

BMJ *Supportive & Palliative Care*

ANZSPM Conference 2026



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Thursday 24 September

TRAMSHEDS (4 Invermay Road)

0700	TRAMSHEDS Registration Desk open
	Trainee Forum
0800	Forum opening
	Cultural Considerations around Death and Dying Nina Evason, Mosaica, Brisbane
	Talking to Children about Death and Dying Dr Naomi Katz, Alfred Health and Melbourne Health / Peter MacCallum Cancer Centre, Melbourne Dr Daniel Dorevitch, Children's Health Queensland, Cairns
	Morning Refreshments
	Behavioural and psychological symptoms in advanced dementia Dr Aaron Wong, Eastern Health, Melbourne
	Trauma-informed care Dr Sharonne Zaks AM, Melbourne Dental Clinic and University of Melbourne, Melbourne
	Lunch
	Kintsugi QI: Making broken healthcare better Prof Karl Lorenz, Stanford School of Medicine, USA Michelle DeNatale, Stanford Health Care, USA
1500	Forum close Afternoon Refreshments & relocate to conference if registered for ANZSPM 2026 conference programme (10-15 min walk)
	Communication Skills Workshop
0800	Workshop opening
1215	Workshop close
1215 - 1300	Lunch & relocate to the conference (Albert Hall Launceston) if registered for the ANZSPM 2026 conference programme (10-15 min walk)

ALBERT HALL LAUNCESTON (47 Tamar Street)

0900	ALBERT HALL FOYER Registration Desk open
0930	ALBERT HALL FOYER Morning Refreshments
1000	Special Interest Workshops (running concurrently):
	JOHN DUNCAN ROOM Kidney Supportive Care
	TAMAR ROOM Neuropalliative Care: Navigating Complex Symptoms and Decisions at the End of Life
	CONVERGE, VERGE HOTEL Public Health: From TOO-ism to WITH-ism
1200	Lunch
1300	Special Interest Workshops (running concurrently):
	JOHN DUNCAN ROOM Respiratory – Breathing well at home: more than the lungs
	TAMAR ROOM Rural and Remote / GP: Sharing Complexity: Hard Cases, Real Strategies for Palliative Care in Rural, Remote and Primary Practice
	CONVERGE, VERGE HOTEL Spiritual Dimension of Palliative Care
1500 - 1545	ALBERT HALL FOYER Afternoon Refreshments
1600	GREAT HALL Conference Opening Assoc Prof Odette Spruijt, ANZSPM 2026 Convenor Aunty Delia Summers, Elders Council of Tasmania Aboriginal Corporation Minister Bridget Archer MP, Tasmanian Government Minister for Health, Mental Health and Wellbeing / Minister for Ageing Dr Ahmed Nagla, ANZSPM President
1630	GREAT HALL CHAIR: Dr Ahmed Nagla, ANZSPM President Rosalie Shaw Oration Dr Frank Brennan AM
1720	GREAT HALL Plenary 1 CHAIRS: Dr Michelle Gold & A/Prof Carol Douglas The role of creativity in connecting with patients and providing care Dr Sharonne Zaks AM, Melbourne Dental Clinic and University of Melbourne, Melbourne
1805	Close of Day 1
1815 - 2030	ANZSPM 2026 Welcome Reception, Albert Hall Launceston ALBERT HALL FOYER

Friday 25 September

ALBERT HALL LAUNCESTON (47 Tamar Street)

0700	ALBERT HALL FOYER Registration Desk
0715	CONVERGE, VERGE HOTEL, 50 Tamar Street ANZSPM AGM breakfast (members only)
0730	CONVERGE, VERGE HOTEL, 50 Tamar Street ANZSPM AGM (members only)
0830	GREAT HALL Plenary 2 CHAIRS: Prof Jennifer Philip & A/Prof Davinia Seah What is a good death? An economic research agenda for Palliative Care Prof Eric Finklestein, Duke-MUS Medical School, Singapore
0915	GREAT HALL Plenary 3 CHAIRS: A/Prof Odette Spruijt & Prof Melanie Lovell Advocacy for global change – addressing the abyss of lack of access to palliative care and pain relief Dr Elizabeth Saenz, United Nations Office on Drugs and Crime, Austria (virtual) Prof Karl Lorenz, Stanford School of Medicine, USA Dr Shilpa Khanna, Sangwari, India
1015	Poster Speed Talks 1: - Using the Australian Refined Diagnosis Related Groups (AR-DRG) casemix classification to describe complexity in patients admitted under a specialist palliative care service Dr Estelle White, Chris O'Brien, Lifehouse Hospital - No rest for the weary: Case studies of complexities with restless legs syndrome management in an outpatient supportive and palliative care setting Dr Shalini Ponnampalam, Austin Health - A decades-old winning formula: continuous subcutaneous infusions (CSCI) and drug combinations in palliative care Dr Mary Andhoga, Mary Potter Hospice - A Dose of Grief: Death education for medical students Paris Matthews & Isabelle Ewert, University of Melbourne - Diagnosis-associated differences in continuous subcutaneous infusion use and end-of-life decision making: malignant versus non-malignant disease Dr Vivek Narotam, Ipswich Hospital
1020	Poster Speed Talks 2: - Providing outpatient palliative care for patients with non-malignant diagnoses: a pilot evaluation Dr Clare Browne, Austin Health - Impact of COVID-19 pandemic on palliative care delivery for people living with dementia in residential aged care: Facility Manager perspectives Dr Manoshayini Sooriyakumaran, Peter MacCallum Cancer Centre - Rapid Analgesia Without Opioids: Inhaled Methoxyflurane for Acute Pain in Palliative Care — A Prospective Audit Dr Yew Chin Lau, Peel Health Campus - Silencing the persistent cough: speech pathology intervention in palliative care Dr Caroline Xue, Monash Health

1025	Poster Speed Talks 3: • Australia's medication shortages in palliative care – a call for a multi-agency response Dr Shalini Ponnampalam, Austin Health • Experiences of assisted telehealth for medical review in community palliative care: a retrospective cohort review Dr Fan-en (Annie) Chiu, Mercy Palliative Care • Enabling Home with Grace and Dignity: Early Success of a Reliable Harmonised Compassionate Discharge Model Angie Lim, National University Hospital Singapore • Comfort Over Cure: Lessons from a case of End-Stage Kidney Failure in Systemic Sclerosis Dr Shabana Kalla, NSW Health
1030	ALBERT HALL FOYER Morning Refreshments
1100	Concurrent Session 1

GREAT HALL	TAMAR ROOM	JOHN DUNCAN ROOM	CONVERGE, VERGE HOTEL
Timely referral / improving access	International and national advocacy for equity of access to essential medicines and palliative care	Evolving concepts of palliative care practice	Evolving concepts of palliative care
Early palliative care – how do we make it happen? Prof Jenny Philip, Palliative Care Nexus, University of Melbourne	A facilitated structured approach to establish a collective purpose statement to advance palliative care in the Asia Pacific region: the Cynthia Goh Fellowship initiative Dr Aaron Bak Ong Wong, Eastern Health	Comparing symptoms and outcomes between non-malignant patients in Australian inpatient palliative care: a multi-site observational study A/Prof Davinia Seah, St Vincent's Hospital Sydney Ltd	Be SMART: Rethinking Methadone Initiation and Rotation for Cancer Pain in Routine Palliative Care Dr Warrick Jones, North Haven Hospice
	Strengthening palliative care in the Indo-Pacific through a cervical cancer elimination program: the EPICC model Prof Melanie Lovell, Hammondcare	Malignant versus non-malignant inpatient palliative care at three Australian metropolitan services: a 10-year observational cohort study (2015–2024) Dr Hisato Kosai, University of Technology Sydney	A simple approach to improve understanding of why Pro re nata opioids and/or benzodiazepines are being administered in hospitalised palliative care patients Dr Sarah Pascoe, St Vincent's Hospital Melbourne
Moving upstream: Identifying newly referred patients to Medical Oncology suitable for early palliative care by utilising the "Royal Marsden Triggers Tool" Dr Patrick Daly, Southern Adelaide Palliative Care Service	The Economic Impact of Early Palliative Care in Australia A/Prof Chris Schilling, University of Melbourne	Voluntary Assisted Dying in an Inpatient Palliative Care Unit: A 3-Year Retrospective Audit of Prevalence, Clinical Characteristics, and Outcomes Dr Andrew Young, Specialist Palliative Care Service - North	Concurrent sedative use after phenobarbital initiation in palliative sedation therapy: a descriptive audit and guideline-based analysis Dr Hossein Kasiri, Austin Health

Timeliness and appropriateness of referrals to specialist palliative care from primary care: Perspectives from specialist palliative care services Dr Arjun Poudel, Palliative Care Outcomes Collaboration, UOW	Impact of Hydromorphone Slow Release Discontinuation on Opioid Prescribing: A Retrospective Advanced Cancer Cohort Study Dr Aaron K Wong, Peter MacCallum Cancer Centre	Voluntary Assisted Dying in an Institutional Non-Participating Specialist Palliative Care Service – Processes, Outcomes and Learnings Dr Alexander Kochi, Queensland Health	Extended Duration Continuous Subcutaneous Infusions in Rural Community Palliative Care: a Prospective Observational Cohort Study Dr Sophie Alcock, Sir Charles Gairdner Hospital, Western Australia
Care of the most complex-how collaboration is the key Dr Abigail Franklin, Manly Adolescent and Young Adult Hospice	What is a 'good death' in Sri Lanka? A/Prof Odette Spruijt, TAS SPCS North	Perceptions of the Effect of Sound, Light and Temperature in a Palliative Care Ward: Survey of Perspectives of Patients and Staff A/Prof Davinia Seah, St Vincent's Hospital Sydney Ltd	CMV reactivation after Checkpoint Inhibitor Immunotherapy. Thinking outside the box in patients with refractory symptoms Dr Alison Blight, Palliative Care Specialist Private Practice
1215	ALBERT HALL FOYER Lunch		
1315	Concurrent Session 2		

GREAT HALL	TAMAR ROOM	JOHN DUNCAN ROOM	CONVERGE, VERGE HOTEL
Palliative care in underserved populations, including low and middle income countries	Psychoexistential dimensions of palliative care practice, including spiritual care	Evolving concepts of palliative care practice	Models to improve access to palliative care
Empowering Sri Lankan healthcare workers to deliver a 'good death' - a strengths-based framework and approach Prof Jennifer Philip, University of Melbourne	The use of rituals to address spiritual needs in palliative care: An Australian cohort study A/Prof Natasha Michael, University of Notre Dame Australia	Proportionality in palliative sedation therapy: bridging the gap between guideline intent and clinical practice Dr Hossein Kasiri, Austin Health	He Whare Korowai – an innovative approach to community inpatient palliative care. West Auckland, New Zealand Dr Celia Palmer, Hospice West Auckland
End of life care for elderly people with chronic, progressive non-cancer illness – a retrospective audit of the quality of dying in a small metropolitan hospital Dr Phyllis Tay, Tasmanian Health Service	Re-conceptualising well-being in palliative care Dr Claire Stokes, Mater Hospital Brisbane	Body and Mind - the unique role of a psychiatrist in caring for patients in two very different palliative care units in Sydney, Australia Dr Abigail Franklin, Manly Adolescent and Young Adult Hospice	A social history of Palliative Medicine in Australia and New Zealand Dr Ofra Fried, Queensland Health

Bridging the Gap in Specialized Cancer Pain Management: "CHALLENGE-Campaign," a Remote Expert Consultation Platform Dr Eriko Satomi, National Cancer Center Hospital	Evaluating Psycho-existential Outcome Measures for Psychedelic Trials in Palliative Care: A Scoping Review A/Prof Seunghun Lee, Pusan National University & Prof Phillip Good, SVHA/MATER	Implications of High Risk Pharmacogenomic Variants for Symptom Management Prescribing in Palliative Cancer Care Dr Aaron K Wong, Peter MacCallum Cancer Centre	Projecting Unmet Palliative Care Needs in Australia: A Health Workforce Planning Model for Palliative Care Susan-nah Annable & A/Prof Chris Schilling, University of Melbourne
The Cost of Informal Cancer Caregiving (CCC) Questionnaire: pilot of a co-designed tool for palliative oncology Prof Jennifer Philip, University of Melbourne	A Prospective Cohort Study Evaluating the Psycho-Existential Concerns and Psychopathology in Advanced Illness A/Prof Natasha Michael, University of Notre Dame Australia	Chinese-Australian Patients and Carers in Palliative Care: A Qualitative Study of Experiences, Cultural Dimensions and Challenges to Person-Centred Care Dr Theresa Nguyen, Blacktown Hospital	Developing a "Last 1000 Days" Framework in Aged Care: Integrating Frailty, Reablement, End-of-Life Care and Voluntary Assisted Dying into Clinical Governance Glen Williams, One-care Ltd
1415	Concurrent Session 3		

GREAT HALL	TAMAR ROOM	JOHN DUNCAN ROOM	CONVERGE, VERGE HOTEL
International and national advocacy for equity of access to essential medicines and palliative care	Models to improve access to palliative care	Respecting Personhood	Palliative care in underserved populations, including low and middle income countries
A national pharmacoepidemiologic study of rapid-onset opioids for advanced cancer in Australia, 2013–2025: rarely used, intensively dosed Dr Aaron K Wong, Peter MacCallum Cancer Centre	Going the extra mile: Tele-trials in palliative care Dr Claire Stokes, Mater Hospital Brisbane	Reframing Hope Under Time Constraints: A Case of Restoring Patient-Led Decision Making in Hospice Care Misaki Fujiwara, Kin-ikyo Chuo Hospital	How do Sri Lankan newspapers represent palliative care? A discourse analysis Prof Jennifer Philip, University of Melbourne
Improving community-based anticipatory prescribing at end of life: embedding the National Core Community Palliative Care Medicines List Dr Arvind Gunasekaran, Queensland Health	Is palliative care associated with lower terminal hospital costs for people with non-cancer diagnoses? A single site retrospective study A/Prof Davinia Seah, St Vincent's Hospital Sydney Ltd	Bespoke virtual carer support: lessons from lived experience and the Specialist Palliative Care Rural Telehealth (SPaRTa) Service Dr Prem Ram, SCHHS Palliative Care	Mapping Home-Based Palliative Care Need in rural Central India Dr Shilpa Khanna, Sangwari Comprehensive Primary Health Care
Dying Gracelessly? Deaths in hospital of RACF Residents: A retrospective mixed-methods analysis of precipitating factors and the quality of end of life care Dr Shampa Sinha, St Vincent's Hospital	Caring for the Carer: A Pilot Telehealth Carer Coaching Model for Carers of People Receiving Palliative Care in Rural and Remote Queensland Kelly Buzza, Sunshine Coast Hospital & Health Service	Respecting Personhood Through Integrative Care: Making Invisible Clinical Work in Palliative Care Visible Dr Carrie Lethborg, St Vincent's Hospital	Pathways to access timely pain management and palliative care for people with pancreatic cancer Prof Jennifer Philip, University of Melbourne

1500 - 1530	ALBERT HALL FOYER Afternoon Refreshments
1530	GREAT HALL Plenary 4 CHAIRS: Prof Greg Crawford & Dr Sid Vemuri Where science meets the art of caring Dr Masanori Mori, Seirei Mikatahara General Hospital, Japan
1615	GREAT HALL Plenary 5 CHAIRS: Prof Greg Crawford & Dr Sid Vemuri Exploring prognosis with parents of very sick children Dr Naomi Katz, Alfred Health and Melbourne Health / Peter MacCallum Cancer Centre, Melbourne
1645	Close of Day 2
1830 - 2230	ANZSPM 2026 Conference Dinner St John's Church, 157 St John Street
2200 - 2400	Party on at the Dill Pickle Club! Level 1/78 St John Street

Saturday 26 September

ALBERT HALL LAUNCESTON (47 Tamar Street)

0800	ALBERT HALL FOYER Registration Desk open
0830	CONVERGE, VERGE HOTEL, 50 TAMAR STREET AChPM FELLOWS UPDATE
0900	Concurrent Session 4

GREAT HALL	TAMAR ROOM	JOHN DUNCAN ROOM
Quality improvement in palliative care	Quality improvement in palliative care	Humanities and palliative care
Retrospective observational study of levomepromazine use in end-of-life care in a metropolitan palliative care inpatient unit Dr Luc Farnan, Mater Hospital	Palliative Care Input and Treatment Patterns in Heart Failure Patients at End of Life in a Hospital Setting- A Retrospective Cohort Study Dr Than Than Aye, Palliative Nexus, St Vincent Health	Ethical scaffolding and end-of-life care: moral distress and the limits of clinical guidance Aahana Dudani, Monash University
What are the Barriers to Achieving Home Death in Patients Receiving Community Specialist Palliative Care? Dr Danica Pasia, St Vincent's Private Hospital Brisbane	Enhancing telehealth in palliative and cancer outpatient care: Evaluating the implementation of a novel consultation summary software application Dr Laura Bird, Monash Health	Bridging Ethics and Innovation: An ethical evaluation of teletrials in patients with advanced cancer receiving palliative care Dr Claire Stokes, Mater Hospital Brisbane
Assessing quality of dying in patients with advanced renal failure in the Australian Capital Territory: a multi-instrument quality care evaluation Dr Lucy Aitken, QLD Health	Residential aged care staff and their desire for Goals of Care training: Findings from IMPART trial A/Prof Barbara Hayes, Northern Health	The Lethal Absence of Hope Dr Sherina Mubiru, Tasmanian Health Service / Royal Hobart Hospital
Palliative Care clinicians' medication recommendations for Intensive Care Unit patients transitioning to ward-based end-of-life care: a descriptive study Dr Amanda Tan, Melbourne Health & Eastern Health	Consumer dissatisfaction in a specialist palliative care service Prof Phillip Good, SVHA/MATER	The Ethics of Palliative Sedation: Navigating Uncertainty at the End of Life Dr Daniel Dorevitch, Children's Health Queensland
Describing incidence, outcomes and risk factors of falls with injury in the community palliative care setting: a retrospective cohort study Dr Frances Squires, Royal Melbourne Hospital	Simplifying the highly complex-tailored CMLs for adolescent and young adults with palliative care needs Dr Abigail Franklin, Manly Adolescent and Young Adult Hospice	Geographic variation in symptoms at palliative care admission among Australian cancer patients Jared Tang, University of Notre Dame
End-of-life care quality indicators for residential aged care facility residents: a retrospective cohort study of hospital and facility deaths Dr Merlina Sulistio, Cabrini Health		

1030	ALBERT HALL FOYER Morning Refreshments
1030 - 1530	Poet-in-residence Cameron Hindrum will join us for the day, writing poetry and his own <i>reflections</i> . You are welcome to sit and write with him or just stop for a chat.
1100	Poster Speed Talks 4: - Increased collaboration between a hospice and a Māori health and social service provider following joint delirium research Kaye Basire, Te Omanga Hospice - Assessment of Bereavement Risk and the Acceptability and Feasibility of a Bereavement Support Service at an Acute Tertiary Hospital A/Prof Jaclyn Yoong, Northern Health/ Monash Health - Understanding place of death in patients with solid organ malignancies – a retrospective comparison of deaths at an acute hospital and an inpatient palliative care unit Dr Matthew Stanny, Tasmanian Health Service - Advance care planning in end-stage liver disease: A mixed-methods systematic review Dr James Newman, NSW Health - MethoxyFLurane inhaler for single episode cancer-related incident pain in palliative cARE patients: The FLARE Feasibility Study Protocol Dr Ahmed Nagla, Latrobe Regional Health
1105	Poster Speed Talks 5: - The impact of embedding pharmacy expertise in a regional specialist palliative care service - bridging gaps in medication management for patients and healthcare professionals Niamh O'Neill, WNSWLHD - Differences in O₂ related observations in patients who received pleurodesis and patients who received a pleural drain, for the management of malignant pleural effusion Jasmin Juncal, The University of Notre Dame - Going Home on Time (GHOT): A quality improvement project aimed at streamlining workload in a Specialist Palliative Care Consult Team Dr Naomi Gleadle, Tasmanian Health Service - The role of smoking ceremonies in end-of-life care for Aboriginal patients and communities in providing culturally safe, patient-centred care in Western Sydney Jiv Matthews, Western Sydney Local Health District - Examining Advance Care Planning Practices: A Descriptive Study of ACP Tracker Utilisation Dr Prem Ram, SCHHS Palliative Care
1110	Poster Speed Talks 6: - Pilot project: implementation of a structured patient/family experience feedback process to drive quality improvement in a specialist palliative care unit Dr Fan-en (Annie) Chiu, Mercy Palliative Care - End of Life Care for Residential Aged Care Home Residents in a Regional Australian Hospital Dr Lauren Wild, University of Sydney - Ward-Based Palliative High-Flow Nasal Oxygen: Should It Become Standard Practice? Dr Jessica Borbasi, Prince of Wales - An Audit of Sodium Valproate Continuous Subcutaneous Infusion Use in the Inpatient Hospice Setting Dr Sivaraj Rajadorai, Canberra Health Service - Do Nutrition Screening Practices and Dietitian Referrals in a Palliative Care Unit vary by Admission Goals of Care? A Retrospective Audit Alyssa Yap, Monash University - Reframing palliative care conversations: a co designed educational approach to supporting timely integration in cancer care A/Prof Amy Waters, St George Hospital

1115	GREAT HALL Plenary 6 CHAIR: Dr Maxine Glanger FACILITATOR: Heather Kent, CEO Palliative Care Tasmania Creative solutions: food for thought, space to breathe, music to our ears Hanz Lee, JAWS Architect, Hobart Emily Sanzaro, Occupational Therapist and Harpist, Launceston Paul Amourgis & Carly Palmer, Van Diemens Land Creamery, Elizabeth Town Hannah Maloney, Director of Goodlife Permaculture, Author, TV Presenter on ABC's Gardening Australia, Hobart
1230	ALBERT HALL FOYER Lunch
1330	Concurrent Session 5

GREAT HALL	TAMAR ROOM	JOHN DUNCAN ROOM	CONVERGE, VERGE HOTEL
Other	Education and training in palliative care	Quality improvement in palliative care	Relational Care
Patient-reported outcome measures for supportive care in heart failure: results from an Australian heart failure clinician survey Dr Laura Bird, Monash Health	From co-design to clinical practice: designing an online education course to support timely palliative care integration in cancer care A/Prof Amy Waters, St George Hospital	Enabling rapid quality improvement in palliative care: implementing the PCOC digital dashboard Sabina Clapham, Palliative Care Outcomes Collaboration, UOW	WORKSHOP Grief and Art: Honouring the Grieving Process Through Creative Expression Christina Wilson, University of Maryland
Implementation of integrated palliative care outcome scale (IPOS) into palliative care clinics Dr Kimberly Ming Li Gan, Concord General Hospital	A bi-directional approach to education and learning - The Northern Tasmanian Palliative Care Project ECHO Dr Faline Howes, Tasmanian Health Service	Deprescribing practices for elderly patients admitted to a palliative care unit in Sydney, NSW: A retrospective cohort study Dr Ashleigh Elkins, Chris O'Brien Lifehouse	
The challenges of left ventricular assist device de-activation: when the bridge becomes a destination Dr Shampa Sinha, St Vincent's Hospital	Updating ANZSPM Guidance Statement: Use of Palliative Sedation Therapy (PST) in Australia and New Zealand Dr Chien-che Lin, Eastern Palliative Care	Nutrition Screening Practice and Dietitian Referral Patterns in a Palliative Care Unit: Audit of the Malnutrition Screening Tool Use Alyssa Yap, Monash University	
Patterns of Healthcare utilisation and palliative care in the last 12 months of life Dr Megan Opferkuch, Northern Health	Australian Recommendations for the Management of Hepatocellular Carcinoma: A Consensus Statement Dr Maria Cigolini, RPAH Sydney	Home-Based Goals of Care: Enhancing Communication and Decision-Making in the Community Dr Hao Zhuo & A/Prof Barbara Hayes, Northern Health	

