospital stay per patient.^{5 8} These two metrics of quality of care and clinical cost per patient have emerged as key areas of interest in this field of study.

There is proof that tertiary centres around the globe and particularly in Australia are under-identifying these patients with an LLI, and therefore, there is a proportion of LLI patients being treated as patients without an LLI.^{2 10 11} This under-recognition is leading to poor symptom management for such patients, and potentially unnecessary medical intervention in patients whose goals of care are poorly or not defined at all.

Accurately recognising patients with an LLI and treating them with more of a palliative focus not only increases patient satisfaction, it also leads to a reduction in overall cost per patient. This highlights a significant saving that could be made if tertiary care centres made a more concerted effort to appropriately identify and subsequently modify treatment for patients with LLI's.

This project will focus on recommendations for a tertiary centre and broader healthcare system to implement, such that we can better identify patients with an LLI. The goal being that if we can more accurately identify these patients, then we can make a positive impact on both patient satisfaction, and cost per patient.

Results Accurately recognising patients with an LLI and treating them with more of a palliative focus not only increases patient satisfaction, it also leads to a reduction in overall cost per patient. This highlights a significant saving that could be made if tertiary care centres made a more concerted effort to appropriately identify and subsequently modify treatment for patients with LLI's.

Discussion This project recommends the P-CaRES screening tool to be trialled and subsequently introduced to the emergency departments of tertiary centres within Australia. This tool looks to improve recognition of LLI patients by intercepting them at a common point of entry into the Hospital, with a goal of addressing and improving patient satisfaction, and additionally, decreasing overall cost per patient.

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