Antimicrobial prescribing patterns in the last 2 weeks of life at a single tertiary hospital Dr Merlina Sulistio, Cabrini Health		Development of a statewide Community of Practice (COP) for Motor Neurone Disease (MND) Care partnering with people with lived experience Dr Dharshini Kunahlan, Calvary Health Care Bethlehem & Latrobe Regional Health	
The Carbon Footprint of an Australian Palliative Care Unit Dr Scott Bushen, Metro North		Advance care planning in older inpatients being discharged to residential aged care facilities Dr Kevin Danagher, North Metropolitan Hospital Service	
1500	ALBERT HALL FOYER Afternoon Refreshments		
1530	GREAT HALL Plenary 7 CHAIRS: Dr Wendy Pattemore & Dr Florry O'Connell Psychedelics in clinical care Dr Justin Dwyer, Psychiatrist, Melbourne Dr Marg Ross, Clinical Psychologist, Melbourne		
1630 - 1700	GREAT HALL Conference Close - Awards & Reflections Assoc Prof Odette Spruijt, ANZSPM 2026 Convenor Dr Ahmed Nagla, ANZSPM President		
1715 – 1800	ALBERT HALL FOYER Performance: ade ishs, pianist (cash bar open) ade ishs is a Tasmanian-based pianist and composer whose music brings together lyrical melodies, rich harmonies, and an improvisational spirit. A regular performer at festivals and venues, he enjoys creating music that invites listeners to pause, reflect and share in the moment. Away from the piano, ade is a data and technology professional with a PhD and an academic background in computer science and music information retrieval research. These different worlds meet in his music through curiosity, structure and the occasional willingness to ignore algorithms entirely.		
1715 - 1905	GREAT HALL Film: Edge of Life 'The doorway to death is the last great frontier in human life. Intellectually, we all know our lives will end, and yet - in the Western world at least - we act as if death is a mirage, disappearing the closer we move towards it. Two doctors in Australia are using psilocybin to help ease the anguish of their patients at the end of life, and the results they have seen are truly remarkable. But this visioning tool, like other plant medicines, is not new; it comes from ancient traditions.' Writers: Lynette Wallworth & Tashka Yawanawa Director: Lynette Wallworth Producer: Jo-anne McGowan, Stranger Than Fiction Films 1 hour 50 minutes duration		

Oral Presentations (OP)

OP1 ASSESSING QUALITY OF DYING IN PATIENTS WITH ADVANCED RENAL FAILURE IN THE AUSTRALIAN CAPITAL TERRITORY: A MULTI-INSTRUMENT QUALITY CARE EVALUATION

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10.1136/spcare-2026-ANZSPM.1

Background Chronic kidney disease (CKD) is increasingly prevalent in Australia and is associated with substantial symptom burden at the end of life. Despite this, there is limited evidence describing the quality of dying for people with advanced renal failure, and no single validated instrument captures all relevant domains of care.

Study Objectives This study aimed to assess the quality of dying for patients with advanced renal failure in the Australian Capital Territory (ACT) and evaluate the feasibility of an audit framework utilising multiple tools.

Methods A quality dying evaluation program was implemented along with retrospective audit of outcomes for patients with CKD stage 4 or 5 who died in the ACT between July-December 2025.

Quality of dying was assessed using the Canterbury Quality of Death Instrument (CQDI), the Dialysis Quality of Dying APGAR (QOD-APGAR), and the Care of the Dying Evaluation caregiver survey (CODE). Non-parametric statistical analyses were used, including Kruskal-Wallis tests for group comparisons and Spearman rank correlation to assess relationships between instruments.

Summary of Results Fifty-eight patients were included in the study. Quality-of-death scores were generally high across all instruments, with evidence of ceiling effects. CQDI scores were significantly higher for hospice deaths compared with acute hospital settings ($p = 0.004$) and among patients reviewed by specialist palliative care ($p < 0.001$). Scores did not differ by dialysis status, chronic kidney disease stage, age, sex, or preferred language. Moderate correlations between CQDI and QOD-APGAR supported convergent validity, while highlighting that instruments capture complementary domains. Feasibility was demonstrated with median completion times of 20 minutes for CQDI and 15 minutes for QOD-APGAR, and high acceptability of the CODE survey with a 52% response rate. In addition, 89% of participants rated the survey as appropriate, with distress attributed to bereavement rather than survey design.

Discussion These findings suggest that quality of dying for patients with advanced renal failure in the ACT is generally favourable, with meaningful variation by care setting and specialist palliative care involvement. The absence of differences across demographic and treatment groups suggests broadly equitable care, although this requires confirmation in larger cohorts.

No single instrument comprehensively captured all domains of care; a multi-instrument approach provided a more complete assessment, including caregiver perspectives. Embedding this feasible audit framework into routine clinical governance

may support benchmarking, identify areas for improvement, and drive targeted quality improvement in renal end-of-life care.

OP2 ABSTRACT WITHDRAWN

OP3 PROJECTING UNMET PALLIATIVE CARE NEEDS IN AUSTRALIA: A HEALTH WORKFORCE PLANNING MODEL FOR PALLIATIVE CARE

Susannah Annable*, Chris Schilling*, Jack McLaughlin. *University of Melbourne, Melbourne, Australia*

10.1136/spcare-2026-ANZSPM.2

Background and Objectives With growing demand for palliative care and an ageing workforce, many health systems face increasing difficulty providing timely access to specialist palliative care. Workforce planning tools are needed to identify future workforce shortfalls and associated unmet palliative care need. We developed a palliative care service planning (PCSP) model to project specialist workforce capacity and quantify unmet need over the next 20 years.

Methods A bespoke system dynamics PCSP model was developed to capture workforce inflows, outflows and workforce stocks, consistent with good-practice reporting guidelines for health workforce projection models. The model projects specialist palliative care workforce headcount, full-time equivalent (FTE), and clinical FTE to 2045 by profession (palliative medicine physicians and palliative care nurses), age group, sex, state, and remoteness area (Australian Statistical Geography Standard). Projections were based on observed workforce transitions using data predominantly sourced from the national Health Workforce Data Tool and validated against historical data from 2013–2024.

Unmet need for specialist palliative care was estimated by comparing projected specialist clinical workforce capacity against minimum service benchmarks and applying these gaps to the projected number of people expected to benefit from palliative care at the end of life. Service benchmarks were increased over time in line with projected deaths to reflect growing demand.

Results The national headcount of palliative care physicians is projected to grow at an average annual rate of 3.3% (95% CI: 2.9–3.6), reaching 831 physicians (95% CI: 732–933) and 1.8 clinical physician FTE per 100,000 population (95% CI: 1.6–2.0) by 2045. Growth varied geographically, with major cities projected to reach 2.2 clinical physician FTE per 100,000 population (95% CI: 1.9–2.5) compared with 0.7 (95% CI: 0.4–1.0) in outer regional areas.

The national headcount of palliative care nurses is projected to grow at 1.2% annually (95% CI: 1.0–1.4), approximately matching population growth, resulting in little change in clinical

cal nurse FTE per capita. Nurse workforce trends were broadly similar across major cities and regional areas.

Need for palliative care is projected to increase by 2.6% annually, with more than 238,000 people expected to benefit from palliative care in 2045. Despite workforce growth, an estimated 96,257 people (95% CI: 86,856–106,648) are projected to miss out on specialist palliative care in 2045, an increase of more than 30,000 people from current levels. Unmet need was disproportionately concentrated in outer regional areas, which accounted for 18% of unmet need despite containing only 8% of the population.

Discussion Current specialist workforce trajectories are unlikely to meet future demand for palliative care. Substantial expansion in training capacity, alternative service delivery models, and greater involvement of generalist providers will be required to reduce unmet palliative care need across Australia, particularly outside major cities.

OP4

PALLIATIVE CARE INPUT AND TREATMENT PATTERNS IN HEART FAILURE PATIENTS AT END OF LIFE IN A HOSPITAL SETTING - A RETROSPECTIVE COHORT STUDY

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10.1136/spcare-2026-ANZSPM.3

Background Heart failure (HF) is a leading cause of hospitalisation and death worldwide, yet end-of-life care in this population remains underexplored, particularly in hospital settings. Differences in HF phenotypes, heart failure with reduced ejection fraction (HFrEF) and other types (HF other), may impact palliative care involvement and management practices.

Objective This exploratory retrospective cohort study aimed to assess the role of specialised palliative care at the end of life for patients with HF, comparing patterns of care and outcomes between HFrEF and HF other phenotypes.

Methods Medical records of adult inpatients who died from HF at a metropolitan Australian hospital between December 2019 and December 2023 were reviewed. Data on demographics, specific comorbidities, hospital admissions, medication use, palliative care involvement, and place of death were analysed.

Results Fifty-eight patients were included (HFrEF: n=30; HF other: n=28). Community palliative care (CPC) involvement was 37.9%, with CPC patients significantly more likely to be admitted to the palliative care unit (PCU) (95% CI: 0.00–0.15, $P < 0.001$). HF other patients were more likely to receive hospital-based palliative care consultation (40% vs 26%) and to die in the PCU (67.9% vs 43.3%). Specialized palliative care input was associated with higher rates of continuous subcutaneous infusion (CSCI) and anticipatory medication prescribing. Conversely, patients without palliative care input had more frequent use of diuretics in the terminal phase, particularly in the HFrEF group.

Conclusion Specialised palliative care input significantly influenced end-of-life care for hospitalised HF patients, particularly regarding access to PCU and use of appropriate symptom management. Differences in care patterns between HF phenotypes suggest gaps in palliative care integration, especially for HFrEF. Enhancing both specialist and primary palliative care capabilities

is essential to ensure equitable, high-quality end-of-life care for all patients with HF.

OP5

ENHANCING TELEHEALTH IN PALLIATIVE AND CANCER OUTPATIENT CARE: EVALUATING THE IMPLEMENTATION OF A NOVEL CONSULTATION SUMMARY SOFTWARE APPLICATION

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10.1136/spcare-2026-ANZSPM.4

Background Patient-centred communication and patients' retention of complex medical information are essential for quality healthcare. Yet, challenges with delivering patient-centred communication persist across many medical specialties. In palliative care, inadequate clinician-patient communication is particularly detrimental to identifying care needs and supporting collaborative decisions about care. The surge in telehealth use has brought many benefits, along with technological challenges that can exacerbate inadequate patient-centred communication.

Objective We aimed to evaluate the pilot implementation of a new, multidisciplinary and collaboratively developed Patient Consultation Summary software application within real-world routine telehealth practice across palliative care and cancer hospital outpatient services at Monash Health.

Methods Surveys completed by patients and their clinicians captured expectations and experiences of using the Patient Consultation Summary application over a 6-month implementation period. Application and consultation summary usage patterns and platform analytic data were also used to examine implementation success, guided by the Feasibility, Reach-Out, Acceptability, Maintenance, Efficacy, Implementation, and Tailorability (FRAME-IT) framework for evaluating health interventions.

Results Descriptive statistics were examined for quantitative data, and content analysis performed for qualitative data. The Patient Consultation Summary application was used by 13 of 23 initially recruited clinicians, and 17 of 36 patients (29 total separate uses, >1 use for 41% of patients). Clinicians were 77% women, mostly aged <46 years, medical experience ranging from early career (0-5 years; 44%) to senior (11-20+ years; 30%), averaging 2-4 years telehealth experience, and used telehealth a few times a week. Patients were 53% women, average 60 years old, predominantly English-only-speaking, mostly between 1-5 years telehealth experience, and typically used telehealth once a month.

Clinicians were satisfied with ease of using the application, and the quality and usefulness of generated summary documents. They used it primarily to provide instructions about medications or managing the patient's condition. Despite reporting increased time spent in consultations and writing notes, clinicians perceived significant benefits of providing clear written instructions and plans for patients, which could be sent

immediately via the telehealth platform. Other clinician-focused barriers included technical limitations of the application (limited usability and adaptability of summary document structure and headings, lack of automated sending of summaries to patients, inability to save summary templates) and workflow difficulties (remembering to use it, discomfort around typing while patient waiting).

Patients were highly satisfied with all aspects of using the application, reporting positive impacts on communication, rapport, quality of care received, understanding and remembering information about their illness and care plan. They referred to summary documents for instructions and shared with family and healthcare professionals, similarly appreciating having something in writing to help them keep track and remember information.

Discussion Numerous benefits were associated with real-time preparation and sharing of a patient consultation summary during telehealth encounters, via this novel software application. Despite adding steps to clinicians' telehealth workflows, it enabled immediate access to a written summary of important medical information such as medication instructions, aligning with patient-centred communication practices and supporting patient agency and confidence in managing complex health needs. Outcomes guided refinement of the software for broader commercial roll-out.

OP6

PATIENT-REPORTED OUTCOME MEASURES FOR SUPPORTIVE CARE IN HEART FAILURE: RESULTS FROM AN AUSTRALIAN HEART FAILURE CLINICIAN SURVEY

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10.1136/spcare-2026-ANZSPM.5

Background Advanced heart failure is a progressive terminal condition associated with significant physical symptoms and psychosocial burden. Although a frequent cause of hospital presentation, referrals to supportive care services are often late or non-existent. In the first part of a sequential mixed-methods study that intends to test the feasibility of using patient reported outcome measures (PROMs) to identify and respond to supportive care needs in heart failure patients, we sought to understand how PROMs are currently used in clinical heart failure care across Australia.

Methods We surveyed heart failure clinicians across Australia to establish the current use of PROMs in heart failure care. Invitations to participate were disseminated via professional organisations to their members and snowballing via word of mouth/email.

Results 101 responses were received from multiple states, with 67 complete and 13 partially complete. Respondents were predominantly nursing (65%) and medical staff (29%). They were largely experienced heart failure clinicians (>5yrs practice), with almost half caring exclusively for heart failure patients.

Less than half of respondents currently use PROMs in heart failure care. 77% of those who do, perceived them to be at least moderately useful for patient care. Additionally, 70% of those

not currently using PROMs still believed they would improve heart failure care. PROMs in use are primarily disease-specific (>70%), such as the Kansas City Cardiomyopathy Questionnaire. Dedicated quality of life measures such as EQ-5D were far less frequently employed, and palliative-specific tools very rarely used.

Respondents not currently using PROMs identified the physical symptom domain as the highest priority for desired information from patients, followed by information about level of function, and biometric parameters (such as weight or blood pressure). Quality of life and psychological symptoms were considered of intermediate importance, with social and supportive care concerns of lowest importance.

Discussion These insights into the use of PROMs in routine heart failure care across Australia are consistent with published experiences in other countries. Most clinicians perceived PROMs as beneficial to patients and able to support better care, regardless of their current use. The majority use of disease-specific PROMs, and the priority placed on the physical symptom domain, is to be expected in a cohort of specialist heart failure clinicians who use such information to classify severity of disease, and direct treatment.

It is impractical to expect specialist heart failure clinicians to manage the wide range of supportive care needs known to exist in their patient group. However, their apparent belief in the benefit of PROMs overall affords an opportunity to assess whether PROM use within routine heart failure care could enhance the identification of supportive care needs (prompting timely referral to additional services, improving patient quality of life, and/or reducing dependence on acute care services).

This study will now proceed to survey patients and caregivers to understand consumer perspectives on the feasibility and value of PROMs within heart failure care. Subsequent focus groups will explore clinician and consumer preferences for PROM deployment into a clinical heart failure care environment, and the practicalities of so-doing.

OP7

CMV REACTIVATION AFTER CHECKPOINT INHIBITOR IMMUNOTHERAPY. THINKING OUTSIDE THE BOX IN PATIENTS WITH REFRACTORY SYMPTOMS

Alison Blight*, Richard Lawrence. *Private Practice, Coffs Harbour, Australia*

10.1136/spcare-2026-ANZSPM.6

The case of an 81yo woman with biphasic pleural mesothelioma being treated with immune checkpoint inhibitors (ICI), experiencing refractory nausea and vomiting is presented. Investigations eventually showed cytomegalovirus (CMV) gastritis with superimposed immune-checkpoint inhibitor induced gastritis/duodenitis which responded to valganciclovir & prednisolone. Although CMV seroprevalence is high in our community, reactivation as a cause for symptoms that are often seen as either treatment related adverse effects or disease sequelae is often not considered. CMV gastritis is treatable. Reliance on endoscopy & biopsy, and low prevalence of viraemia suggests that cases may be missed and true incidence of CMV gastritis is underreported & undertreated in our patient cohort.

This patient, from rural NSW, was diagnosed with biphasic pleural mesothelioma in December 2023 after having Video Assisted Thorascopic Surgery (VATS). She received 3 Cycles of dual PD-1/CTLA4 immune checkpoint inhibition (ICI) in a

major centre before returning home. Treatment was complicated by pneumonia, pulmonary embolism, hypothyroidism, ongoing fatigue, rash & itch. Staging demonstrated disease response.

In May 2024 she underwent Cycle 4 of her ICIs back in the rural centre where she lived. 2 weeks later she developed fever, diarrhoea, abdominal pain, nausea & vomiting with CT evidence of colitis. Outpatient symptom management was challenging and she was admitted to hospital with profound nausea, vomiting, epigastric pain, intermittent confusion, and profound depression to the point of requesting euthanasia. Gastroscopy showed gastritis with erosions & biopsy showed active chronic gastritis & duodenitis with rare positive CMV immunostaining nuclei on antral biopsy but negative CMV PCR testing. High affinity serum CMV IgG was detected, suggesting CMV reactivation rather than primary infection. She improved with a short burst of high dose prednisolone then tapered, higher dose Proton Pump Inhibitor (PPI) therapy and was discharged home.

2 weeks after the patient's 5th cycle of ICI she relapsed with severe nausea, vomiting, itch, fatigue and confusion and was readmitted. Repeat gastroscopy demonstrated severe chronic active gastritis & duodenitis with ulceration. CMV PCR was positive in antral and duodenal biopsies, with super-imposed immune-checkpoint inhibitor induced gastritis/duodenitis. Serum CMV PCR remained negative. A painful vesicular lesion developed on her sacrum which has negative for HSV1&2 & VZV which may also have been cutaneous CMV. She was treated with oral valganciclovir, high dose prednisolone and ongoing high dose PPI therapy with resolution of her symptoms over 3-4 weeks. She received no further immunotherapy & her disease remained stable apart from a small frontal cerebral metastasis treated with radiotherapy in July 2025.

This patient now lives independently in a supported-care retirement unit with her husband and dog. She is not requiring home O₂, is using PRN anti-emetics, and remains on 2.5mg prednisone daily due to adrenal suppression. She enjoys regular trips to Melbourne to visit family, and involvement with local activities. She is not currently needing community palliative care involvement and says she is happy to be alive.

OP8

ENABLING RAPID QUALITY IMPROVEMENT IN PALLIATIVE CARE: IMPLEMENTING THE PCOC DIGITAL DASHBOARD

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10.1136/spcare-2026-ANZSPM.7

Digital dashboards are routinely used by clinicians to support their practice.¹ Evidence on how digital dashboards are used to improve practice remains limited, despite their potential to inform patient care, support performance monitoring and resource management.¹⁻³ This presentation will provide insights into how the PCOC digital dashboard has been designed, implemented, and is being used by palliative care services across Australia for quality improvement and benchmarking. It will explore early signs of clinician engagement and deliver fresh perspectives into how a digital dashboard can unlock the real-world value of data for clinical decision-making.

The digital dashboard was developed to support clinicians in having a more rapid and responsive approach to data. It allows

them to explore their data through trend analysis, auditing and benchmarking. The dashboard allows users to move from high-level trends to detailed patient-level information, improving transparency and allowing deeper interpretation of patient outcomes.

Dashboard prototypes were presented to clinicians, consumers and other stakeholders who provided valuable feedback to the development team on how to make the dashboard more meaningful for clinical practice. As a result, the dashboard now includes prompts to help users navigate through the platform and interpret their data. The dashboard has undergone rigorous security testing, meets web content accessibility guidelines and adheres to best-practice standards.

The dashboard, launched in April 2026, and has already been accessed by 145 services demonstrating strong early uptake. The PCOC Communities of Practice are supporting clinicians to use the dashboard for benchmarking and QI activities.

We will describe dashboard use through analysis of metadata. We will also report on clinician feedback and present case studies on how the digital dashboard has been used for quality improvement and service planning around the country using the RE-AIM Framework.⁴

Findings from this work will shape the future of the PCOC digital dashboard, enabling increased data use, driving quality improvement, and investigating how services are translating data into action to improve patient outcomes.

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OP9

THE CARBON FOOTPRINT OF AN AUSTRALIAN PALLIATIVE CARE UNIT

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10.1136/spcare-2026-ANZSPM.8

Background Healthcare related Greenhouse gas emissions are contributing to global warming and impacting planet and human health. Healthcare emissions data, once measured and quantified, can be used to identify significant sources of emissions and assist in directing initiatives.

Aim To calculate the carbon footprint of a palliative care unit in Australia, and identify areas of high emissions, areas for potential action, and staff attitudes to sustainability.

Design This is a single-center study that collected retrospective emissions data for the year 2024. Process- and financial-based calculations were made using emissions factors from governmental data or similar studies to determine the overall carbon footprint of the unit. Staff and inpatient data were collected and included a staff survey to determine attitudes to sustainability.

Setting/Participants A 40-bed palliative care unit occupying one floor of a six-floor sub-acute hospital, with a weekday ‘snapshot’ of inpatients and staff.

Results The carbon footprint was calculated at approximately 600tCO₂e. The highest contributions were energy use (43%), staff and visitor travel (20%), and catering (9%). The response rate to the staff survey was 84%, with sustainability rated high importance.

Conclusions This is the first study to quantify the carbon footprint of an Australian palliative care unit and identify the highest priorities are reducing use of grid electricity, increasing renewable energy generation and reducing petrol or diesel transportation. It highlights that switching to renewable energy sources and improving public transport or providing incentives to hybrid or electric cars would have the biggest impact at present.

OP10

CARING FOR THE CARER: A PILOT TELEHEALTH CARER COACHING MODEL FOR CARERS OF PEOPLE RECEIVING PALLIATIVE CARE IN RURAL AND REMOTE QUEENSLAND

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10.1136/spcare-2026-ANZSPM.9

Background Carers are essential in supporting people receiving palliative care, yet up to 88% report unmet needs and significant psychological burden (Hart et al., 2022; Johnson et al., 2024; Wang et al., 2018). Variability in carer knowledge and preparedness, combined with limited access to structured education in rural and remote Queensland, contributes to sub-optimal experiences and outcomes. The Specialist Palliative Care Rural Telehealth (SPaRTa) service identified these gaps and developed a novel Telehealth Carer Coaching model to provide tailored, multi-disciplinary education and support.

Objectives To implement and evaluate the effectiveness and acceptability of a Telehealth Carer Coaching Program and its impact on carer knowledge and preparedness.

Methods Healthcare redesign methodologies, including Lean Thinking, Six Sigma, and Plan Do Study Act cycles, were used to identify system variation and co design solutions with stakeholders. Diagnostic activities included carer interviews, staff surveys, data audits, process mapping and literature review.

The pilot Carer Coaching Program commenced in April 2026 is being evaluated using a mixed-method pre-post design. The primary outcome is change in Death Literacy Index short-format questionnaire (DLI-9) scores, analysed using paired statistical tests. Secondary outcomes include satisfaction and perceived usefulness from anonymous feedback surveys. Qualitative data from semi-structured interviews are analysed using reflexive thematic analysis.

Results Baseline findings showed substantial variability, with information provided to carers documented in as few as 25% of cases. Early implementation data demonstrates strong uptake of Telehealth Carer Coaching sessions, alongside improved engagement with allied health services and increased documentation of education provided. Quantitative results are expected to demonstrate statistically significant improvement in DLI-9

scores post-intervention, while qualitative findings are expected to highlight increased confidence, preparedness, and ability to navigate end-of-life care.

Discussion This innovative Telehealth Carer Coaching Program offers a scalable, person-centred approach to address unmet carer needs in a rural palliative care setting. By integrating validated carer needs assessment tools, multi-disciplinary collaboration, and a flexible ‘pull-based’ service design, the model aligns with national standards and overcomes geographic barriers.

Improving carer preparedness has important implications to reduce caregiver burden, enhance patient outcomes, support end-of-life care at home and strengthen system efficiency. This model provides a framework for other services seeking sustainable solutions to support carers in complex care environments.

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OP11

SIMPLIFYING THE HIGHLY COMPLEX-TAILORED CMIS FOR ADOLESCENT AND YOUNG ADULTS WITH PALLIATIVE CARE NEEDS

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10.1136/spcare-2026-ANZSPM.10

Work undertaken at: Adolescent and Young Adult Hospice (AYAH), Manly, NSW, Australia.

Background Consumer Medicines Information (CMI) sheets provide essential information on the safe and effective use of medicines. However, formal CMIs produced by pharmaceutical companies often do not address common palliative care scenarios (e.g., off-label indications, subcutaneous administration, or practical advice for administration of medications via an enteral access device), limiting their usefulness for adolescents and young adults (AYA) and their families.

Objectives

- To develop AYA-appropriate palliative care CMIs for commonly used medications at AYAH, including information relevant to off-label use and non-oral routes.
- To ensure these resources are readable, acceptable to consumers, and suitable for local governance approval.

Methods Tailored CMIs for paediatric patients are currently available through the Victorian Paediatric Palliative Care Program. However, these resources are not entirely suitable for AYAs. The AYAH pharmacist obtained permission from the Royal Children's Hospital (Melbourne) to adapt these CMIs for AYA patients aged 16–30 years. Content and language were revised for this age group and reviewed by a multidisciplinary team at AYAH, including palliative care physicians, specialist nurses, and a clinical psychologist. They were subsequently assessed by a minimum of five patients and family members for

content and readability before being submitted to the Northern Sydney Local Health District (NSLHD) Drug and Therapeutics Committee (DTC).

Results Six CMI's have been developed to date. Following DTC feedback, two versions were produced for each medication: one aimed at patients and the other for families and caregivers of patients with cognitive impairment. The CMI's received a Consumer Tick from the NSLHD Consumer and Patient Experience Unit. The resources cover information on off-label prescribing, enteral preparation and administration, subcutaneous use where relevant, advice on drug-drug interaction, potential adverse effects, and non-pharmacological symptom management. Approved CMI's currently include clonidine, gabapentinoids, benzodiazepines, levomepromazine and opioids. CMI for methadone is currently being developed. A QR code for ongoing patient and family feedback is included on each sheet.

Discussion Developed collaboratively with input from multi-disciplinary stakeholders and patient feedback, these CMI's seek to meet the specific needs and diverse nature of AYA patients and aim to enhance communication, facilitate informed decision-making, empower individuals and their families and by doing so contribute to improved patient outcomes.

OP12 MOVING UPSTREAM: IDENTIFYING NEWLY REFERRED PATIENTS TO MEDICAL ONCOLOGY SUITABLE FOR EARLY PALLIATIVE CARE BY UTILISING THE 'ROYAL MARSDEN TRIGGERS TOOL'

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10.1136/spcare-2026-ANZSPM.11

Background Integrating palliative medicine upstream in the trajectory of life-limiting illness remains challenging despite a decade long, evolving evidence base of demonstrating acceptability and positive impact. Providing early palliative medicine input alongside active oncology management is endorsed by international professional oncology organisations such as ESMO and ASCO - although remains scarce in routine practice. Triage of new referrals to medical oncology with the 'Royal Marsden Triggers Tool' - which includes both needs-based criteria relating to significant distress (physical and psychological) and criteria which are potential markers of a change or deterioration in health status - provides a mechanism to identify patients with cancer who seek to benefit from early palliative care input.

Objective To assess the effectiveness of applying the 'Royal Marsden Triggers Tool' to a cohort of newly referred medical oncology patients in the outpatient setting.

Method A retrospective case notes analysis of outpatient clinic correspondence applied to a randomly selected sample of new patients referred to ICON Cancer Centre, Adelaide, between June 2024 & June 2025 was conducted. HREC approval was obtained via Bellberry with support from the ICON HREC team. A sample size of 254 was calculated to give a 95% confidence interval (CI) precision excluding zero from the lowest bound in the literature.

The random sample of deidentified patients was generated using 'R' (www.r-project.org) statistical software. Initial outpatient consultation letters and associated electronic medical records were reviewed for demographics, the seven 'Roy-

al Marsden Trigger Tool' criteria, intent of therapy (curative or palliative) and if referral to palliative care within 8 weeks occurred.

Results There were 735 new medical oncology consultations. 254 patients were randomly selected and reviewed. 3 patients had too little data in the correspondence, giving 251 eligible patients. Commonest diagnoses were breast cancer 13%, lung 13%, head & neck 14% and genitourinary 36%. 30% were being treated with palliative intent. Median age was 71 (range 29 - 100), 63% were male.

70 patients (27.5%; 95% CI 23-33%) met one or more 'trigger' criteria at first outpatient review. The breakdown of number of positive factors is shown in the table. Median age of 'trigger-positive' patients was 72, 50% were male. 14% of 'trigger-positive' patients had breast cancer, 20% lung, 13% head and neck and 26% genitourinary. Importantly, treatment intent was curative in 16 (22.9%) and palliative in 54 (77.1%) according to diagnosis review by the reference oncologist. Only 15 positive patients (11.5%) received a palliative care referral within 8 weeks of first outpatient review.

Triggers Met 1 2 3 4

Frequency 37 (53%) 19 (27%) 10 (14%) 4 (6%)

Curative Intent Treatment 11 4 0 1

Palliative Intent Treatment 26 15 10 3

Conclusion Applying the seven 'Royal Marsden Triggers Tool' criteria to new patients referred to medical oncology suggests that over a quarter of patients may have symptoms necessitating early palliative care input - including patients who have potentially curative disease.

This study highlights potential unmet patient need, requiring increased integration and upstream assessment from palliative care specialists in the outpatient medical oncology setting.

OP13 ADVANCE CARE PLANNING IN OLDER INPATIENTS BEING DISCHARGED TO RESIDENTIAL AGED CARE FACILITIES

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Background/Introduction The Transition Support Navigator (TSN) Service, staffed by senior palliative care nurses, was piloted at Sir Charles Gairdner Osborne Park Healthcare Group in WA from 2022-24 to assist in the transition of hospital inpatients aged over 65 years who were living at home at time of admission and being newly discharge to residential aged care facilities (RACF). In addition to addressing unmet palliative care needs, one of the TSN's roles was to assist patients (and/or their carers where relevant) to undertake advance care planning (ACP), complete ACP documents and communicate ACP to relevant stakeholders.

Objective This audit aimed to describe the ACP role of the TSN, including diagnoses, capacity to participate in ACP (as determined by treating medical team) and rates of ACP documentation.

Methods We conducted a retrospective audit of all patients assessed by the TSN Service between December 2022 and March 2024 using data collected by the TSNs as required by the pilot's funding source. Approval was obtained from the health service's Quality Assurance program.

Results Data was available for 175 patients. Dementia (50.3%), frailty (15.4%) and malignancy (12.7%) were the commonest diagnoses. Prior to TSN review 5.7% (10/175) had either a statutory Advance Health Directive (AHD), or non-statutory Advance Care Plans (ACP). Enduring Power of Guardianship (EPG) was present in 39.4% (69/175) and 155 (88.6%) had a hospital 'Goals of Patient Care' form.

Only 33 (18.9%) of patients had full decision-making capacity to participate in ACP and 34 (19.4%) had partial capacity, i.e. could complete some ACP with support. Most patients (89, 50.9%) had no capacity to participate in ACP, the majority of these (66) having a primary diagnosis of dementia.

Following TSN review, 26.3% of patients (or carers) underwent ACP discussions and 8 (4.6%) proceeded with new ACP documents. A further 11 (6.3%) carers agreed to receive written ACP resources.

TSNs facilitated upload of 63 ACP documents to the patient's MyHealthRecord and/or the hospital's electronic alert system, where these were not previously available electronically.

Conclusion ACP uptake following TSN intervention remained low, even with one on one support available from skilled palliative care CNCs.

Due to high rates of cognitive impairment in this cohort, most patients lacked capacity to participate in ACP, even with supported decision-making for non statutory documents. Carer stress during transition to residential aged care (administrative load, financial stress, grief, and long term caregiver burden) likely reduced engagement in ACP. ACP should ideally begin much earlier in the disease trajectory in outpatient and community settings and will be explored as part of the health service's geriatric medicine outpatient clinics and Older Adult Health Hubs.

OP14 ABSTRACT WITHDRAWN

OP15 THE ETHICS OF PALLIATIVE SEDATION: NAVIGATING UNCERTAINTY AT THE END OF LIFE

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Palliative sedation is widely accepted as an appropriate therapy for refractory suffering at the end of life, yet it continues to generate ethical uncertainty in clinical practice. Questions persist around intention, proportionality, informed consent, existential distress, duration of sedation, and the distinction between symptom relief and practices intended to hasten death. These challenges become even more acute in the context of surrogate decision-makers (paediatrics, mental health etc).

This presentation will examine the ethical foundations underpinning palliative sedation, drawing on contemporary ethical frameworks and cases to illustrate the tensions clinicians commonly encounter. Rather than seeking definitive answers, the session will explore practical approaches to ethical reasoning, communication and multidisciplinary decision-making,

aiming to equip clinicians with a framework for navigating one of palliative medicine's most nuanced and emotionally challenging interventions.

OP16 ETHICAL SCAFFOLDING AND END-OF-LIFE CARE: MORAL DISTRESS AND THE LIMITS OF CLINICAL GUIDANCE

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Moral distress in physicians is increasingly associated with long-term consequences which negatively impact clinician wellbeing and quality of patient care. Clinical Practice Guidelines (CPGs) play a central role in structuring medical decision-making, yet their function as ethically-laden documents capable of generating moral distress remains underexplored. This paper investigates whether increased ethical scaffolding within CPGs could increase physicians' decision-making confidence and reduce moral-uncertainty distress.

Using continuous deep sedation for existential suffering (CDS-ES) as a case study, it was found that existing guidelines on palliative sedation largely delegate the responsibility for determining the ethical permissibility of CDS-ES to palliative care clinicians without providing them structured ethical guidance. Building on Morley's Moral Distress Model,³ this paper conceptualises moral uncertainty and moral constraint along intersecting axes, proposing that CPGs be developed in a way that facilitates a 'Zone of Moral Confidence'; an optimal balance of providing situation-specific ethical advice with room for clinician judgement and discretion.

92 palliative care physicians across the UK, Europe, India and Australia, were surveyed on their experiences of moral uncertainty, moral agency and moral distress. Findings suggest a disconnect between the perceived usefulness of CPGs in supporting ethical reasoning, and their actual uptake, suggesting that existing written frameworks fall short of supporting physicians' moral confidence. Overall, this research highlights the promising role of CPGs as underutilised forms of moral infrastructure, which if deliberately designed to support both clinical and ethical competence – can be leveraged as proactive tool that prevents moral distress and engenders moral confidence.

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OP17 DEPRESCRIBING PRACTICES FOR ELDERLY PATIENTS ADMITTED TO A PALLIATIVE CARE UNIT IN SYDNEY, NSW: A RETROSPECTIVE COHORT STUDY

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Introduction Polypharmacy at end-of-life is associated with higher symptom burden and poorer quality of life. Deprescribing

ing potentially inappropriate medications (PIMs) needs to be considered in palliative care to reduce pill burden, reduce the risk of drug interactions and improve medication adherence.

Aim The primary aim was to assess deprescribing rates for PIMs and pill burden amongst elderly patients with life-limiting illnesses. Secondary aims assessed whether deprescribing practices differed between patients with malignant or non-malignant diagnoses, whether discharge destination, functional status and demographics affected deprescribing.

Methods This was a retrospective cohort study of patients aged 75 and over discharged from a palliative care unit over two years. Data collected included malignant or non-malignant primary diagnosis, functional status and length of stay at admission and discharge, total medications, PIMs and pill burden, as well as demographic information including discharge destination.

Results A total of 135 patients met the inclusion criteria. Patients were discharged on an average of 1.6 more medications and 2.7 more pills compared to admission and 96.3% of patients had polypharmacy on discharge. Statins were the most deprescribed class, with 51.3% of patients admitted on a statin deprescribed on discharge, with high deprescribing rates for vitamins and minerals (46%), oral hypoglycaemics (44.4%) and antihypertensives (39.5%). Proton pump inhibitors were commenced in 8.1% of all patients. Patients with malignancy were more likely to have statins deprescribed, and those discharged home were less likely to have anticoagulants, vitamins and minerals deprescribed.

Discussion Statins, vitamins and minerals, oral hypoglycaemics and antihypertensives were likely the most de-prescribed medications due to their limited symptom benefit and potential for adverse effects. Proton pump inhibitors were likely commenced during admission for possible symptomatic benefit. Statins were more likely to be deprescribed in patients with malignant disease given predictable disease trajectory.

Conclusion Polypharmacy is common in palliative care and commencement of symptom management medications increases pill burden and potential for harm through drug interactions, especially in elderly patients. Deprescribing of PIMs needs to be considered to potentially improve quality of life.

OP18

RETROSPECTIVE OBSERVATIONAL STUDY OF LEVOMEPRMAZINE USE IN END-OF-LIFE CARE IN A METROPOLITAN PALLIATIVE CARE INPATIENT UNIT

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Background and Objectives Levomepromazine is used in palliative care to manage two of the most distressing end-of-life symptoms, delirium and agitation (present in 42–88% of palliative care inpatients) and nausea (reported in 40% of cancer patients in their final weeks of life). There is limited literature guiding its use, particularly in an Australian setting. This retrospective observational study aimed to determine the incidence, indications, and doses of levomepromazine use in a metropolitan palliative care inpatient unit, and to compare concurrent opioid and benzodiazepine use between patients who received levomepromazine and those who did not.

Methods Retrospective cohort study of all inpatient deaths over a 6-month period at a 40-bed metropolitan palliative care unit. Patients were excluded for incomplete data, absence of a continuous subcutaneous infusion (CSCI) at time of death, or death via voluntary assisted dying (VAD). Medication data were captured from the CSCI prescribed at death and all breakthrough (PRN) medications administered in the final 48 hours. Continuous variables are reported as median (range); categorical variables as n (%).

Results Of 209 deaths during the study period, 156 were included (excluded: 26 no CSCI, 12 VAD, 15 incomplete data). Levomepromazine was used in 49 patients (31%). Primary indications were agitation (n=33, 67%), nausea (n=24, 49%), and secretions (n=5, 10%). Levomepromazine was administered via CSCI in 40 patients (82%), with a median dose of 50mg/24h (mean 49mg; range 0–125mg). Patients receiving levomepromazine had higher scheduled opioid doses (median 90mg vs 60mg oral morphine equivalent) and higher benzodiazepine doses (median 20mg vs 10mg midazolam equivalent) compared to the non-levomepromazine group (n=107). Despite higher background medication requirements, PRN opioid use (median 6 vs 5 doses) and PRN benzodiazepine use (median 5 vs 3 doses) in the final 48 hours were only marginally higher in the levomepromazine group.

Discussion Levomepromazine was used in nearly one in three deaths at this unit, higher than most published European data, but consistent with reported rates in the United Kingdom and Netherlands. The median dose of 50mg/24h aligns with contemporary practice. The levomepromazine cohort represented a more clinically complex group. That PRN use was only marginally higher despite substantially elevated scheduled doses suggests levomepromazine may contribute to symptom stability in refractory cases. This audit provides Australian benchmarking data in a field currently dominated by European literature and supports levomepromazine as a clinically relevant adjunct in complex end-of-life symptom management.

OP19

IMPROVING COMMUNITY-BASED ANTICIPATORY PRESCRIBING AT END OF LIFE: EMBEDDING THE NATIONAL CORE COMMUNITY PALLIATIVE CARE MEDICINES LIST

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Background Timely access to symptom management is critical to quality community-based end-of-life care. Terminal phase patients can deteriorate rapidly, with common symptoms including pain, dyspnoea, nausea, agitation and secretions. In community and aged care settings, variability in anticipatory prescribing and access to medicines contributes to avoidable hospitalisations and reduced ability to remain in a preferred place of care.¹

To address this, the Quality Use of Community Palliative Care Medicines Project is delivering prescriber education to strengthen confidence and consistency in anticipatory prescribing of the National Core Community Palliative Care Medicines List² across Australia.

Objectives Strengthen prescribing practice and improve timely access to essential medicines to enable high-quality end-of-life care in preferred settings.

Methods Education will target general practitioners and nurse practitioners providing generalist palliative care in community and aged care settings. Delivered via a digital learning platform, it will include an RACGP and ACRRM CPD-accredited module, clinical audit, webinar, treatment algorithms and shared decision-making tools. Content focuses on anticipatory prescribing, appropriate use of the core medicines, and common prescribing challenges in community and aged care settings.

An expert medical, nurse practitioner and pharmacy advisory group co-design the education to ensure clinical relevance and applicability across diverse contexts. Implementation will be phased between April and September 2026 to support iterative engagement and uptake.

Results Mixed-methods evaluation is underway. Measures include completion rates, participant characteristics and self-reported changes in knowledge, confidence and intended practice. Analysis will assess the extent to which the education supports improved anticipatory prescribing behaviours and more timely symptom management in community and residential aged care settings.

Implications This quality improvement initiative is aligned to the National Palliative Care Standards for All Health Professional and Aged Care Services, including proactive identification, anticipatory planning and access to medicines, carer support and minimising avoidable hospitalisations.³ It also supports Strengthened Aged Care Quality Standards relating to clinical care, medication safety and enabling care in a preferred place,⁴ and as well as the National Safety and Quality Health Service Standards, particularly the Comprehensive Care and Medication Safety Standards, by supporting safe, appropriate prescribing and continuity of care at the end of life across settings.⁵

By translating policy into practical education, this initiative represents a scalable approach to strengthening prescriber practice, supporting equitable and timely access to essential medicines, and enabling more people to receive end-of-life care in their setting of choice.

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OP20 CARE OF THE MOST COMPLEX - HOW COLLABORATION IS THE KEY

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10.1136/spcare-2026-ANZSPM.18

Background Evidence shows that hospital inpatients are becoming more complex over time.¹ Anecdotal evidence sug-

gests patients with specialist palliative care needs are becoming more complex, with more research being undertaken into specific palliative care complexity scores.² We present a single case referred to a community palliative care team, detailing the extensive multiteam input discussions and reviews to allow an optimal plan to be instituted.

Case A patient in their 30s was referred to a Palliative Care Navigator service by their GP. The past history included very extensive neurological, psychiatric, surgical, gastroenterological, rehabilitation and pain team input over decades. There was ongoing regular psychiatry review in the community, as well as recent gastroenterology, rehabilitation and pain team review. The patient had a jejunostomy tube for enteral feeds and medications, an ileostomy, an indwelling urinary catheter and had previous pressure areas despite air mattress. The referral reported the patient as deteriorating and potentially approaching the end of life.

Given the significant complexity, including cognitive impairment, long term complex mental health challenges, and an uncertain trajectory, one senior clinician undertook same day extensive data gathering (electronic medical records review, retrieval of specialist letters and telephone discussion with the patient's long-term GP). A next day meeting was convened with 5 senior palliative care clinicians (4 from community palliative care, 1 from Adolescent and Young Adult Hospice, AYAH) to go through the available history, and institute a review plan. The patient was reviewed at home the following day by 3 senior palliative care clinicians (2 medical, 1 nursing) and telephone calls made with the gastroenterologist and GP. A virtual meeting with the psychiatrist, neurologist, 2 community palliative care consultants, the community palliative care CNC and the AYAH consultant was instituted for the following day to clarify patient decision-making capacity, stability of mental health and ensure consensus decision making regarding pursuing a palliative approach for this patient and facilitating palliative care unit admission. Given clear consensus was reached on this, there was an in-home review by the AYAH consultant and CNC, and the community palliative care CNC, and admission was arranged for the subsequent day.

Discussion Referral to admission to the AYAH took 6 days. In this time there were multiple telephone calls to many treating clinicians, 2 virtual meetings (including one with external psychiatrist and neurologist present), 2 in home reviews, each with 3 specialist clinicians, an MDT discussion at AYAH and multiple emails. Data regarding the amount of time clinicians spend on patient care is kept, with a total of 20 hours of clinician time spent from referral to admission to the AYAH.

Conclusion Given the increasing complexity of patients, a review of resourcing for palliative care services is likely to be needed to ensure sustainability for the future.

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OP21

BODY AND MIND - THE UNIQUE ROLE OF A PSYCHIATRIST IN CARING FOR PATIENTS IN TWO VERY DIFFERENT PALLIATIVE CARE UNITS IN SYDNEY, AUSTRALIA

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Background There has been an increasing recognition of the importance of integrating psychiatry into specialist palliative care in the adult system.^{1,2} The 2024-5 PCOC report demonstrates 61.6% of patients have a malignant disease process. Conversely, 73% of patients referred to the Adolescent and Young Adult Hospice (AYAH) have a non-malignant diagnosis. We discuss the role of specialist psychiatry review in an adult palliative care unit (PCU) patient and two Adolescent and Young Adults (AYA).

Case 1 A patient in their 40s with end stage liver disease was admitted to the PCU. There was a complex psychosocial background and a history of long-term alcohol dependence. Team observations included pressured speech and tangential thinking. Psychiatry and neuropsychology reviews were requested to exclude a mental health disorder and assess financial decision-making capacity, due to family concerns about possible financial exploitation.

Case 2 A patient in their 20s with a partial chromosomal duplication, type 1 diabetes mellitus and renal dysfunction on a renal supportive care pathway was referred to AYAH. The patient is non-speaking at baseline, with a long-term diagnosis of sleep disorder and possible manic episodes. The patient was reviewed during recurrent admissions over a two-year period, allowing weaning of nephrotoxic treatments, and rationalisation of their medication regimen.

Case 3 A patient in their 20s with a rapidly progressive recent onset dementia syndrome was referred to AYAH. Initial symptoms had included anxiety and depression, requiring ongoing care by a psychiatrist in the community. After further deterioration the patient was admitted to AYAH with progressive frontotemporal-type dementia symptoms and worsening agitation, requiring a titration of antidepressant, benzodiazepines, clonidine, gabapentinoids and antipsychotics.

Discussion All three cases demonstrate the complex needs palliative care patients requiring specialist psychiatry input may have. Both AYA patients required highly nuanced reviews, with neither patient able to speak with the psychiatrist. History taking from the AYA patients' relatives revealed a likely high prevalence of psychological symptoms in this cohort requiring significant efforts to link them with their own supports. Collaborative discussion with community teams involved in the AYA patients' care was essential for background information, and to help guide care for patients on discharge. Linking patients in with sub-specialist psychiatrists with an interest in palliative care is very challenging, due to very limited availability of these services.

Conclusion Palliative care psychiatry is becoming a unique subspecialty. Patients admitted to the AYAH may require further

subspecialised 'thinking outside the square' psychiatry assessment and management which currently has very limited availability. Immediate family members may need guiding towards their own psychiatric and psychological supports.

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OP22

A SOCIAL HISTORY OF PALLIATIVE MEDICINE IN AUSTRALIA AND NEW ZEALAND

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This presentation shares findings from my PhD Thesis exploring the social history of Palliative Medicine in Australia and New Zealand. My goals in this work were to understand how and why the discipline of Palliative Medicine came about in our local context, its impact on palliative care itself and on health care more generally, and what has been gained or lost in that process.

Using a combination of questionnaires and narrative interviews, I documented the experiences and professional journeys of the first cohort of Australian and New Zealand Palliative Medicine Specialists, the 'Foundation Fellows' of the Chapter of Palliative Medicine. Through their eyes I investigated the development of Palliative Medicine in modern Australia and New Zealand and sought a unique and informed insight into the future of palliative practice.

Most of those interviewed were experienced mid-career doctors who had become disillusioned with conventional practice and found in palliative care a more congenial and effective form of practice. Unusually for medical specialists, they came from diverse backgrounds, and the workforce was highly feminised. They were of a generation born in the shadow of two world wars, and raised during the mid-20th century, when many new ideas were percolating throughout society; it is my contention that this may have facilitated their openness to a new way of practicing medicine. Basing their practice on the values and goals of care of the 'palliative care movement', they challenged mainstream medical practice to improve the care of people with life limiting illnesses and those who were dying.

Well beyond their clinical roles, they took on a range of tasks needed to advance the new discipline, including setting up formal training programs to induct those who came after them, developing the research programs that grounded their practice, establishing the literature needed to support it, and creating the formal professional bodies that would shape and sustain it. By these activities they succeeded in establishing an entirely new professional discipline, Palliative Medicine.

In that process of professionalisation, and in becoming part of mainstream health care, compromises had to be made. There has been an ongoing struggle to maintain the values of palliative practice while fitting into the constraints of mainstream health care. The development of Palliative Medicine has impacted other professional groups providing palliative care. This has been both positive, by creating a professional space that validates and normalises palliative practice; and negative, by challenging some of the founding values of palliative care including its non-hierarchical and interdisciplinary nature.

The thesis explores the fitness of Palliative Medicine to meet the challenges of contemporary practice. In a rapidly changing world, the experiences, adaptability and passion for palliative practice of the Foundation Fellows helps winnow out what is most important to keep as the field develops and provides guidance for the next generation.

OP23 REFRAMING HOPE UNDER TIME CONSTRAINTS: A CASE OF RESTORING PATIENT-LED DECISION MAKING IN HOSPICE CARE

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Background In end-of-life cancer care, patients and families may avoid sharing their true thoughts to protect one another, leading to mutual withholding of information and emotions about prognosis while sustaining unrealistic goals as 'hope'.¹ Although such dynamics are recognised, there remains limited description of brief interventions that support patient-led decision-making under hospice time constraints. This case illustrates a hospice intervention in which a multidisciplinary team (MDT) used a structured family meeting to reframe hope and address family roles.

Case and Intervention An older woman in her 80s with advanced gastrointestinal cancer was admitted to a hospice. Owing to infection-related deterioration, chemotherapy was no longer an option. Both the patient and her family repeatedly expressed the wish to regain strength and become able to receive chemotherapy despite multiple explanations of her clinical condition. The MDT confirmed that the patient retained decision-making capacity but grew concerned about continuing to support unrealistic goals within the context of mutual avoidance of openly acknowledging the possibility of death.

Separate interviews revealed differing inner experiences. The patient disclosed, 'Sometimes I think this may be the end', while her family members admitted difficulty acknowledging the reality in her presence. Neither recognised that the other already anticipated death. The patient was identified as the emotional and practical anchor with significant dependence from her family members. Given the likelihood that she would lose the ability to express her wishes within weeks, intervention was considered urgent. Two priorities were defined: reframing hope and supporting the maintenance and reorganisation of family roles.

As explanations of her clinical condition had previously been provided separately to the patient and to the family members, the MDT determined that sharing the same information in the same setting was key. A single structured family meeting was convened with the patient and all family members present. The physician provided a concise, consistent explanation of the clinical situation, while a nurse facilitated the meeting using open-ended questions to support the patient in articulating her understanding and values, and ensured time for the family to listen without interruption.

Results At the family meeting on day five, the patient demonstrated awareness of approaching death and articulated value-based wishes: that her assets be used to prioritise her family's future needs, and that she wished to spend her remaining time as peacefully as possible with her family. This marked a turning point. The family began to share the same reality, and the pattern of avoidance gradually dissolved. The initial unrealistic goal of receiving chemotherapy was reframed into more achievable hopes grounded in relationships and daily life.

Conclusion This case suggests that, even under severe time constraints, hospice MDTs can help patients and families shift from unrealistic treatment-focused goals to value-based hopes by intentionally creating structured spaces for shared understanding. Such interventions may restore patient-led decision making while supporting family functioning at the end of life.

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OP24 IMPLEMENTATION OF INTEGRATED PALLIATIVE CARE OUTCOME SCALE (IPOS) INTO PALLIATIVE CARE CLINICS

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Executive Summary This quality improvement project implemented the Integrated Palliative care Outcome Scale (IPOS) across two outpatient clinics using a PDSA framework. Of 786 clinic visits, 149 IPOS entries were completed (18.9% screening rate). Findings revealed high symptom burden, with 91% of patients moderately affected; weakness (73.15%) and pain (56.37%) were most prevalent. While physical symptom completion was high (97.9%), psychosocial data showed significant attrition (up to 20.81%). Barriers included patient fatigue and administrative constraints. The first cycle confirms the clinical need for screening; the second PDSA cycle will focus on form revision and staff education to improve uptake and data integrity.

Introduction The outpatient setting of palliative care is essential for the systematic assessment and longitudinal tracking of symptoms and wellbeing in patients with complex and dynamic medical and oncological needs with high symptom burdens and psychosocial stressors. The integrated Palliative care Outcome scale (iPOS) is a globally validated, multi-lingual tool designed

to quantify physical and psychosocial symptoms in a concise, two-page questionnaire.

Methodology/Process A quality improvement (QI) project was launched to implement the iPOS across two outpatient palliative care clinics. Utilizing a Plan-Do-Study-Act (PDSA) framework, iPOS assessments were collected and recorded monthly into a REDCap database. Data were audited to evaluate screening completion rates and the prevalence of physical and psychosocial symptoms. We report here on the outcomes of the first PDSA cycle.

Results/Outcomes Between March 4 and October 13, 2025, 149 iPOS entries were completed, representing an overall screening rate of 18.9% (149/786 clinic visits). Analysis revealed a significant symptom burden, with 91% (135/149) of patients moderately affected (score of 2 or more) in the preceding three days. The most prevalent symptoms were weakness (73.15%, 109/149), followed by pain (56.37%, 84/149), poor mobility (47.65%, 71/149), and drowsiness (46.3%, 69/149).

Completion rates of the iPOS varied by section; while the physical symptom section (Page 1) was nearly complete (97.9%), the psychosocial section (Page 2) showed significantly higher attrition. Non-completion was most frequent for practical problems being met or not (20.81%), feeling at peace (20.13%), and their ability to share with family or friends (19.46%).

Conclusion The initial PDSA cycle identified a high symptom burden among outpatient palliative patients, confirming the clinical necessity of systematic screening. However, the low overall screening rate (18.9%) and psychosocial data attrition highlight significant implementation barriers, including patient fatigue, administrative workflow constraints, and form-entry errors due to misinterpretation. Clinician feedback supports the value of longitudinal data, though optimization is required. The second PDSA cycle will focus on form revision, targeted health-care provider education, and enhanced administrative support to improve screening uptake and data integrity.

OP25

RESIDENTIAL AGED CARE STAFF AND THEIR DESIRE FOR GOALS OF CARE TRAINING: FINDINGS FROM IMPART TRIAL

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Aim To determine Goals of Care (GoC) training needs from the perspective of aged care staff.

Background Use of GoC medical treatment plans is well established in some Australian states and settings. GoC plans are shared decision-making documents completed by a doctor and complement advance care planning. They combine the person's current medical context with prior ACP or communicated wishes. Many people admitted to Residential Aged Care (RAC) will

have lost capacity to undertake their own ACP, and for this frail multi-morbid population, there will usually be medically indicated limits to appropriate medical treatment escalation, in the event of deterioration. IMPART (Improving Palliative care in Residential aged care using Telehealth) intervention is an interactive, co-designed study that includes GoC training.

Methods NHMRC-funded, 2.5-year pragmatic stepped-wedge cluster randomised trial (ACTRN12622000760774) commenced in May 2023. 'Planning Ahead Teams' comprising RAC staff and visiting GPs were established in 10 Melbourne participating RACs. Each team: (i) undertook a needs analysis by auditing 5-10 files of current or recently deceased residents to identify areas where care might be improved; (ii) completed anonymous surveys about how confident they were to provide EOLC; and (iii) engaged with members of the research team in an interactive workshop to co-design their action plan, including goals to be achieved over the 6-month intervention.

Results Descriptive statistics is used for this analysis. Ten RACs participated in the study. Not all completed all components of the 6-month intervention. Nine completed the needs analysis and reported that EoL planning documents currently provided sufficient detail to guide EoL care in 5 RACs, but only sometimes in 4 RACs. Analysis of action plans (N=8) developed from the needs analysis revealed eight goals related to the theme, 'Documentation of GoC and resident care preferences'. All 9 RACs who completed the needs analysis, identified GoC training as a strategy for addressing their needs gap.

Forty-seven staff, including 4 GPs, participated in the IMPART GoC training that was tailored to each of the RAC's identified needs.

Discussion Aged care staff identified the need for GoC training; a core component of the IMPART intervention. RAC GoC medical treatment plans are a way to facilitate and improve discussions about treatment goals and limitations, and to communicate plans for sudden deterioration. For many residents, this will include planning for palliative and end-of-life care, ensuring treatment delivered aligns with the preferences and values of the older person, and within appropriate medical limitations. Supporting aged care staff to identify EOLC training needs can help target training that is wanted by the staff and improve engagement and learning.

Implications This study has implications for high-quality, person-centred care that aligns with a resident's goals and preferences for EOLC. It provides evidence for GoC training for all RAC staff, emphasizing tailored programs that address specific facility needs. Policy implications include collaborating with staff to undertake needs analysis to develop GoC training that is wanted and valued by staff, funding its development, and incorporating it into accreditation standards.

OP26

A BI-DIRECTIONAL APPROACH TO EDUCATION AND LEARNING - THE NORTHERN TASMANIAN PALLIATIVE CARE PROJECT ECHO

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Background Challenges to delivering rural healthcare include geographical isolation, staff recruitment and retention, resource limitations and persistent health disparities. Increasing demand

and dual personal and professional relationships further complicate the provision of palliative care in place.

In 2024, the Northern Specialist Palliative Care Service commenced Project ECHO (Extension for Community Healthcare Outcomes) aimed at developing an online Community of Practice to foster case-based learning, build workforce capacity and increase access to specialty palliative care.

Monthly ECHO sessions included a 10-minute presentation from a palliative care specialist on a topic identified as a priority learning area codesigned by participants and a GP volunteer presented a de-identified case for discussion.

The aim of this presentation is to describe the implementation of the Project ECHO program, reflect on the evaluation findings, and describe the medical and ethical issues faced by rural GPs and district hospital staff.

Method Prior to each session, the GP presenter was asked to provide a brief (de-identified) case summary and questions for discussion. Post session, participants were sent the didactic presentation, a summary of the case discussion, management recommendations and further reading suggestions. A short participant survey was also distributed via MS Forms.

An iterative descriptive thematic analysis of the case summaries, questions posed, recommendations and session notes was undertaken by two authors (FH, OS).

Results During 2024 and 2025, 14 Project ECHO sessions were delivered. In addition to panel members, multidisciplinary staff from four general practices and six district hospitals attended. The areas of Tasmania involved were classified as Modified Monash Model remoteness area 5 (small rural town) to 7 (very remote community).

Post session evaluation surveys rated relevance to practice as 'very good' or 'excellent' and reported knowledge about best practice and confidence in managing patients 'improved' or 'greatly improved'. Most also 'agreed' or 'strongly agreed' that they would use what they had learned.

The 13 cases discussed were complex and most (9/13) had a cancer related principal diagnosis. Inter-related themes included: managing severe symptoms, providing best-possible care, and caring in place.

Symptoms commonly discussed included the management of severe agitation and wandering, shortness of breath, complex pain, delirium, and anxiety. Ideas of equity and access to best possible care need to be considered through a rural cultural values lens. The GPs' principal desire was to honour their patients wish to die in place even when this involved difficult decision-making challenges weighing up ethical challenges and duty of care to the patient, patient's family, colleagues, wider healthcare team, and the broader community.

Discussion Project ECHO provides an opportunity to bring specialist and primary care teams together to facilitate mutual understanding, build social capital, and create virtual teams around individual patient's care. Over time, the Project ECHO sessions fostered a community of practice evidenced by mutual trust, respect, professionalism, and gratitude. Other benefits included peer-to-peer and bidirectional learning and support.

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OP27

CONCURRENT SEDATIVE USE AFTER PHENOBARBITAL INITIATION IN PALLIATIVE SEDATION THERAPY: A DESCRIPTIVE AUDIT AND GUIDELINE-BASED ANALYSIS

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Background The revised European Association for Palliative Care (EAPC) framework provides a stepwise approach to palliative sedation therapy (PST), with midazolam and antipsychotics as first- and second-line agents, and propofol recommended for refractory cases. Escalation to propofol typically involves replacing, rather than continuing, prior sedatives. In contrast, guidance for phenobarbital infusion and PRN, despite its common use as a third-line agent, is limited.¹

Aim To describe patterns of concurrent sedative use following phenobarbital initiation in PST and to examine these practices in the context of existing guideline recommendations.

Methods A retrospective clinical audit was conducted in a tertiary Australian palliative care service. Patients receiving phenobarbital for PST were identified. Data collected included indication for sedation, concurrent continuous sedative infusions, PRN medication use, and dosing patterns. Practice patterns were analysed descriptively and interpreted in relation to contemporary Australian and international guidance, including the EAPC framework.

Results Phenobarbital was typically introduced following prior use of benzodiazepines and/or antipsychotics.² Continuation of these agents after phenobarbital initiation was common but variable, with many patients remaining on midazolam and/or levomepromazine infusions, while others had partial or complete discontinuation.

PRN sedation practices were also inconsistent. Although phenobarbital was commonly prescribed as a PRN agent, benzodiazepines and antipsychotics were still frequently used for breakthrough sedation.²

Phenobarbital dosing varied widely. Higher continuous doses appeared to be associated with reduced reliance on additional PRN sedation and fewer concurrent agents, although this was not formally compared. In contrast, multimodal sedation was associated with greater regimen complexity and increased reliance on breakthrough dosing.

Discussion These findings highlight a key clinical dilemma in PST: whether to continue previously ineffective sedatives when introducing phenobarbital. While guidelines support substitution of agents when escalating to propofol, equivalent guidance for phenobarbital is limited, and continuation of benzodiazepines and antipsychotics is common in practice.

One possible rationale is the assumption of additive or synergistic effects, whereby phenobarbital augments partially effective agents such as midazolam or levomepromazine. This may explain the tendency towards multimodal sedation, particularly in patients with incomplete responses to first- and second-line PST.

However, this approach introduces treatment complexity and potential pharmacological interaction. Phenobarbital is a known inducer of hepatic enzymes and may reduce the efficacy

of concurrently administered benzodiazepines, raising the possibility that multimodal sedation may not always provide additional benefit.

Clinical observations from this cohort suggest an alternative pattern. In selected cases, phenobarbital used as a primary or dominant agent achieved effective symptom control with minimal or no additional sedatives. In other cases, phenobarbital alone was sufficient without the need for further escalation or additional PRN medications.

These findings suggest that while additive effects may be relevant in some scenarios, they are not universally required. The persistence of multimodal strategies may instead reflect clinical habit, uncertainty regarding dosing, or caution in escalation. Lower initial dosing may further contribute to reliance on PRN sedation and additional agents, whereas higher therapeutic dosing appeared to reduce the need for concurrent medications and improve consistency of symptom control.

This highlights a gap in guidance and the need for clearer recommendations for phenobarbital in palliative sedation.

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OP28

PROPORTIONALITY IN PALLIATIVE SEDATION THERAPY: BRIDGING THE GAP BETWEEN GUIDELINE INTENT AND CLINICAL PRACTICE

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Background Australian and New Zealand palliative sedation guidance defines proportionality as the use of sedation titrated to relieve refractory suffering, with dosing individualised to clinical need. However, in practice, sedation is commonly initiated using low starting doses with stepwise escalation. This may reflect an implicit interpretation of proportionality as gradual dose titration rather than timely symptom relief.

Aim To examine how proportionality in palliative sedation therapy is applied in clinical practice and to develop a pragmatic framework aligned with guideline intent.

Methods This study integrates findings from a retrospective clinical audit of phenobarbital use for palliative sedation in a tertiary Australian hospital with a narrative review of contemporary Australian and international guidance. Clinical variables included indication, initial dosing strategy, escalation patterns, and time to symptom control. Practice patterns were compared with stated principles of proportional sedation.

Results Guidelines consistently emphasise that sedation should be titrated to achieve symptom relief within an acceptable timeframe and be tailored to individual patient characteristics. However, audit data demonstrated a consistent pattern of low initial dosing with delayed escalation. This approach was associated with ongoing distress, increased reliance on breakthrough medications, and prolonged time to symptom control.

In contrast, earlier use of higher initial doses in selected patients was associated with more rapid symptom relief without observable adverse effects. These findings suggest that proportionality is often operationalised as a cautious escalation process rather than as context-responsive dosing aligned with

the urgency and severity of suffering. These findings highlight a conceptual–operational gap, where proportionality is defined as an outcome (relief of suffering) but applied in practice as a process (incremental escalation).

Discussion Current guidelines emphasise outcome-based proportionality but provide dosing frameworks that may unintentionally reinforce stepwise escalation. This suggests that clinicians may prioritise perceived safety of dosing over the ethical imperative of timely symptom relief, creating a disconnect between guideline intent and bedside practice. In patients with severe or rapidly escalating distress, a rigid escalation approach may delay adequate symptom control and prolong suffering.

We propose reframing proportionality as context-based dosing, where initial dose selection reflects key determinants such as symptom severity, rate of deterioration, prior treatment failure, and patient goals of care, consistent with guideline intent. Incorporating such an approach may reduce reliance on repeated breakthrough interventions, improve the timeliness of symptom control, and better align clinical practice with the ethical intent of palliative sedation therapy.

Conclusion Proportionality in palliative sedation therapy should be understood as achieving timely relief of suffering, rather than adherence to incremental dosing strategies. Aligning clinical practice with the conceptual intent of guidelines may enable more timely, effective, and ethically consistent relief of suffering at the end of life. Further prospective work is needed to evaluate whether this approach improves patient comfort, clinician confidence, and consistency of care.

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OP29

VOLUNTARY ASSISTED DYING IN AN INSTITUTIONAL NON-PARTICIPATING SPECIALIST PALLIATIVE CARE SERVICE – PROCESSES, OUTCOMES AND LEARNINGS

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Background Voluntary assisted dying (VAD) legislation has been implemented across all Australian states since 2019, yet the interface between VAD and palliative care remains contentious, particularly within healthcare organisations that hold policies of institutional non-participation (INP). A paucity of data exists on the experience of patients who pursue VAD when under the care of specialist palliative care services (SPCSs) operating under INP.

Aim To determine incidence, characteristics and outcomes of patients accessing VAD information within a SPCS with a policy of INP.

Design A single-centre retrospective cohort study.

Setting A large metropolitan SPCS in Brisbane, providing inpatient and community palliative care, operating under INP.

Participants Adult patients in the community and inpatient specialist palliative care setting who enquired about or engaged with VAD between 1 January 2023 and 31 December 2025.

Outcome measures To determine the incidence of VAD assessments, death via the VAD process, and the characteristics around VAD experience (timing, administration, location, reasons, communication).

Results Of 2,647 deaths of patients involved in the SPCS, 208 patients (8%) enquired about VAD and 85 patients (3%) died via VAD. Patients dying via VAD were predominantly older (median 76 years), male (61%), with malignant disease (80%) and died at home (62%). Motivations for VAD were multifactorial, with the most frequently documented reasons being poor quality of life and autonomy. Documentation and communication of VAD assessments and administration methods were incomplete. Where known, the VAD process was often rapid: median of 9 days, from first assessment to death, 36% using an expedited pathway, and 37% of patients having VAD on the day of their final assessment.

Conclusions INP specialist palliative care services play a meaningful role in providing palliative care to patients who seek information on the VAD process. These findings demonstrate a need to improve documentation and communication frameworks, to explore clinician experiences in INP settings, and clarify the relationship between palliative care needs and VAD engagement.

OP30

MALIGNANT VERSUS NON-MALIGNANT INPATIENT PALLIATIVE CARE AT THREE AUSTRALIAN METROPOLITAN SERVICES: A 10-YEAR OBSERVATIONAL COHORT STUDY (2015–2024)

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Introduction/Background Palliative care has historically focused on cancer, yet patients with non-malignant conditions experience comparable symptom burden and functional decline with substantially lower access to specialist services. Australia's Palliative Care Outcomes Collaboration (PCOC) routinely captures standardised outcomes across both groups. We aimed to compare presenting characteristics, within-admission outcomes, and discharge patterns of malignant and non-malignant patients at three Australian metropolitan inpatient palliative care services.

Method A retrospective cohort study used PCOC data from three St Vincent's Health Australia (SVHA) inpatient palliative care services (Sydney, Melbourne, Brisbane) over 2015–2024. PCOC sentinel codes were recoded to missing per convention. Pre-specified strict-exclusion criteria addressed diagnostic ambiguity and essential-covariate completeness. Outcomes included Symptom Assessment Scale (SAS; total range 0–70, higher = worse) total at admission and discharge, Resource Utilisation Groups–Activities of Daily Living (RUG-ADL; total range 4–18, higher = more dependent) functional status, length of stay (LOS), in-hospital mortality, and discharge to usual place of residence (admission accommodation matching discharge accommodation by category). Generalised estimating equations with patient-level clustering and site as a fixed effect provided adjusted estimates; ANCOVA was primary for change-score outcomes.

Results/Findings Of 12,335 patients (15,136 episodes), 8,982 (73%) had malignant and 3,353 (27%) had non-malignant diagnoses. Non-malignant patients were older (mean age 80.4 vs 73.5 years), more functionally impaired (admission RUG-ADL 15.6 vs 12.2), and more often admitted in the Terminal palliative care phase (24.3% vs 10.1%) (all $p < 0.001$). Admission SAS total was higher in malignant patients (15.0 vs 10.4, $p < 0.001$); non-malignant patients had higher breathing scores (2.1 vs 1.8, $p < 0.001$), reflecting end-stage cardiorespiratory disease.

Crude in-hospital mortality was higher in non-malignant episodes (68.2% vs 63.0%, $p < 0.001$), with shorter LOS (median 5 vs 9 days, $p < 0.001$). After adjusting for admission phase, age, sex, site, and admission year, non-malignant disease was associated with marginally lower odds of in-hospital death (adjusted OR 0.83, 95% CI 0.75–0.93); without admission-phase adjustment, the total-association OR was 1.11 (95% CI 1.00–1.24, $p = 0.052$), indicating the crude difference is largely accounted for by case-mix at admission.

Among alive-discharge episodes, discharge SAS levels were equivalent after accounting for admission burden (ANCOVA adjusted mean difference +0.02, $p = 0.92$); a change-score analysis showed 1.6 SAS points smaller absolute improvement in non-malignant patients, below the established minimal clinically important difference. Discharge to usual place of residence did not differ between groups (adjusted OR 0.88, $p = 0.28$).

Implications/Key Message Malignant and non-malignant inpatient palliative care patients in this 10-year SVHA cohort presented with substantially different characteristics — non-malignant patients arriving older, frailer, and in more advanced phase — but achieved broadly comparable within-admission outcomes. The higher crude in-hospital mortality observed in non-malignant patients is largely attributable to later presentation, not to disease-group-specific differences in inpatient care. Earlier specialist palliative care referral for non-malignant disease — particularly at the community level — may expand the range of feasible end-of-life trajectories by enabling symptom stabilisation and discharge to usual place of residence. These findings support investment in community-level palliative care engagement pathways for non-cancer end-stage diseases.

OP31

DEVELOPMENT OF A STATEWIDE COMMUNITY OF PRACTICE (COP) FOR MOTOR NEURONE DISEASE (MND) CARE PARTNERING WITH PEOPLE WITH LIVED EXPERIENCE

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Background/Objectives Communities of practice vary, but with shared commonalities of facilitating learning and the exchange of information, or to improve practice.¹ We sought to develop a Community of Practice (COP) for Motor Neurone Disease (MND) care to directly influence Neuropalliative clinical practice and attitudes in this rare and complex terminal disease.

Methods The COP for MND Care was developed to improve the delivery of Neuropalliative care from a compassionate care

lens by incorporating lived experience involvement. The main stakeholders of this initiative are people with lived experience of MND, Calvary Health Care Bethlehem (CHCB) neurologist, palliative care physicians, neuropsychologist and nurses including MND Victoria and Palliative care Victoria representation. These stakeholders meet to steer the delivery of the content, based on the priorities of people with lived experience and clinical or system challenges encountered by health and service providers. COP participation is open to any Victorian health professional or service provider who are involved or interested in improving MND care. Meetings are conducted online via videoconference on a themed topic. The format includes short educational presentations from people with lived experience of MND and or specialist experts leading to group reflections, sharing of experiences, and ideas for service improvement. Participant surveys are distributed and completed anonymously at the end of each meeting.

Results The COP for MND Care was initiated in June 2024. Meetings run on a quarterly basis. A multidisciplinary cohort of participants including allied health disciplines, MND regional advisors, community palliative care nurses from metropolitan and regional Victoria and people with lived experience attend these meetings. Participants surveys have demonstrated the value and interest in the COP as a forum for peer support, networking, gaining a better understanding of the needs and preferences of people with lived experience of MND, sharing knowledge and listening to expert opinion. It has also highlighted the overwhelmingly positive reception and importance of the inclusion of people with lived experience of MND in these meetings which has strengthened shared understanding of clinician and consumer perspectives, improved clinician confidence and knowledge in a rare disease space, directly influenced and shaped clinical practice and encouraged dissemination of new learnings within individual workforces.

Discussion People with lived experience of MND commonly encounter disease and system challenges due to the complexity and rarity of the disease. Similarly, health and service providers may feel unequipped, isolated and lack support in this challenging space. The development of this COP has allowed the tacit exchange of knowledge and a greater understanding of the needs and preferences of people living with MND and their carers helping to guide more compassionate care.

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2. 'People with lived experience'

OP32

EVALUATING PSYCHO-EXISTENTIAL OUTCOME MEASURES FOR PSYCHEDELIC TRIALS IN PALLIATIVE CARE: A SCOPING REVIEW

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Background Psycho-existential symptoms are major sources of suffering in palliative care. Psychedelic-assisted therapies have emerged as potential interventions for addressing these complex symptoms; however, the heterogeneity in outcome measures makes it difficult to compare results across trials and to determine the true therapeutic value of these interventions in palliative care or advanced cancer population.

Methods A scoping review was conducted to identify clinical trials investigating psychedelic medications including psilocybin, lysergic acid diethylamide (LSD), 3,4-methylenedioxymethamphetamine (MDMA), and ketamine, in palliative care or advanced cancer populations. All searches were conducted in PubMed from inception to March 2026. Eligible studies were completed clinical trials reporting psycho-existential primary outcomes. Identified outcome measures were evaluated for their validity in palliative care or cancer populations and minimal clinically important difference (MCID) and clinically relevant improvement (CRI) thresholds. A descriptive synthesis was performed without meta-analysis.

Results A total of 292 records were identified, of which 12 clinical trials were included in the final analysis (7 psilocybin studies, 1 LSD study, 1 MDMA study, and 3 ketamine studies). A wide range of outcome measures were used across trials, including 17-item Hamilton Depression Rating Scale (HAM-D-17), Montgomery-Åsberg Depression Rating Scale (MADRS), Beck Depression Inventory (BDI), Hospital Anxiety and Depression Scale (HADS), Hamilton Anxiety Rating Scale (HAM-A), Spielberger State-Trait Anxiety Inventory (STAI), Beck Scale for Suicidal Ideation (BSSI), the suicidal part of the MADRS (MADRS-SI), and Profile of Mood States (POMS). Several depression, anxiety, and mood measures demonstrated validity in palliative care or cancer populations. Validation studies of outcome measures for suicidal ideation were limited. No established MCID or CRI values were identified for any outcome measures in these populations. Some depression measures have established MCID or CRI values in patients with major depressive disorder.

Discussion This review identifies a key gap in the outcome measures used in psychedelic-assisted therapy trials in palliative care. Although several instruments assessing depression, anxiety, and mood have demonstrated validity in these populations, no established MCID or CRI values were identified for these measures in this context. In the absence of such thresholds, the clinical relevance of observed changes remains unclear, even when statistically significant differences are reported. This may also pose challenges for comparing across studies, particularly given heterogeneity in outcome measures. Further work to establish clinically meaningful change thresholds for these instruments in palliative care and advanced cancer populations would support more consistent interpretation of findings.

Conclusions Psychedelic-assisted therapy trials in palliative care and advanced cancer populations used heterogeneous outcome measures, many of which lack established clinically meaningful interpretation thresholds. This limits the ability to translate statistically significant findings into clinically relevant outcomes. The use of validated outcome measures and the establishment of MCID and CRI values are essential to improve the quality and interpretability of further research.

OP33 RESPECTING PERSONHOOD THROUGH INTEGRATIVE CARE: MAKING INVISIBLE CLINICAL WORK IN PALLIATIVE CARE VISIBLE

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10.1136/spcare-2026-ANZSPM.31

Background Respecting personhood is a defining principle of palliative care. Yet personhood cannot be contained within the traditional 'square' of biomedical models, organisational boundaries or healthcare funding frameworks. It is honoured through the continual integration of each person's relationships, values, culture, goals, psychosocial circumstances and changing clinical needs. As health systems become increasingly fragmented, this relational and integrative work has become both more complex and more essential. Every family meeting, goals-of-care discussion, ethical dilemma, transition between services and act of advocacy contributes to sustaining personhood throughout illness. Despite being fundamental to person-centred care, this work remains largely invisible within contemporary models of healthcare measurement, funding and evaluation.

Aim To introduce the Intersecting Systems Complexity Model (ISCM) as a systems-informed framework for understanding how integrative care enables clinicians to respect and sustain personhood in contemporary palliative care.

Methods The ISCM was developed using systems thinking, clinical case analysis and policy critique. The framework conceptualises complexity as the interaction of clinical illness, psychosocial vulnerability and structural disadvantage, positioning personhood at the centre of intersecting systems rather than within any single clinical, organisational or professional domain. Contemporary evidence and clinical case examples were examined to explore how complexity shapes clinical practice and service coordination.

Results The ISCM demonstrates that contemporary palliative care is increasingly coordination-intensive rather than solely clinically intensive. At the centre of these intersecting systems lies integrative care work—the expert relational practice of continually weaving together clinical expertise, patient values, family relationships and fragmented health and community services around evolving goals of care. This work includes facilitating shared decision-making, advance care planning, trauma-informed and culturally responsive practice, supporting families through conflict and grief, navigating ethical uncertainty, addressing structural disadvantage and coordinating care across organisational boundaries. Far from being ancillary to clinical care, these activities represent sophisticated clinical expertise through which personhood is recognised, protected and sustained. Yet this expertise remains poorly recognised within existing funding and performance frameworks because it occurs beyond the traditional boundaries through which healthcare is measured.

Conclusion Respecting personhood requires more than acknowledging the individual; it requires the clinical expertise to hold together the intersecting systems that shape their experience of illness. The ISCM makes this integrative work visible, reframing complexity from something patients have to something clinicians actively navigate. In doing so, it invites us to think beyond the traditional 'square' of diagnosis, organisational silos and activity-based measures, recognising integrative

care as expert clinical practice. Perhaps the defining expertise of contemporary palliative care is not symptom control alone, but the capacity to hold the whole person together within increasingly complex systems.

OP34 UPDATING ANZSPM GUIDANCE STATEMENT: USE OF PALLIATIVE SEDATION THERAPY (PST) IN AUSTRALIA AND NEW ZEALAND

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10.1136/spcare-2026-ANZSPM.32

Background Australia and New Zealand Society of Palliative Medicine (ANZSPM) Guidance Document for Palliative Sedation Therapy (PST) was first published in 2017 and had been referenced widely. It was updated in 2025, specifically in consideration of the 2023 update of European Association of Palliative Care's (EAPC) recommended framework for palliative sedation.

Methods An expert working group of ten Palliative Medicine Specialists / Consultant Physicians was formed via expression of interest of ANZSPM members. With administrative support from ANZSPM and volunteer chair from the group, two teleconferences were held, with three cycles of six-weekly reviews in between to action updates.

Results Updates were made with majority of quorum to: 1) maintain the original structure and guidance principles of the document; 2) exclude specific procedural guidance due to inherent variabilities in resources and regulations; 3) described common local variations and with reference for additional guidance from current local guidelines; 4) changing the name of this document to Guidance Statements – Use of Palliative Sedation Therapy in Australia and New Zealand; 5) added section to outline the scope of this document and highlighted EAPC and local guidelines referenced were not specifically written for paediatric settings; 6) updated the definition of PST to align with revised EAPC framework and intentionally mentioning social and ethical implications; 7) specifically highlight continuous deep sedation to be the most common example referred to as PST in Australia and New Zealand; 8) listed other examples referred to as PST in EAPC framework with caveat added for use of transient and respite sedations; 9) expanded the definitions section to include proportionality (in PST), refractory suffering and existential suffering; 10) endorsed the medications recommended by EAPC framework and other local guidelines as essential medicines for palliative care; 11) maintained endorsement with updated wording of PST as an essential high-level skill and outlining the roles and responsibilities of Palliative Medicine Specialists / Consultant Physicians in the interdisciplinary / multi-professional team as well as overtly stating the patient's role in determination of refractory suffering; 12) acknowledged rural and remote practice realities and supported input for PST from Palliative Medicine Specialists / Consultant Physicians 'where available with due urgency'; 13) further associated the use of continuous deep sedation for refractory suffering in the final stage of life; 14) continued to reiterate the difference between PST and death hastening interventions; 15) specifically highlighted the absence of specific guidance on use of phenobarbital in EAPC framework; 16) referenced easily accessible, high quality and periodically reviewed

local guidelines that contained additional specific procedural guidance to phenobarbital, clonazepam and haloperidol; and 17) reminded readers to refer to the latest version of the guidelines referenced.

Discussions There was feedback that additional opportunities for verbal group discussion for debated points would be desirable. There may be benefits for ANZSPM to have a formal structure and methodology for approaching the guideline review process. Future review would benefit from additional targeted expressions of interest to seek multi-professional, especially pharmacist and nursing, and consumer, including first nations, representatives.

OP35

GEOGRAPHIC VARIATION IN SYMPTOMS AT PALLIATIVE CARE ADMISSION AMONG AUSTRALIAN CANCER PATIENTS

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Background Geographic inequities in healthcare access remain a persistent challenge in Australia, particularly for cancer patients and is now addressed by National and Regional Cancer Strategies. Our aim was to ascertain the disparity between palliative care symptoms for cancer patients at initial presentation to inpatient services, as measured by the Palliative Care Outcomes Collaboration (PCOC), and rurality, as defined by the Modified Monash Model (MMM).

Methods This nationwide cohort study included 169,322 adults who received SPC for cancer between 1 January 2020 and 31 December 2024. Demographic and clinical characteristics were summarised and stratified by metropolitan, regional, and rural/remote categories. Symptom burden at SPC initiation was assessed using the Symptom Assessment Scale (SAS). For each of the seven SAS symptoms, binary logistic regression models estimated the association between geographical category and the odds of presenting with moderate to severe symptoms (versus none-to-mild), using the Modified Monash Model to define remoteness. Models were adjusted for age, sex, Australia-modified Karnofsky Performance Status (AKPS), RUG-ADL, primary diagnosis, and palliative care phase. Adjusted odds ratios (aORs) with 95% confidence intervals (CIs) were reported, with statistical significance set at $p < 0.05$. Analyses were performed in R version 4.5.1.

Results The mean age at SPC initiation was 73.0 years (SD 13.2), and 53.8% of the cohort were male. Lung cancer was the most common diagnosis (20.3%), followed by colorectal (10.2%) and other gastrointestinal cancers (9.4%). Nearly half of all patients (48.6%) had substantial functional impairment (AKPS ≤ 40).

Patients from regional and rural/remote areas consistently exhibited a higher prevalence of moderate to severe symptoms at SPC initiation. Fatigue and pain were the most common moderate to severe symptoms across all regions, with metropolitan prevalence at 23.6% and 22.4%, respectively, compared with 27.5% and 26.7% in regional areas, and 24.8% and 25.4% in rural/remote areas.

After adjustment, patients in regional and rural/remote areas had significantly higher odds of moderate to severe symptoms across all SAS domains. The strongest associations were observed for insomnia (regional aOR 1.45, 95% CI 1.38–1.52; rural/remote 1.35, 1.29–1.43) and nausea (regional 1.35, 1.28–1.42; rural/remote 1.23, 1.16–1.30). Elevated odds were also noted for pain, breathlessness, fatigue, appetite problems, and bowel difficulties.

Conclusions Cancer patients living in regional and rural/remote Australia present to SPC with greater symptom severity than those in metropolitan areas. These findings highlight persistent geographic inequities and underscore the need for targeted interventions to enhance timely access to palliative care across the country.

OP36

THE USE OF RITUALS TO ADDRESS SPIRITUAL NEEDS IN PALLIATIVE CARE: AN AUSTRALIAN COHORT STUDY

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Objectives This study aimed to examine the religious and post-Christian spiritual orientations, types of spiritual and ritual activities, and coping strategies of patients with advanced illness and explore associations between spiritual needs, practices, well-being, quality of life, and coping styles.

Methods One hundred and two patients completed validated instruments, including the post-Christian Spirituality Scale, Spiritual Needs Questionnaire, Spiritual Practices Questionnaire, Functional Assessment of Chronic Illness Therapy-Spiritual Well-being Scale, Global Quality of Life scale, and Brief COPE questionnaire. Descriptive statistics summarised participant characteristics and scale distributions. Spearman correlations (Bonferroni-adjusted) were used to examine associations among spiritual needs, practices, and coping modes. Multivariate regression analyses assessed whether ritual practices predicted spiritual needs.

Results Participants reported low religious importance, with 38% reporting high post-Christian spirituality. Inner peace (median 1.4; IQR 1,2) and humanistic/prosocial practices (median 66.6; IQR 44.4,83.2), were the most prominent spiritual needs and frequently used rituals, respectively. Just over half of the sample reported poor to moderate quality of life. Strong correlations were observed between religious needs and religious rituals ($\rho=0.87$). Existential, inner peace, and giving/generativity needs correlated moderately with existentialistic practices ($\rho=0.56$ – 0.69). Humanistic/prosocial spiritual practices were moderately associated with giving/generativity ($\rho=0.52$) and inner peace ($\rho=0.42$) needs. Emotion-focused coping, particularly acceptance and emotional support, was most consistently associated with spiritual needs and practices, reinforcing the centrality of relational and embodied forms of spirituality at the end of life. Regression analyses confirmed that existential

practices predicted existential and inner-peace needs, whereas humanistic practices predicted generativity needs.

Significance of Results Findings demonstrate strong alignment between spiritual needs and ritual activity, supporting the development of personalised, ritual-based spiritual care frameworks. Determining individual orientations towards embodied, relational, and humanistic practices rather than religious or existential forms in patients nearing the end of life may offer an inclusive, adaptable means of addressing spiritual suffering.

OP37

A PROSPECTIVE COHORT STUDY EVALUATING THE PSYCHO-EXISTENTIAL CONCERNS AND PSYCHOPATHOLOGY IN ADVANCED ILLNESS

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Purpose Psycho existential distress is common yet under-recognised in palliative care. Our development of the Psycho-existential Symptom Assessment Scale (PeSAS) in Australia stemmed from recognising clinicians' limited skills in identifying psycho-existential distress, and the absence of a validated tool for rapid bedside screening. Our preliminary studies involving 216 clinicians and 1405 patients confirmed the substantial burden of existential distress in the Australian palliative care population, with a third of patients reporting clinically meaningful existential symptoms.^{1,2} Targeted training improved clinician self-efficacy in promoting psycho-existential wellness¹ and longitudinal findings indicated that patients with severe PeSAS scores are more likely to improve over time.² The PeSAS facilitated communication of difficult emotions, providing acknowledgement of unrecognised distress and enhancing patient agency.³ Following the implementation of the PeSAS in Australia and its translation to Italian,^{4,5} Bahasa Malaysia and Chinese, we examined associations between psycho-existential symptoms and psychological, functional, and quality-of-life factors.

Materials and Methods A cross-sectional study was conducted across seven Australian palliative care services. Adult patients with a prognosis ≤ 12 months completed a questionnaire. Measures included the PeSAS, Edmonton Symptom Assessment Scale, Patient Health Questionnaire-9, Generalised Anxiety Disorder-7, Schedule of Attitudes toward Hastened Death (SAHD), McGill Quality of Life (MQoL) and Australian-modified Karnofsky Performance Scale. Descriptive statistics, Spearman correlations, logistic regression, and k-means clustering explored symptom prevalence and relationships.

Results Among 168 participants with a mean age of 68, most were male, married/de facto, and Australian-born. The most common clinically significant psycho existential symptoms were entrapment (61.7%), hopelessness (48.2%), and anxiety (47.6%). Clinically significant depression, anxiety, and desire for hastened death were present in 41.8%, 21.0% and 13.4% of

participants, respectively. Higher PeSAS scores correlated with lower MQoL subscale scores ($4 = -0.15$ to -0.68), except for depression and physical wellbeing. Cluster analysis suggests hopelessness, pointlessness, and a wish to die are associated with SAHD (OR 1.83), anxiety, discouragement, hopelessness, and depression with clinically significant anxiety (OR 1.72), entrapment with physical symptoms and anxiety with nausea, appetite and bowel problems.

Conclusion Psycho existential distress is associated with psychological morbidity, functional decline, and reduced quality-of-life. Clustering of existential and physical symptoms provides a clearer picture of what underpins patients' behaviours and coping, facilitating shared understanding across teams and coordinated responses to distress.

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OP38

THE LETHAL ABSENCE OF HOPE

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I am eager to get started. But we have never met before. By way of greeting, I will tell you that I am here on behalf of my past, our present, and future generations. I am a drop in the ocean of our existence. We are all in this together. We are all in this room together. In this field of work together. On this earth together. But lately, I have felt so alone.

Maybe it is the fact I am the sole paediatric palliative care specialist on this island off an island, confined to the south by invisible salary borders. Wondering once again at the injustice of the postcode lottery, just as in the Northern Territory. Quietly reaching out for something – validity of the uniqueness of paediatric palliative care? Relevance in an adult service? Inspiration for a way forward? Something.

Maybe it is this gnawing hunger for a sense of our collective direction of effort. A wanting to know where our ship is sailing. Haven't our leaders noticed the storm clouds brewing on the horizon, looming closer, bringing frozen unfilled positions, increased 'efficiencies' that return us to a biomedical model of care, reduced morale, increased burnout, staff attrition, climate distress, spiritual overwhelm? No wonder nobody wants to sit next to me in the tearoom.

But I am here to talk about hope. Hope for ways we can collectively flourish through time, with all our worries and responsibilities. The ultimate touchstone of hope is not the arrival but the fortitude of our imagination and our sense of support. For all of us, hope can be nurtured by taking a long-time perspective and gathering collective energy, imagination, and creativity within our teams, to illuminate our vision. Inviting each one

of us to step forward together on a meaningful path into an imagined, but tangible, future. Accompanying one another, for however brief our time, in building our palliative care legacy for future generations.

I am here as a palliative specialist to try and resuscitate that little bird within the soul. The one who is trying to sing the song without the words. And never stop. At all.

OP39 CHINESE-AUSTRALIAN PATIENTS AND CARERS IN PALLIATIVE CARE: A QUALITATIVE STUDY OF EXPERIENCES, CULTURAL DIMENSIONS AND CHALLENGES TO PERSON-CENTRED CARE

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Background Palliative care involves a holistic approach which encompasses culturally sensitive support for patients and their families. While social and cultural factors are known to influence Chinese patients' understanding, acceptance and experience of palliative care, there is limited research exploring these aspects in the Chinese-Australian context.

Aim This study aims to explore the experiences of Chinese-Australian patients and their caregivers in the context of palliative care.

Methods Ethics approval was granted by the Sydney Local Health District Ethics Review Committee RPAH Zone (protocol X24-0180, 2024/ETH00832). This qualitative study used a descriptive phenomenological approach to analyse interviews conducted with 21 Chinese-Australian participants. Participants were recruited from the Royal Prince Alfred Hospital palliative care service between October 2023 and March 2026. Each participant underwent a semi-structured interview covering topics such as experiences with illness, caregiving, palliative care services, cultural values and future-planning. Transcripts from the interviews were analysed through close reading and iterative rounds of coding to identify emergent themes.

Results Interviews were conducted with nine patients and eleven carers. Five themes were identified: 1) limited awareness and acceptance of palliative care, 2) influence of cultural taboos surrounding discussions of death and dying, 3) the challenges posed by language barriers, 4) the central role of family and filial piety and 5) Chinese cultural conceptions about health and what constitutes a good death.

Discussion This study highlights cultural and social factors contributing to reduced engagement with palliative care services and advance care planning among Chinese-Australians. Awareness of palliative care was low, influenced by language barriers, misconceptions related to cultural beliefs about food and energy as indicators of health, and limited acceptability of discussions about death. However, participants expressed appreciation for palliative care, once explained as a holistic approach to symptom management for patients with incurable illnesses, suggesting that palliative care per se is not inherently unacceptable to Chinese-Australians. Although previous literature has associated cultural 'death taboos' with lower uptake of advance care planning, participants in this study indicated a willingness to engage in collective future decision-making when guided by a trusted physician and undertaken in a culturally sensitive manner, underscoring the importance of physician

continuity and non-abandonment. The importance of family in Chinese culture was strongly emphasised in this study; however, participants also described challenges related to migration and changing social contexts, including limited social support, the legacy of the One Child Policy placing caregiving responsibilities on a single child, and social isolation linked to maintaining cultural values of face.

Conclusion These findings highlight opportunities for palliative care services to enhance culturally responsive care for Chinese-Australian patients. Further research is required to assess the impact of such approaches and the effectiveness of targeted interventions.

OP40 BE SMART: RETHINKING METHADONE INITIATION AND ROTATION FOR CANCER PAIN IN ROUTINE PALLIATIVE CARE

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10.1136/spcare-2026-ANZSPM.38

Background Methadone is an effective opioid for cancer pain but remains underutilized due to guideline driven reliance on complex opioid conversion ratios, perceived toxicity, and assumptions that initiation requires specialist or inpatient settings. These barriers disproportionately limit access in community palliative care, where most cancer pain is managed. We describe a pragmatic alternative in which methadone is introduced at low doses, without formal conversion ratios, and escalated according to clinical response.

Objectives To evaluate the effectiveness, safety, and dosing patterns of a low dose, start slow methadone strategy when used as a primary opioid or as a co analgesic in routine palliative care.

Methods We conducted a retrospective observational study of all methadone prescription episodes at North Haven Hospice (community and inpatient settings) over two years (June 2023–June 2025). Each prescription episode was analyzed independently. Data included demographics, pain mechanism (Edmonton Classification System for Cancer Pain), pain intensity and response documented in clinical records, methadone role (primary or co analgesic), starting and maximum methadone doses, concurrent opioid doses expressed as morphine daily dose (MDD), and reasons for discontinuation. Descriptive statistics were used, with non parametric and categorical tests for group comparisons ($p < 0.05$).

Results One hundred and seventy one methadone prescription episodes were analyzed, including 155 cancer related episodes. Mean patient age was 69.7 years (SD 13.9); 51.5% were female. Severe or excruciating pain was present at initiation in 77.8% of episodes. Methadone achieved good or excellent analgesia in 118/171 episodes (69%), with no response in only 7 episodes (4%).

Median methadone starting doses were low across all roles (5–6.3 mg). When used as the sole primary opioid, the median maximum methadone dose was 11 mg with minimal concurrent opioid use (median MDD ~1 mg). When used as a co analgesic, methadone remained at low doses (median maximum 10 mg) alongside higher opioid requirements (median MDD 120 mg). Escalation from co analgesic to primary opioid therapy occurred in 14% of episodes and was associated with higher methadone doses (median maximum 20 mg) and substantial-

ly reduced opioid burden (median MDD 10 mg). Neuropathic pain (59% of episodes) required higher maximum methadone doses than nociceptive or mixed pain (median 15 mg vs 10 mg; $p=0.039$). Methadone was discontinued in 19 episodes (11.1%), including 8 for lack of efficacy.

Discussion and implications This study challenges the assumption that methadone initiation must rely on complex opioid conversion ratios or inpatient supervision. Role specific dosing patterns suggest that low dose co analgesic initiation provides a safe, real world assessment of methadone responsiveness before escalation. Modest effective doses and reduced opioid burden support earlier, simpler, and more accessible methadone use in community palliative care, with implications for future guideline development.

OP41 PATTERNS OF HEALTHCARE UTILISATION AND PALLIATIVE CARE IN THE LAST 12 MONTHS OF LIFE

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10.1136/spcare-2026-ANZSPM.39

Background Demand for healthcare increases significantly in the last year of life, with a small group of patients accounting for a disproportionate share of resource use and cost. Palliative care is associated with improved quality of end-of-life care and reduced acute healthcare utilisation and cost, though evidence across cancer and non-cancer populations remains variable. This study describes patterns of healthcare utilisation in the last 12 months of life and examines the association between palliative care involvement and end-of-life outcomes at a tertiary hospital in Victoria, Australia.

Methods Linked administrative data on all decedents were obtained from 2018 to 2023. Outcomes included emergency department (ED) presentations, hospital admissions, intensive care unit (ICU) admission, length of stay (LOS), chemotherapy administration, and inpatient costs in the last 12 months and 30 days of life. Quality end-of-life metrics were derived from the literature, including high-intensity care (ICU admission, inpatient chemotherapy, or dialysis) in the last 30 days of life. Palliative care exposure, identified as inpatient palliative care, specialist consultation, or coded palliative diagnosis (Z51.5) and categorised as early (<90 days before death) or late (90+ days before death).

Results A total of 5,449 decedents were included. The mean age at death was 77.8 years (std dev 12.9), 45.7 percent were female, 23.7 percent died of cancer. Healthcare utilisation was highly skewed across the cohort. On average, decedents spent 25 days in hospital in the last year of life, with associated inpatient costs of \$51,000. For the top decile of decedents by healthcare utilisation, this increased to 62 days in hospital with average inpatient costs of \$174,000. Although 73.9 percent of decedents accessed palliative care, only 11.4 percent received it early. Patients receiving palliative care had higher overall healthcare utilisation in the last 12 months of life but lower inpatient costs, and less high intensity care in the final 30 days, including fewer ICU admissions (18.7% vs 37.4% in non-palliative patients).

Conclusion In this tertiary hospital cohort, both the number of decedents and hospital resource use increased over time. A small subgroup of patients with prolonged LOS accounted for

a disproportionate share of inpatient costs and bed days. Palliative care was associated with reduced high-intensity care in the final 30 days of life and lower inpatient costs but was initiated late. These findings suggest a role of earlier integration of palliative care in reducing high-intensity care and inpatient costs at the end of life, particularly among high-resource utilisers. However, further research is needed to better understand longer-term patterns of healthcare use, particularly in complex, non-cancer populations.

OP42 HE WHARE KOROWAI – AN INNOVATIVE APPROACH TO COMMUNITY INPATIENT PALLIATIVE CARE. WEST AUCKLAND, NEW ZEALAND

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10.1136/spcare-2026-ANZSPM.40

Background In Aotearoa New Zealand, palliative care is delivered in the community, however most community services have access to a specialist inpatient unit. In our part of Auckland, the closure of our local inpatient hospice required patients to travel across the city for care, creating access barriers and contributing to inequities, particularly for Māori and Pacific peoples. In response, a hospice model, He Whare Korowai, was developed, staffed by generalists with specialist in-reach from the current community team.

Objectives To describe the implementation and early outcomes of a community palliative inpatient model integrating generalist continuity with specialist in-reach. To evaluate early service utilisation, patient outcomes, and equity impact during the first months of operation.

Methods He Whare Korowai is a three-bed inpatient hospice operating since November 2025, staffed by a consistent generalist core team providing 24/7 care. The key specialist supports are provided by the interdisciplinary specialist community team during work hours and a 24-hour specialist advisory line overnight and at weekends. A descriptive service evaluation was undertaken over the first months of operation, including service utilisation, patient demographics, bed occupancy, discharge outcomes, and patient-reported outcomes using the Integrated Palliative care Outcome Scale (IPOS) and a patient experience questionnaire.

Results In the first 4.5 months, there were 33 acute admissions and 16 respite admissions. Bed occupancy averaged 78%. Among acute admissions, 12% identified as Māori and 6% as Pacific peoples. The average length of stay was 7 days. Of acute admissions, 19 patients died in the unit, 10 were discharged home, 2 were transferred to hospital, and 2 remained in care at the time of analysis.

Patient-reported outcome data (IPOS) were available for 9 patients with paired assessments; 3 demonstrated mild improvement and 6 demonstrated moderate to major improvement. Early findings suggest improved local access and engagement from populations previously underrepresented in inpatient hospice care, alongside reduced need for cross-city travel.

Discussion This model challenges the assumption that inpatient hospice care must be provided by a 24-hour present specialist team. By embedding inpatient capacity within a community-anchored framework, it addresses structural barriers to access while aligning service delivery more closely with community

need. It also demonstrates a pragmatic approach to redistributing hospice resources toward equity, accessibility, and system efficiency.

Conclusion He Whare Korowai demonstrates a feasible community-anchored inpatient hospice model with early evidence of utilisation, equity reach, and patient-reported benefit. These findings suggest that small-scale, locally embedded models may offer a sustainable and more equitable alternative within contemporary palliative care systems. Data will be updated to 9 months at the time of conference presentation.

OP43

A SIMPLE APPROACH TO IMPROVE UNDERSTANDING OF WHY PRO RE NATA OPIOIDS AND/OR BENZODIAZEPINES ARE BEING ADMINISTERED IN HOSPITALISED PALLIATIVE CARE PATIENTS

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Many people dying from advanced diseases have symptoms requiring both background [via a Continuous Subcutaneous Infusions (CSCI)] and Pro re Nata (PRN) subcutaneous opioids and/or benzodiazepines. In this setting PRN medications are typically given either pre-emptively prior to nursing interventions, or for the acute management of unstable symptoms. Pro re Nata use is one factor considered when assessing the need for CSCI adjustment, however this should primarily be guided by PRNs administered specifically for symptom management (not all PRN used). Currently there is no way of judging from the Barwon Health (BH) medication charts the purpose of subcutaneous PRN medication administration in this setting.

The aim of this QI project was to pilot a simple method of differentiating why PRN opioids and/or BDZs were administered in palliative care unit (PCU) patients prescribed a CSCI. It was anticipated that this would:

- provide a clearer indicator of how much PRN medications were required for the different indications
- make CSCI adjustment easier.
- if successful be transferable to other care settings

Methods Patients admitted to the BH PCU between December 2025 and February 2026 and prescribed a CSCI containing an opioid and/or BDZ, and the same classes of PRN medications were included. The reasons for PRN administration were stratified using dual and sequential PRN medication chart entries for subcutaneous opioids and/or BDZs each with the same dose, same hourly frequency (q1h) but with different indications for use. The two different indications for use were:

Indication one = acute symptom management. E.g. For opioids = pain/shortness of breath, for BDZs = anxiety/distress

Indication two = pre-nursing care (pre-emptive administration)

For the fortnight before, and fortnight after the pilot, when adjusting a CSCI the PCU medical team recorded whether it was difficult to determine the reason for PRN administration, and whether the patient was able to be involved in decision-making around CSCI adjustment. Following the pilot, PCU nursing and doctor feedback was obtained via a brief survey containing a five item, five level Likert questionnaire and free-text oppor-

tunity. Data were aggregated, analysed, and presented descriptively.

Results The medical team in the post-pilot period reported less difficulty in determining why PRN medications were administered, despite similar proportions of patients being able to be involved in decision-making around CSCI adjustment across both time periods. The staff satisfaction survey was completed by 21 clinicians – 16 nurses and five medical officers. The majority of respondents felt the pilot improved patient outcomes and clinical communication, was easily understandable and easy to explain to new staff. Most did not feel it increased their workforce, although two medical respondents felt it led to an increase.

Discussion There were high levels of staff satisfaction with a new, simple prescribing system for PRN opioids and/or BDZs with most respondents believing it improved patient outcomes. Data before and after the pilot confirmed improved clarity around why PRN medications were being administered. There is clear scope for this simple idea to be rolled out in non-specialist palliative care settings to optimise patient care.

OP44

WHAT ARE THE BARRIERS TO ACHIEVING HOME DEATH IN PATIENTS RECEIVING COMMUNITY SPECIALIST PALLIATIVE CARE?

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10.1136/spcare-2026-ANZSPM.42

Background Preferences regarding place of death are central to patient-centred palliative care, with home being the most commonly preferred setting. The ability to remain at home until death is influenced by a complex interplay of patient, caregiver, and system-level factors. Within Australia, evidence describing barriers to achieving a home death remains comparatively limited. Understanding these barriers is critical to informing service development and improving alignment between patient preferences and end-of-life care delivery.

Aims To quantify the proportion of patients with a final preference for home death who did not achieve it, and to identify key barriers influencing access to home-based end-of-life care within a community specialist palliative care service.

Methods A retrospective cohort study was conducted using routinely collected clinical data from the community specialist palliative care service at St Vincent's Private Hospital, Brisbane, Australia. All patients who died between January 2020 and December 2024 (5 years) with a documented final preference for home death were included. Demographic and clinical characteristics were summarised descriptively. Documented barriers were categorised using predefined domains and analysed using frequencies and proportions.

Results Of 3,506 patients who died during the study period, 1,595 (45%) expressed a final preference for home death. Among these, 1,116 (70%) achieved a home death, while 479 (30%) did not. Patients who did not achieve a home death were more likely to live alone (18% vs 8%) and had longer median length of stay (81 vs 40 days). A total of 1,172 barriers were identified. The most frequently documented were symptom burden (37%) and caregiver exhaustion or inability to continue

care (15%). Additional barriers included limited caregiver skills or support (8%), medication management challenges (3%), and social constraints such as limited family support (3%). Symptom-related deterioration, particularly pain, reduced mobility, and falls, commonly led to transitions away from home.

Discussion and Conclusion These findings reinforce that home death is not simply a function of preference or service availability, but the outcome of a dynamic interplay between clinical needs, caregiver capacity, and structural supports. Caregiver burden, escalating symptom complexity, medication management challenges, and social constraints emerged as persistent and interdependent determinants of transitions away from home.

By identifying the specific barriers encountered within a large Australian community palliative care service, this study offers an understanding of the limits of home-based end-of-life care. Future work should examine how preferences evolve and how systems can better respond as circumstances change. These findings challenge the assumption that home death should be the primary marker of high-quality palliative care. Preferences are dynamic and context-dependent, and adaptable care may be more meaningful than achieving a fixed place of death.

OP45 THE COST OF INFORMAL CANCER CAREGIVING (CCC) QUESTIONNAIRE: PILOT OF A CO-DESIGNED TOOL FOR PALLIATIVE ONCOLOGY

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Background Informal caregivers are recognised as the foundation of the palliative care workforce, yet their substantial economic contribution remains largely invisible in evaluations focused on health-system expenditure. The Cost of Cancer Caregiving (CCC) Questionnaire was co-designed to quantify the full societal economic burden of caregiving in advanced cancer. **Aim** To pilot the CCC Questionnaire and quantify the societal cost of caregiving for people with advanced cancer, and to assess its feasibility, acceptability, and face validity.

Methods This qualitative study formed the third phase of a broader mixed-methods project. Participants were recruited from two tertiary hospitals and completed the draft CCC Questionnaire while taking part in semi-structured cognitive interviews using 'think-aloud' and verbal-probing techniques. Transcripts were thematically analysed to assess item comprehension, response processes, and perceived burden. Iterative revisions enhanced clarity, response options, and timeframes. Early economic data collection using the revised instrument has commenced.

Results Twelve caregivers (nine female, three male) were interviewed. Following initial revision, the final 37-item CCC Questionnaire demonstrated face validity, feasibility and acceptability, with participants reporting it as clear, respectful, and reflective of their experiences. Preliminary pilot data (n=6 to date, with further numbers available at presentation) show average monthly out-of-pocket costs per caregiver of AUD \$1163.86. Temporary or permanent employment disruption was reported by 83% of participants and 50% delayed accessing their own healthcare due to caregiving demands. The monthly replacement cost of caregiving labour provided per caregiver was AUD\$7,425.95.

Discussion CCC Questionnaire is the first co-designed, comprehensive tool to quantify the economic costs borne by informal caregivers in advanced cancer. It provides a feasible, valid and acceptable means of embedding a societal perspective into economic evaluations to inform equitable research, policy and service design. Early data suggests that the costs incurred are significant.

OP46 PATHWAYS TO ACCESS TIMELY PAIN MANAGEMENT AND PALLIATIVE CARE FOR PEOPLE WITH PANCREATIC CANCER

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Background People with pancreatic cancer face high symptom burden, including pain, distress and potentially short survival. While pain management and palliative care services exist, there are gaps in care with many people accessing them late, or not at all. Cancer Australia (an agency for national cancer control) commissioned the University of Melbourne to develop clear referral pathways to access timely pain management and early palliative care to improve care.

Aim To develop evidence-based, community-informed, web-based pathways to early palliative care and timely pain management for people with pancreatic cancer, plus associated clinical guidance and implementation plans, a clinician education module and patient information about interventional pain management.

Method A mixed method, iterative approach where rapid literature summaries and expert review using a deliberative dialogue approach via focus groups (n=44 members) was utilised to develop pathways incorporating a pain assessment tool, clinical guidance and educational materials. The pathways were then presented for review to multiple stakeholders, including consumers, Aboriginal and Torres Strait Islander community members, cultural experts, specialist and primary health care professionals (n=40) across all states and territories of Australia. Stakeholders identified barriers and enablers to implementation and recommended strategies to embed the pathways into practice.

Outcomes Two pathways were developed and are presented on the Pancare website; a pathway for pain management for people with resectable (potentially curable) disease and an integrated pathway for pain management and palliative care for unresectable disease.

[<https://www.pancare.org.au/pancreatic-cancer-roadmap-projects/pancreatic-cancer-pathways>]

Tailored pain assessment and clinical guidance, plus accredited clinician education and patient information materials specific to interventional pain management, were developed to support clinical application.

Discussion The pathways provide an agreed, consistent approach to care, with the extensive clinical and community engagement ensuring relevance and the authority of endorsement. Next steps supporting implementation will ensure access to pain management and palliative care is realised in routine clinical care.

Funding source 'The 'National Pancreatic Cancer Roadmap – Delivery of early implementation priorities: Developing pathways to pain management and early palliative care for people with pancreatic cancer' project was funded by Cancer Australia' 53

OP47

TIMELINESS AND APPROPRIATENESS OF REFERRALS TO SPECIALIST PALLIATIVE CARE FROM PRIMARY CARE: PERSPECTIVES FROM SPECIALIST PALLIATIVE CARE SERVICES

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Background Timely referral to palliative care services is associated with improved patient outcomes. However, referrals from primary care remain variable and may occur later than optimal. This study aims to explore specialist palliative care services' perspectives on the timeliness and appropriateness of referrals from general practice in Australia.

Methods This study reports part of the findings from a national cross-sectional survey of specialist palliative care services. A total of 142 services participated. Qualitative data from five open-ended questions were analysed using thematic analysis to examine perceived challenges, barriers, and facilitators influencing referral timing and appropriateness.

Results Referral timing and appropriateness are influenced by inconsistent definitions of timely palliative care, the persistent misconception that palliative care is synonymous with end-of-life care, variability in the quality of referral information, and structural limitations affecting both primary and palliative care services. System-level constraints, including workforce and capacity limitations, further shaped referral patterns and acceptance.

Conclusion Findings highlight that referral practices are driven by a combination of clinician, system, and service-level factors. Addressing these issues requires coordinated strategies, including improving role clarity and awareness, standardising and easing referral processes for GPs, and strengthening integration between primary care and palliative care services. These insights can inform policy and service development to support more timely, appropriate, and equitable access to palliative care.

OP48

BESPOKE VIRTUAL CARER SUPPORT: LESSONS FROM LIVED EXPERIENCE AND THE SPECIALIST PALLIATIVE CARE RURAL TELEHEALTH (SPARTA) SERVICE

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Background and Aim Although the National Palliative Care Standards recognise carers as integral to the care team, in practice carers are often treated as collateral to the patient-centred encounter, with limited structured follow-up after initial

assessment. This presentation draws on the author's personal transition from palliative care physician and service director to husband-carer during his wife's cancer treatment, and uses that lived experience to inform the design of a bespoke virtual carer support model delivered through the Sunshine Coast Specialist Palliative Care Rural Telehealth (SPaRTa) Service.

Methods A reflective practice approach was combined with service development methodology. Personal carer experience was interrogated against the published evidence on family carer interventions, carer-valued attributes of palliative care (responsive care, trajectory signposting, effective communication, 24/7 support), and local SPaRTa service patterns. These insights were translated into a structured Carer Coaching Program (CCP) model, with implementation piloted in partnership with Emerald Hospital, Central Queensland.

Results Reflection identified specific carer needs that were poorly served by the traditional palliative pathway, including the disempowering nature of open-ended offers of help, the value of peer lived-experience contact, and the importance of accessible nursing advice lines. In response, a CCP model was developed in which the community nurse and carer attend from the patient's home or local rural outpatient service, while the specialist medical officer and an allied health clinician join virtually from the hub. Allied health leads are matched to carer need: social work for advance care planning and bereavement; pharmacist for medications including subcutaneous injectable education; occupational therapist for safe transfers and home safety; and the SMO for disease trajectory and symptom anticipation. The model leverages existing resources (Caring@Home), is coordinated by the palliative care CNC, and is financially sustainable through MBS multidisciplinary case conference item numbers (3040, 3044) and ABF Tier 2 code 40.62.

Discussion and relevance This work demonstrates how clinician lived experience can be a legitimate and powerful prompt for redesigning palliative care delivery - a genuinely 'outside the square' solution. The CCP model anticipates measurable benefits including fewer unplanned admissions, greater alignment between place of death and family goals, and reduced demands on community nursing, with carer experience to be evaluated using PREMs and CREMs and complemented by peer mentorship. More broadly, it argues for a relational shift: carers should not be treated as collateral, but integrated early, supported consistently, and valued for their lived expertise. The model is transferable to other rural and regional palliative care services seeking to elevate carer support within existing telehealth and funding infrastructure.

OP49

BRIDGING THE GAP IN SPECIALISED CANCER PAIN MANAGEMENT: 'CHALLENGE-CANPAIN,' A REMOTE EXPERT CONSULTATION PLATFORM

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Background While approximately half of cancer patients in Japan experience significant physical distress in their final

month, a scarcity of specialists exacerbated by a shrinking population has created 'medical deserts' that hinder equitable access to specialized interventions such as nerve blocks and methadone therapy. Consequently, we developed 'CHALLENGE-Canpain,' a web-based remote consultation platform designed to bridge these geographical gaps by connecting community practitioners with experts to optimize the management of refractory cancer pain and regional referral pathways.

Aims To evaluate user demographics, consultation content, and the utility of the CHALLENGE-Canpain platform in clinical decision-making during its pilot phase.

Methods Launched in 2024, the platform allows registered physicians to submit complex cases to a certified expert panel comprising palliative care specialists, pain clinicians, radiation oncologists, and interventional radiologists. Experts provide multidisciplinary guidance on treatment indications, interventional techniques, and regional resources. We analyzed data from the initial year of operation, including registrant profiles, consultation topics, and user motivations.

Results In FY2024, 72 physicians registered, and 12 formal consultations were completed. Users comprised 8 palliative care specialists, 3 primary care physicians, and 1 anesthesiologist. Consultation topics (with overlap) included nerve blocks (n=11), radiotherapy (n=4), image-guided procedures (n=2), and methadone management (n=2). Inquiries primarily addressed treatment indications (n=9), general management of refractory pain (n=3), optimal timing for intervention (n=1), and specialized medical device handling (n=1). Primary motivations for platform utilization were: lack of local specialists (n=6), unresolved issues despite internal multidisciplinary discussions (n=5), and a desire to obtain multiple expert opinions simultaneously (n=2). Overall user satisfaction and the perceived quality of advice were high.

Conclusion & Future Challenges The pilot phase demonstrates that CHALLENGE-Canpain effectively supports clinicians seeking expert guidance on specialized pain strategies. However, several challenges for long-term sustainability remain. First, utilization remains low among non-palliative specialists, such as oncologists; broader promotion is essential. Second, expanding the platform to include multidisciplinary input from non-physician healthcare professionals is warranted. Third, operational costs and technical maintenance require a robust long-term financial model. Finally, the scope should ideally expand to cover general palliative care. Future efforts will focus on integrating this web-based tool into regional networks to ensure expert support is available even in resource-limited areas.

OP50

THE ECONOMIC IMPACT OF EARLY PALLIATIVE CARE IN AUSTRALIA

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10.1136/spcare-2026-ANZSPM.48

Background Early integration of palliative care improves end-of-life care quality and reduces acute healthcare utilisation, yet the international body of evidence to quantify the economic impact of this is sparse.

Objective To estimate the average treatment effect of early (at least 90 days before death) versus late palliative care referral on healthcare costs among cancer decedents in Australia.

Design Economic evaluation adopting a health funder perspective, using inverse probability of treatment weighting applied to linked administrative health data. Reported in accordance with CHEERS 2022 guidelines.

Setting and Participants Adults aged 18 years or older who died of cancer-related causes in Victoria between 1 January 2018 and 31 January 2023, identified through the Victorian Cancer Registry and linked to routinely collected administrative health records (n = 38,697 palliative care recipients; 17,409 early, 21,288 late).

Main Outcome Measures The average treatment effect on healthcare costs in the final 90 days of life was estimated on case-mix weighted hospital activity (acute hospitalisations, chemotherapy, and emergency department presentations) and valued using the efficient price per activity, indexed to present value using growth in the national efficient price.

Results Early palliative care was estimated to reduce average per person healthcare costs in the final 90 days of life by AUD \$3,858 (95% CI: \$2,592–\$5,131), representing a 14% reduction in estimated average healthcare costs in the final 90 days of life for cancer patients. Savings were driven primarily by reductions in acute hospitalisation costs (\$2,340), with additional contributions from chemotherapy (\$1,338) and emergency department presentations (\$180). Results were robust across a comprehensive series of sensitivity specifications.

Conclusions Early palliative care referral is estimated to significantly reduce end-of-life healthcare expenditure in Australia. These findings reinforce the case for system-level investment in early palliative care referral pathways as a high-value policy lever that supports patient-centred care while reducing low-value acute healthcare utilisation.

OP51

COMPARING SYMPTOMS AND OUTCOMES BETWEEN NON-MALIGNANT PATIENTS IN AUSTRALIAN INPATIENT PALLIATIVE CARE: A MULTI-SITE OBSERVATIONAL STUDY

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Introduction Despite the growing proportion of patients with non-malignant conditions being referred to palliative care, symptom profiles and care patterns are poorly understood. This study aimed to compare the symptom burden and functional status of 5 non-malignant disease groups (neurological, respiratory, heart, renal, and liver disease).

Method A retrospective cohort study used the Patient Collaborative Outcomes Collection data from inpatient palliative care units from three St Vincent's Health Australia sites (Sydney, Melbourne, Brisbane) over 2015–2024. Measures described included Symptom Assessment Scale (SAS) scores (Range 0-10), total SAS scores (Range 0-70), Resource Utilisation Groups-Activities of Daily Living (RUG-ADL) (Range 4-18), length of stay, and discharge disposition. Admission and discharge scores were compared for patients discharged alive.

Results Of 2600 patients, 1346 (51.7%) were male. 848 (32.6%) had neurological, 592 (22.8%) had respiratory, 627

(24.1%) had heart, 357 (13.7%) had renal, 176 (6.8%) had liver disease.

At admission, the oldest patients were patients with heart disease (mean age 84.0, Standard Deviation, SD =11.2), with patients with liver disease being the youngest cohort (mean age 64.7 [SD 13.1]).

Patients experienced symptoms differently across the cohorts; patients with respiratory disease had the highest mean SAS total score, 13.1 (SD 10.9), with breathlessness having the highest mean individual symptom score, 3.8 (SD 3.0). For the other 4 groups, fatigue scores were the highest compared to other symptom scores (heart: 3.0[SD 2.8], renal:2.6 [SD 2.7], liver:2.6 [SD 2.9], neurological:1.6[SD 2.4]). Bowel symptom severity appeared to be similar across the cohorts. For all patients discharged alive, mean total SAS symptom scores were lower at discharge (-7.1, 95% CI -7.73 to -6.47) compared to admission, signifying improvement. Patients with heart disease had the largest change in total SAS scores of -8.6 (95% CI -10.06 to -7.14), whilst patients with neurological disease had the smallest change of -5.1 (95% CI -6.17 to -4.03).

At admission, RUG-ADL scores were highest, indicating the poorest performance status for patients with neurological disease (mean score 17.1, SD 2.3), and lowest for those with liver disease (mean 13.2, SD 5.2). For those discharged alive, the RUG ADL improved in all groups from -1.0 (95% CI -1.21 to -0.79), with heart disease having the largest change, -1.6 (95% CI -2.10 to -1.10) and neurological disease having no statistically significant change, -0.1 (95% CI -0.40 to 0.20).

The most common admission phase was unstable in respiratory patients (37.8%), while deteriorating predominated in other groups (38–44%). Patients with neurological disease had the shortest length of stay (5 days), but the highest mortality (73.6% died). Patients with liver disease had the longest length of stay (7 days). Patients with respiratory disease had the lowest mortality (58.0%), with 42.0% being discharged at the end of the admission.

Conclusion Patients with non-malignant diseases have distinct needs characterised by varying symptomatology, functional impairment, and mortality. Disease-specific variations underscore the need for tailored management. These findings have implications for equitable resource allocation and health service planning in palliative care.

OP52

IS PALLIATIVE CARE ASSOCIATED WITH LOWER TERMINAL HOSPITAL COSTS FOR PEOPLE WITH NON-CANCER DIAGNOSES? A SINGLE SITE RETROSPECTIVE STUDY

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Background Non-cancer diagnoses are the leading causes of death globally and in Australia yet palliative care access for these populations remains inconsistent. Inpatient health care costs for this cohort for those who access and miss out on palliative care are not well understood.

Objective To compare clinicodemographic characteristics between patients who did and did not access palliative care

among individuals who died in hospital from non-cancer conditions and selected inpatient health care service utilisation and costs such as length of stay, total inpatient costs and daily costs for the terminal admission.

Methods Retrospective cohort study using linked routinely collected hospital and statewide patient data of all patients who died from non-cancer diseases between 1 January 2018 and 31 December 2019 at St Vincent's Hospital, Sydney. An a priori criterion identified patients who were likely to have benefited from palliative care.

Results Of 1,079 deaths, 439 (41%) patients with non-cancer diagnoses were identified as likely to benefit from palliative care, of whom 240 (55%) patients accessed palliative care. Patients who accessed palliative care were associated with lower total hospital costs (\$14277 versus \$18,015, $p<0.001$), average daily costs (\$1779 versus \$5880, $p<0.001$), lower intensive care unit admissions (15% versus 56%, $p<0.05$) but longer median lengths of stay (10 versus 5 days, $p<0.001$) in their terminal admission compared to those who did not access palliative care.

Nursing costs were the largest cost component for patients who accessed palliative care (21%), while critical care accounted for the largest cost component among those who did not (40%).

When patients who did not have an ICU stay were excluded (293 remaining patients without an ICU admission), 205 (70%) accessed palliative care whilst 88 (30%) did not. Patients who accessed palliative care had lower average daily costs (\$1526 versus \$2295, $p<0.001$), but higher total costs (\$12,520 versus \$7,647, $p<0.001$), and longer length of stay (9 versus 4 days, $p<0.001$). Nursing costs remain the main contributor to the cost of the terminal admission regardless of access to palliative care.

Conclusions Nearly half of patients with non-cancer diseases who may have benefited from palliative care did not access these services. Although palliative care was associated with lower daily costs, longer hospital stays may contribute to higher total costs, highlighting the need for alternative care models to better support patients with high nursing needs who are dying from non-cancer diseases which are less predictable.

OP53

PERCEPTIONS OF THE EFFECT OF SOUND, LIGHT AND TEMPERATURE IN A PALLIATIVE CARE WARD: SURVEY OF PERSPECTIVES OF PATIENTS AND STAFF

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10.1136/spcare-2026-ANZSPM.51

Background The environment of palliative care wards plays a critical role in patients' comfort, symptom burden, and staff wellbeing experience. Sound, light, and temperature are modifiable environmental factors, yet their perceived impacts are underexplored in inpatient palliative care units. The results of this survey are part of a larger study objectively measuring sound, light and temperature.

Objectives To describe and compare patients' and staff's perceptions of the effects of sound, light, and temperature within an inpatient palliative care ward. Additionally, patients' responses based on whether they were in a single room for four bedrooms were compared.

Methods A cross-sectional survey was conducted in a metropolitan, teaching inpatient palliative care ward surveying palliative care patients and palliative care staff. A 28-item survey for patients, and 40 items for staff, was distributed in paper and electronically using a 7-point Likert scale with 1 being strongly disagree, and 7 being strongly agree.

Results Participants included patients (n = 24, F:M 29% :71%) and staff (n = 33, F:M 67% :30%). Participants described sound, light, and temperature as highly influential on comfort, symptom control, emotional well-being, and care delivery.

Patients and staff mostly agreed on their perception of their environment but had high discrepancies in three areas: patients felt that acoustic privacy was being met (median score 6), but staff disagreed (median score 3). Patients disagreed that it was not easy for them to rest or sleep due to the noise level (median score 2), whilst staff believed that noise negatively impacted on patients' sleep quality in the palliative care inpatient ward (median score 6). Patients disagreed that ward lighting affected their overall comfort during interactions with staff or family during the night (median score 2), whilst staff rated the lighting in the ward as benefiting interactions with patients or their family during the night (median score 5).

Staff agreed that alarms generate significant noise in the palliative care inpatient ward (median score 6).

There was a high discrepancy between those in single rooms and 4-bedrooms for 2 items. Patients who were in the multi-bed rooms agreed with having difficulty staying asleep throughout the night (Single: median score 2 versus Multi: median score 5) and waking up earlier than they would like (Single: median score 2 versus Multi: median score 5).

Conclusions Sound, light, and temperature are central to the palliative care experience for both patients and staff. Environmental design and ward-level practices that prioritise sensory comfort may improve patient experience and staff wellbeing.

OP54

DYING GRACELESSLY? DEATHS IN HOSPITAL OF RACF RESIDENTS: A RETROSPECTIVE MIXED-METHODS ANALYSIS OF PRECIPITATING FACTORS AND THE QUALITY OF END OF LIFE CARE.

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Background Residential Aged Care Facilities (RACFs) are the most common place of death for elderly Australians with many residents dying within three months to a year of admission.¹ Nevertheless, RACFs have not traditionally been regarded as palliative institutions and have lacked adequately trained staff and timely access to primary care and specialist palliative care services that would enable them to provide high quality end of life care to residents on-site.² This has resulted in ongoing transfer to and subsequent deaths in hospital of up to a fifth of RACF residents annually.³

Aims To gain a clearer understanding of the precipitating factors, including systemic and institutional issues contributing to hospital transfers and in-hospital deaths of residents of Residential Aged Care Facilities (RACFs) and assess the quality of these deaths.

Methods This was a mixed-method study comprised of two parts; a quantitative analysis of 763 deaths in hospital of RACF residents at a major tertiary hospital in Southern Tasmania from 2013-2021 extracted from an existing hospital dataset of all deaths during this period and secondly, an additional detailed qualitative and quantitative analysis of a subsample of 107 patients for the calendar year, 2021. The analyses focused on exploring the factors leading to hospital transfer and the care in hospital prior to death.

Results The study found that respiratory distress and fractures due to falls were the most common presenting complaints on admission to hospital and more likely than other presentations to receive intravenous medications and fluids and have blood tests and imaging undertaken at the end of life. The involvement of specialist palliative care (either as a consult or primary care team) was significantly correlated with a reduction in these tests and imaging. Cognitive status, gender and ceiling of care did not significantly affect whether these interventions were undertaken. There was rarely any formal documentation about the resident's preferred place of death.

Conclusions The study's results highlight the need for better palliative care outreach to RACFs and the need for upskilling RACF staff. It also underscores the need for ACPs to be accompanied by more in-depth, dynamic conversations about likely disease trajectories prior to clinical deterioration and to incorporate documentation about preferred place of death.

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OP55

THE CHALLENGES OF LEFT VENTRICULAR ASSIST DEVICE DE-ACTIVATION: WHEN THE BRIDGE BECOMES A DESTINATION

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Background Globally, an estimated 64 million people live with heart failure, with 5-10% suffering from Advanced Heart Failure (AdHF).¹ In Australia, 100-120 Left Ventricular Assist Devices (LVADs) are implanted annually to replace the function of the left ventricle.² Originally designed as a 'bridge to transplant,' the evolution of durable mechanical support has shift-

ed the paradigm. With the success of trials like REMATCH, LVADs are increasingly utilized as ‘destination therapy.’ However, this technological advancement brings profound clinical, ethical, and logistical challenges at the end of life, particularly surrounding the de-activation of these devices.

Aim This presentation explores the multifaceted challenges of LVAD de-activation, highlighting patient, family, and inter-disciplinary perspectives, and introduces newly proposed institutional guidelines to ensure safe, ethical, and compassionate palliative de-activation.

Clinical Context and Case Studies The complexities of LVAD de-activation are illustrated through two distinct clinical scenarios based on actual cases. ‘Sylvia’ represents a conscious, planned de-activation following a multidisciplinary family conference establishing limits of medical optimization. Conversely, ‘Alan’ highlights an unplanned, unconscious de-activation following rapid clinical deterioration. Both cases underscore key systemic challenges: a lack of specialist knowledge of mechanical circulatory support devices outside major transplant centres, profound distress and uncertainty regarding the ‘timing’ of de-activation, and the reality that de-activation often does not occur in a planned manner.

Perspectives and Ethical Dilemmas Living with an LVAD involves a ‘second chance paradox’— deep gratitude juxtaposed against the constant physical burden of the machine and profound psychosocial shifts. For families, the culture of rescue fosters persistent hope, leaving them emotionally unprepared for terminal decline. Furthermore, there is often discordance between specialties. Studies indicate significant differences between cardiology and palliative medicine clinicians regarding the optimal timing for de-activation, the ethical interpretation of the act, and personal comfort levels in ordering de-activations. These factors raise vital ethical questions regarding equitable access to proactive palliative care, the timing of advance care planning (ACP), and the immense moral distress placed on surrogate decision-makers.

Proposed Guidelines To address these challenges, St Vincent’s Hospital has developed comprehensive ‘Palliative Deactivation of LVAD’ guidelines. These guidelines establish clear roles for the multidisciplinary team (Medical, LVAD Coordinator, Palliative Care, Nursing, Social Work). They detail meticulous pre-deactivation planning, including extensive preparatory discussions with patients, their substitute decision-makers and all medical and allied health team members involved in the patient’s care, the silencing of alarms, and specific pharmacological pathways (differentiating between opioid-naïve and opioid-tolerant patients) to ensure patients are comfortably settled prior to de-activation.

Conclusion As the bridge increasingly becomes the destination, the palliative de-activation of LVADs requires iterative, interdisciplinary discussions and comprehensive discussions with patients and their substitute decision-makers well before a crisis occurs. Standardized, symptom-directed guidelines are essential to minimize awareness of the dying process, reduce distress for patients and families, and support clinicians in delivering cohesive, patient-centred end-of-life care.

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OP56

STRENGTHENING PALLIATIVE CARE IN THE INDO-PACIFIC THROUGH A CERVICAL CANCER ELIMINATION PROGRAM: THE EPICC MODEL

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Background Cervical cancer is a leading cause of cancer and premature mortality, with 90% of deaths occurring in low-and-middle-income countries.¹ Despite progress towards the WHO cervical cancer elimination targets in the Indo-Pacific, many women still present with advanced disease and experience significant, often untreated pain and suffering.² Access to palliative care remains limited due to workforce shortages, restricted access to essential medicines, and weak integration into national health systems.³ The Elimination Partnership in the Indo-Pacific for Cervical Cancer (EPICC), which includes palliative care, is a multi-year program that responds to the WHO 3-pillar strategy to eliminate cervical cancer.⁴ With multiple partners and a footprint in more than nine countries (including Papua New Guinea (PNG), Malaysia, Indonesia, Timor-Leste, Solomon Islands, Vanuatu, Tuvalu, Fiji and Nauru), this consortium-based model, funded by DFAT and the Minderoo Foundation, works with governments and communities to support sustainable progression towards cervical cancer elimination, while strengthening health systems more broadly.

Objective To describe scope and initial implementation of palliative care activities in the Indo-Pacific supported by EPICC.

Results The EPICC palliative care program focuses on four main areas: clinical capacity building; policy and planning, including safe access to opioids; community engagement; and research. Key activities have been co-developed across these areas, with strong linkages to other EPICC workstreams and to complement palliative care initiatives led by other organisations working in the region.

Regarding capacity-building, the EPICC-supported program activities include:

- The EPICC Australia Awards Fellowship Program (2024–2025), which enabled 15 multidisciplinary Fellows from PNG, Vanuatu and Timor-Leste to participate in a comprehensive and tailored two-week training program in Sydney. Follow-up country visits allowed additional progress in training, policy and planning discussions, and advocacy.
- A foundational online training course, delivered through the IAHP-ELNEC program.
- Clinical observerships in Australia, in partnership with Australian health organisations and UICC, allowing immersion in palliative care practice.
- Integration of palliative care principles within cervical screening training programs.
- The online EPICC-ECHO palliative care program, which commenced in May 2026, to foster the creation of a regional community of practice and continued mentoring.

These activities will be supplemented by a multi-country training and policy workshop, planned for June 2026, organised in collaboration with UN agencies, Fiji-MoH and Fiji Cancer Society, bringing together over 40 delegates from six countries, representing MoHs, clinical champions and civil society. This workshop presents a critical opportunity to explore locally-led and owned collaborative solutions to overcome barriers to more equitable access to medicines and quality end-of-life care.

Discussion Strengthening palliative care has emerged as a key priority within the wider EPICC program for women with advanced cervical cancer. Importantly, EPICC recognises that the skills learnt, and policies and services developed, will benefit patients with all diagnoses, cancer and non-cancer. This collaborative cross-country body of work will serve as an enabler of palliative care development within the Indo-Pacific region.

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OP57

DESCRIBING INCIDENCE, OUTCOMES AND RISK FACTORS OF FALLS WITH INJURY IN THE COMMUNITY PALLIATIVE CARE SETTING: A RETROSPECTIVE COHORT STUDY

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Background Falls are a common cause of injury, functional decline and reduced quality of life, and carry substantial health system costs (Australian Institute of Health and Welfare. Falls [Internet]. Canberra: AIHW; 2025 [cited 2026 May 12]. Available from: <https://www.aihw.gov.au/reports/injury/falls>.) In community palliative care, falls risk assessment and prevention strategies are largely extrapolated from evidence in community-dwelling older adults. However, palliative care patients may differ in important ways, including medical complexity, disease trajectory, functional status, and delirium risk. This study describes the incidence, outcomes and risk factors of falls resulting in injury amongst community palliative care patients. **Methods** This retrospective cohort study examined one hundred falls resulting in injury in an Australian community palliative care service. All adult patients of the service who reported a fall with injury between 1 November 2023 and 31 October 2024 were eligible, from which a quasi-randomised sample of 100 falls incidents was selected. De-identified data on demographics, fall outcomes and specified risk factors was extracted from routinely-collected medical records.

Results The incidence of injurious falls was 3.814 per 1000 patient days. Patients were aged 38–94 years (mean 75.95), 54% were male and most (74%) lived with others. Sixty five percent of falls occurred in the deteriorating or terminal phase, and all patients had an Australia modified Karnofsky Performance Status ≤ 60 . Medical review was required after 39% of

falls (27% led to hospital presentation; 11% caused fractures). Nearly half (48%) resulted in temporary functional decline, 5% caused permanent decline, and 14% percent of patients died within seven days.

Regarding risk factors, 64.6% had a prior falls history, and 29.1% had fallen three or more times in the previous year. Over 75% had malignant disease, 7.6% had cognitive impairment, and features of delirium were present in 15% of incidents. Polypharmacy was common: 89.9% were taking five or more medications, frequently opioids (78.5%), antidepressants (34.2%), benzodiazepines (31.7%), and antiepileptics (24%). Comparison of patients who fell once ($n=62$) with patients who fell more than once ($n=17$) suggested patients who fell multiple times were older (mean age 79.2 years) and were more likely to be female (58.8%) or taking five or more medications (94.1%). **Discussion** This is the first study to examine falls incidence, outcomes and risk factors specific to the community palliative care population. Our results suggest that falls resulting in injury are common amongst community palliative care patients, with rates comparable to palliative care inpatients (Stack P, Fischer A, Good P. Incidence and outcomes of falls in an inpatient palliative care unit: a single-centre retrospective study. *BMJ Supportive and Palliative Care.* 2024;**14**:e1758-e1761.) Falls frequently result in functional decline and interaction with the health system in this cohort. Further research is required to validate fall risk factors amongst community palliative care patients and to inform targeted prevention strategies that balance safety, function, comfort and patient-centred goals of care.

Conclusion Injurious falls are common and clinically significant in community palliative care, highlighting the need for further research to identify population-specific risk factors and inform tailored assessment and prevention strategies.

OP58

RE-CONCEPTUALISING WELLBEING IN PALLIATIVE CARE

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Background Dominant approaches to conceptualising – and thus measuring – wellbeing prioritise physiological understandings of wellness, such as symptom burden relief and/or psychological functioning. Such approaches fall short in attending to the relative and relational experiences of wellbeing relevant to patients in palliative care, calling for an ‘outside the square’ approach to advance understanding and measurement of wellbeing in palliative medicine.

Methods This presentation draws on data from interviews lasting between 20 and 90 minutes (conducted in person $n=12$, by telephone $n=21$, or videoconference $n=1$) with patients ($n=34$; 38% male, 76% female) with advanced cancer participating in a randomised clinical trial of medicinal cannabis in a palliative care context (ethics approval: HREC/MML/86472; HREC_22-11_PGOO). Following verbatim transcription, interviews were analysed inductively and then abductively, in alignment with reflexive thematic analysis conventions.

Results Themes related to wellbeing included wellbeing as a multiplicity comprising inward- and outward-focused elements, relational positionality and social experiences. These findings were then furthered through abductive theory-informed analysis drawing on happiness and wellbeing scholarship in the humanities and social sciences.

Discussion Building on these findings, we developed a bio-psycho-social-occupational model of wellbeing that foregrounds freedoms (from and to) regarding both inward states (e.g., freedom from pain and anxiety) and outward-focused capabilities and meaningful social entanglements (e.g., freedom to travel, plan, maintain social connections and independence). In this presentation, we explicate this model, drawing on data displays and visual representations, while prioritising consideration of how the model can be translated for clinical trials and clinical practice in palliative medicine.

OP59 BRIDGING ETHICS AND INNOVATION: AN ETHICAL EVALUATION OF TELETRIALS IN PATIENTS WITH ADVANCED CANCER RECEIVING PALLIATIVE CARE

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Background The Queensland Palliative Care Clinical Trials Network is attempting to construct a state-wide palliative care research teletrial network. Teletrials, connecting smaller research centres (satellite sites) to experienced research centres via telehealth, can address functional and geographic barriers and promote universal trial access in patients with advanced cancer receiving palliative care. However, attempts to define the role and design of teletrials in this vulnerable population should carefully weigh the potential benefits and harms. The four pillars of bioethics: beneficence, non-maleficence, autonomy and justice, offer a useful framework for grounding this discussion.

Objectives To evaluate teletrials in patients with advanced cancer receiving palliative care with reference to the four pillars of bioethics.

Methods A descriptive evaluation of the Queensland Palliative Care Teletrial Network was undertaken using the four core bioethical principles: beneficence, non-maleficence, autonomy, and justice. These principles were examined in the context of recruitment to a randomised controlled trial investigating medicinal cannabis for the relief of symptoms in patients with advanced cancer receiving palliative care.

Results and Discussion The Queensland Palliative Care Teletrial Network promotes beneficence by addressing barriers related to geography and functional status, enabling no-cost access to novel therapies in a closely monitored, protocol-driven, high-contact model of care. The network also facilitates access to specialist palliative care physicians and nurses throughout trial participation and beyond. The principle of non-maleficence has been prioritised through careful trial design, including selection of an investigational product with an established tolerability profile and minimal adverse events. The study protocol has been carefully designed to minimise participant burden in this vulnerable cohort. Broader public health considerations

have also been addressed using screening questionnaires and couriered investigational product to minimise diversion risk.

Autonomy, particularly the principle of informed consent, presents unique challenges in telehealth settings where non-verbal communication and body language may be less apparent. Within the Queensland Palliative Care Teletrial Network consent may be obtained virtually or in person. All staff members receive training in informed consent processes, including identification and management of participant concerns. Participants are also reassured that trial participation will not affect access to standard clinical care.

The Queensland Palliative Care Teletrial Network advances justice by reducing geographic inequities and improving access to specialist care and clinical trials. However, the model may inadvertently introduce digital inequity, potentially excluding individuals without access to digital technologies or the confidence to use them. Participation requires, at minimum, mobile network coverage and ideally internet access. While this may limit complete equity of access, it does not negate the meaningful expansion of research and care access achieved in many rural and regional communities.

Conclusion Teletrials can be ethically implemented in patients with advanced cancer receiving palliative care.

OP60 GOING THE EXTRA MILE: TELETRIALS IN PALLIATIVE CARE

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Background Patients receiving palliative care can experience complex symptoms including pain, fatigue and breathlessness. Participation in clinical trials can improve symptom management and quality of life by expanding access to novel therapies and the care that accompanies participation in clinical trials. However, many Australians living in regional, rural, and remote areas face geographic and functional access barriers to clinical trial participation. Teletrials, one type of decentralised clinical trial, uses telehealth to connect smaller research centres, often located in regional, rural, or remote areas, to a primary research centre, allowing patients to participate in clinical trials closer to home.

Objectives To design and implement a Queensland-based, state-wide palliative care research teletrial network recruiting to a randomised controlled trial investigating medicinal cannabis for the relief of symptoms associated with advanced cancer.

Methods Mater Health in South Brisbane, in collaboration with the Queensland Regional Clinical Trial Coordinating Centre have co-designed a state-wide palliative care research teletrial network that leverages existing health infrastructure by linking each of Queensland's fifteen adult Hospital and Health Services (HHSs) as satellite sites to Mater Health (the primary site). Connecting entire HHSs, rather than individual hospitals, allows for state-wide coverage of the network and universal trial access.

Results Since April 2024 ten HHSs have been activated as satellite sites, each contributing patient referrals. 14 patients have been enrolled in the teletrial, all of whom (100%) have reached the primary outcome measurement at day 14. This compares

to a retention rate of approximately 92% in the non-teletrial cohort. The network has facilitated participation of highly geographically remote patients, including the most remote Australian patient to have ever participated in an investigational drug teletrial. Key implementation challenges, many relating to the novel statewide approach, include delays in HHS governance approvals, the need for HHS-wide governance approvals (versus traditional individual hospital site approvals), low capacity for research support in specialist palliative care services, and lack of access to local research staff. Ongoing evaluation includes feasibility (recruitment), efficiency (cost per participant), scientific validity (comparability of demographic and outcome data between teletrial and conventional arms), safety (rate of adverse events), usability (validated questionnaire), and ethical considerations.

Discussion This teletrial network has provided patients living in regional, rural, and remote regions of Queensland with the opportunity to participate in a clinical trial, indicating that teletrials are a feasible trial model in patients receiving palliative care. The high retention rate to the primary outcome timepoint suggests that decentralised trial delivery may reduce attrition in this setting, although caution must be exercised when drawing conclusions due to the small sample size. Construction of the network remains incomplete with ongoing challenges related to governance approvals, research staff recruitment, and local clinical oversight. Addressing these barriers will be critical to optimising scalability and sustainability of teletrial models.

Conclusion A statewide teletrial model can successfully recruit and retain patients receiving palliative care across geographically dispersed regions, although operational and governance barriers remain.

OP61 ANTIMICROBIAL PRESCRIBING PATTERNS IN THE LAST 2 WEEKS OF LIFE AT A SINGLE TERTIARY HOSPITAL

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Background Antimicrobial use at the end-of-life is common in 50–90% of hospitalised patients.^{1,2} Their use should align with patients' goals of care.^{1,2} When antimicrobials are prescribed in a palliative care cohort, symptom relief is inconsistent, with benefit observed in around 60% of cases.¹ Their use is associated with adverse effects, longer hospital stays, and the emergence of resistant organisms.¹ Few antimicrobial stewardship programs or national policies provide guidance specific to palliative and end-of-life care, contributing to wide variation in practice.³ The study aimed to determine antimicrobial prescribing rates in the last 14 days of life, comparing hospitalised patients with and without palliative care involvement.

Methods A retrospective review of all adult inpatient deaths at a single metropolitan tertiary hospital between March 2022 and March 2025. Data on antimicrobial prescribing, demographics, and palliative care involvement (direct admission, consult, or no input) were extracted from electronic medical records. Descriptive statistics and multivariable logistic regression were used to assess factors associated with antimicrobial prescribing.

Results Of 1,835 deceased patients, 799 (43.6%) received at least one antimicrobial in the final 14 days of life. Prescribing rates were significantly lower in patients admitted under pal-

liative care (30.3%, 333/1,098) compared to those with a palliative consult (57.9%, 219/378) or no palliative care involvement (68.8%, 247/359). Patients without palliative care input were 3.7 times more likely to receive antimicrobials (OR 3.69, 95% CI 2.88–4.72; $p < 0.0001$). Mean Charlson Comorbidity Index scores were highest in patients admitted under palliative care (8.4 [4.2]) compared with those receiving a palliative care consult (7.2 [3.6]) or no palliative care involvement (7.0 [3.7]). Palliative care involvement was also associated with shorter length of stay and earlier cessation of antimicrobial therapy.

Conclusion These findings demonstrate that palliative care involvement is associated with reduced antimicrobial use at the end-of-life, supporting a comfort-focused approach. Integration of palliative principles into antimicrobial stewardship frameworks may help clinicians balance comfort, safety, and patient goals when making prescribing decisions in patients with a life-limiting illness in the last days of life.

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OP62 END-OF-LIFE CARE QUALITY INDICATORS FOR RESIDENTIAL AGED CARE FACILITY RESIDENTS: A RETROSPECTIVE COHORT STUDY OF HOSPITAL AND FACILITY DEATHS

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Background Evidence-based palliative care within residential aged care facilities is an international priority. Measurable quality indicators of end-of-life care for older adults should be assessed.

Aim To describe residents of aged care facilities who died in hospital vs facility, compare pragmatic end-of-life quality indicators between cohorts and characterise terminal hospitalisations.

Design Retrospective cohort study using hospital and community palliative care databases. Variables of interest included documented advance care plan and preferred place of death, symptom burden, prescribed medication and specialist palliative care involvement. Terminal hospitalisations were classified as potentially avoidable or unavoidable.

Setting/participants Facility residents aged ≥ 65 years who died between 1 July 2022 and 30 June 2024 cared by Cabrini Health ($n=478$; 378 facility deaths, 100 hospital deaths).

Results Facility deaths commonly involved cancer (39.6% vs 27.0%), whereas hospital deaths frequently involved dementia/frailty (51.0% vs 25.3%, $p < 0.001$), with 24% transfers classified as potentially avoidable. Among residents with documented preferences, preference-concordant death was higher in facility deaths (99.7% vs 22.4%, $p < 0.001$). Continuous subcutaneous infusion (74.3% vs 61.0%, $p = 0.012$) and benzodiazepine prescription (97.6% vs 91.0%, $p = 0.005$) were higher in facility deaths, while antipsychotic prescription (65.0% vs 36.0%, $p < 0.001$) and intravenous antibiotic use (24.0% vs 2.4%, $p = 0.002$) were higher in hospital deaths. Decedents in

facilities were referred earlier to the specialist palliative care service (median 40.5 vs 7 days, $p < 0.001$).

Conclusions Earlier specialist palliative care, structured advance care planning with explicit transfer limits, and proactive recognition of deterioration may reduce potentially avoidable terminal hospitalisations and support high-quality, preference-concordant care.

OP63

PALLIATIVE CARE CLINICIANS' MEDICATION RECOMMENDATIONS FOR INTENSIVE CARE UNIT PATIENTS TRANSITIONING TO WARD-BASED END-OF-LIFE CARE: A DESCRIPTIVE STUDY

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Background End-of-life care (EOLC) is common in the Intensive Care Unit (ICU). Specialist Palliative Care (PC) may be consulted to facilitate transition to ward-based EOLC. Evidence is limited regarding converting intravenous opioid and benzodiazepines infusions administered in the ICU, where doses are usually intended to sedate, to ward-level continuous subcutaneous infusions (CSCI) for symptom control at end-of-life.

Aim To describe current practice of PC clinicians' recommendations regarding transitioning medications from intravenous to CSCI, in ICU patients receiving EOLC.

Methods Retrospective audit at a quaternary hospital with co-located PC ward in Melbourne, Australia. Patients included were aged 18 and older, in ICU between 2019-2023, who received PC review for EOLC in the context of one-way extubation. Demographics, clinical characteristics and medication recommendations were collected from ICU databases and manual chart review. Oral Morphine Equivalent Daily Dose (OMEDD) and benzodiazepine dose were tracked at key time-points to assess changes.

Results Of the 112 patients included, median age was 69 years, 65% were male, and 92.9% were admitted to ICU for non-malignant causes. Subgroup analysis was performed on patients transitioned from intravenous infusions to CSCI ($n=56$). At initial PC review, median intravenous OMEDD and midazolam dose were 360mg/24hours (IQR 144-414mg) and 72mg/24hours (IQR 48-120mg) respectively. The median CSCI OMEDD and midazolam dose recommended by PC was 90mg/24hours (IQR 30-90mg) and 20mg/24hours (IQR 10-30mg) respectively. There was a statistically significant decrease in median OMEDD (-201mg/24hours, p -value <0.001) and midazolam dose (-46mg/24hours, p -value <0.001) between initial PC review and death.

Discussion This is the first Australian study to describe medication recommendations by PC clinicians, and subsequent medication changes until death, in this patient group. Our findings may provide guidance regarding end-of-life medication dose considerations when transitioning from ICU to the ward and converting sedation to EOLC doses. Further research should include symptom burden and be undertaken in other cohorts of ICU patients.

OP64

END OF LIFE CARE FOR ELDERLY PEOPLE WITH CHRONIC, PROGRESSIVE NON-CANCER ILLNESS – A RETROSPECTIVE AUDIT OF THE QUALITY OF DYING IN A SMALL METROPOLITAN HOSPITAL

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Background Globally, populations are ageing, which is associated with increased burden and prevalence of chronic disease. Australian data demonstrates that four of the five most common causes of death are from non-cancer chronic disease and that most people die with multiple chronic comorbidities.¹ Compared to those diagnosed with cancer, many elderly patients receive multiple, non-beneficial interventions on hospital admission. Uncertainty in prognostication and under-recognition of the terminal phases of illness contribute to these poor outcomes.^{2,3} The 2015 'National Consensus Statement: Essential elements of safe and high-quality end-of-life care' presented standards associated with quality end-of-life care.⁴

Objective This study examines whether increasing consultative palliative care services in a metropolitan hospital changed end-of-life care in this vulnerable population, as measured against the National Consensus Statement standards.

Methods A retrospective audit of the medical records of decedents during three distinct periods was undertaken: 1) consultation by an in-reach CNC only, 2) consultation by a CNC-led model and 3) an integrated consultation service with CNC, registrar and medical specialist on site. Audit data included patient demographics, advance care and resuscitation plans, life-sustaining treatments, whether the clinician recognised the patient was dying and if there was a palliative approach to patient care.

Results There was a correlation between an increase in the intensity of palliative care services on site, and an increase in documented recognition of dying, implementation of a palliative care plan, and number of days between recognition of death and palliative care referral until death. There was a decrease in non-beneficial interventions administered in the last 48 hours of life, although this remained high compared to a national audit of the same.⁵

A comparison of the means with paired t-test for continuous variables, and z-score for categorical variables were used to show statistical significance between these time periods.

Discussion Quality end-of-life outcomes were improved by the introduction and increase of specialist palliative care services for this underserved population. This could be due to increased education or awareness raising by more integrated specialist palliative care into the wider team. Further research and quality improvement is warranted to ensure best practice in this population at the end-of-life.

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OP65

FROM CO-DESIGN TO CLINICAL PRACTICE: DESIGNING AN ONLINE EDUCATION COURSE TO SUPPORT TIMELY PALLIATIVE CARE INTEGRATION IN CANCER CARE

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Background Timely referral to palliative care, in parallel with standard of care cancer treatment has been shown to improve quality of life, symptom control, survival and has reduced hospital stays. Despite known benefit, Australian data indicate many patients either do not access specialist palliative care or are referred late in the disease trajectory.

Methods A multispecialty clinical working group was convened to explore the issue of timely referral and tasked with developing an educational resource to address the issues explored. The working group comprised consumer representatives, specialist physicians in haematology, medical oncology, radiation oncology and palliative care, as well as trainees and representatives from the Royal Australasian College of Physicians, ensuring a comprehensive and person-centred approach. After a facilitated workshop, course content, key messages and online design was determined.

Result A well-tailored, accredited and recognised online Continuing Medical Education (CME) course, designed for specialists and trainees in adult haematology, medical oncology, and radiation oncology has been developed. The course emphasises a shift from an ‘end-of-life’ perception of palliative care towards a personalised, needs-based model of ‘timely’ referral integrated alongside active cancer treatment. Importantly, it embeds practical communication skills training considered essential during difficult conversations.

The co-design process was a key enabler contributing to a better understanding of specialty specific clinician educational needs. The cross sectoral multidisciplinary approach also aligned patient and family perspectives to inform key messaging. Lessons learned about the process are valuable and transferable for other complex system change undertakings.

Conclusion Designing educational content to solve a clinical systems issue has been enhanced by multi-disciplinary, cross sector collaboration. The potential benefit is twofold. Firstly, a tailored quality CPD offering is available for cancer specialists and trainees to support timely palliative care referral and, secondly, a useful design process has demonstrated applicability and potential transferability to be shared for the benefit of colleagues.

OP66

WHAT IS A ‘GOOD DEATH’ IN SRI LANKA?

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Background A ‘good death’ requires understanding the values and preferences of the relevant people, such as patients, family members and healthcare professionals. The majority of work exploring the concept of a good death originates from the Global North, with only preliminary data available in Sri Lanka and the Global South. Without this understanding, it is challenging to deliver palliative care that is congruent with the values of local care receivers and care providers.

Objectives To explore a ‘good death’ through the values and preferences expressed by Sri Lankan patients with advanced cancer, their caregivers, and healthcare workers.

Methods A qualitative study was performed in 2023 at the National Cancer Institute, Sri Lanka, to explore what was considered important at the end-of-life in advanced cancer. A purposive sample of patients with advanced cancer (n=12), current and bereaved caregivers (n=15), and oncology and palliative care doctors and nurses (n=22) was recruited in-person and via letter. Semi-structured interviews were audio-recorded, translated, and transcribed. Thematic analysis was performed.

Results All parties made compromises to achieve a ‘good enough’ death in Sri Lanka. Mutual care occurred between patients, families, healthcare workers, and the community. Within this network, families were the fulcrum, and patients were not always the priority. Families valued feeling and being perceived as having done their best for patients. Patients displayed a deep need to be of service to their families. For the patient to have a ‘good enough’ death, it was critical that their family understood the prognosis and prepared accordingly. Healthcare workers were appreciated for doing their best for patients. Care was often expressed through fulfilling specific duties, visible actions, and compassionate speech, imbued with religious beliefs and practices. These acts of care were perceived by patients and families as maintaining patient dignity.

Discussion The findings highlight the importance of family, relationships, duty, and religion in the ‘good enough death’ in Sri Lanka, with less emphasis on symptom management. Healthcare workers should be reassured that ‘good enough’ is meaningful, and many important aspects of ‘good enough’ death are practical and available to implement. However, working towards the ‘good enough’ death in Sri Lanka does not reduce the urgent need to address the many other barriers impeding access to quality palliative care. Research and policies should focus on implementing a family-centered model of care that integrates the social and religious aspects of dying well. In doing so, Sri Lankan healthcare workers can be empowered to deliver care that aligns with patient and family values, as well as their own. These findings are likely relevant to similar cultures worldwide, particularly in the Global South. The data contribute to reducing the inequity in palliative care research on this topic between the Global North and South.

OP67

EMPOWERING SRI LANKAN HEALTHCARE WORKERS TO DELIVER A 'GOOD DEATH'- A STRENGTHS-BASED FRAMEWORK AND APPROACH

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Background Despite significant focus on policy, drug availability, training and implementation, access to palliative care remains limited in Sri Lanka. One reason for this is the lack of practical, evidence-based, socioculturally sensitive guidance for local healthcare workers on how to deliver palliative care.

Objectives To create evidence-based guidance for Sri Lankan healthcare workers that empowers them to deliver palliative care in real-world clinical settings.

Methods A systematic review and narrative synthesis were performed in 2023 to explore what a good death meant in South Asia (published). A qualitative study (n=49) was performed in 2023 at the National Cancer Institute, Sri Lanka, to explore what was considered important at the end-of-life in advanced cancer (presented as a separate abstract). Based on these findings and the literature, a strengths-based philosophy was used to derive a clinical framework and approach for palliative care in Sri Lanka.

Results The framework and approach draw upon existing sociocultural strengths in Sri Lanka, including the priority given to caregiving by family and the community, community and religious support networks, the significance assigned to religious beliefs and practices, and the value placed on kindness. The overall framework to delivering palliative care suggests that healthcare workers treat both the patient and family concurrently, while demonstrating kindness, allowing hopefulness, and using the existing supports of community and religion. The approach details how to care for the patient and family, depending on the level of palliative care experience of the healthcare worker. Guidance is provided on how to support patients and families according to their needs, including suggested phrases and questions to aid communication. The approach guides healthcare workers to support the family through providing medical information, palliative care education, emotional and psychological support, and counselling on patients knowing about diagnosis and prognosis. It also provides guidance on how healthcare workers can support families through demonstrating care for patients, and by supporting families to support patients. For patients, the approach guides healthcare workers on demonstrating kindness, respect and care, understanding patient priorities, assisting with preparation for death, delivering personalised care and navigating disclosure of diagnosis and/or prognosis.

Discussion This framework and approach aim to empower Sri Lankan healthcare workers in delivering aspects of palliative care that are meaningful to patients and families and utilize existing sociocultural strengths, regardless of prior training, through actionable guidance. They require validation by groups of healthcare workers, patients and families, and ongoing review following implementation. A practical framework and approach for healthcare workers could enable palliative care to be rapidly integrated into standard care in Sri Lanka. These could be adapted to other similar settings in the Global South.

OP68

HOW DO SRI LANKAN NEWSPAPERS REPRESENT PALLIATIVE CARE? A DISCOURSE ANALYSIS

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Background Discourse analysis considers how bodies of texts, such as conversations, media and books, create and maintain the meaning we assign to a given phenomenon, in this case, palliative care. How Sri Lankan media influences the discourse around palliative care, its role as a medical specialty, and its wider implications for life and society are largely unexplored.

Objectives This study aimed to undertake a discourse analysis to explore the representation of palliative care by Sri Lankan newspapers, and to examine the manner in which the information was presented.

Methods A discourse analysis was performed on 16th December 2024. Sinhalese (n=5), Tamil (n=3) and English (n=6) newspapers were searched in the relevant language for the term 'palliative care' between 2017 and 2024. A Google search for each newspaper was also conducted. Search results (n=675) were screened by title and article content for their relevance to palliative care. The approach to analysis incorporated consideration of both constructivist and critical stances, through social linguistic analysis and critical discourse analysis, respectively.

Results Thirty articles (26 English, four Sinhalese, nil Tamil) were analysed. The discourses identified were aimed mostly at the minority English-speaking population, with three main discourses identified. An instructional discourse was led by doctors who were educating the public on 'what is palliative care', with mixed views on how it should be adapted to the local context. A promotional discourse presented competing visions for location of care in either newly launched palliative care centers or at home, influenced by existing and potential local donors and global organisations. A moral discourse urged the public to take responsibility for ensuring equity in access to palliative care for all.

The apparent aims of the articles were to educate the public, create awareness about well-funded and well-equipped palliative care centres, and inspire readers to join the palliative care movement for social justice by contributing personally and financially. There was little representation of patients and families, and limited practical advice for those requiring palliative care.

Discussion The average reader of an English Sri Lankan newspaper would obtain a positive, yet rather unrealistic, understanding of palliative care. This study illustrates the impact of powerful individuals and groups (such as global palliative care organisations, doctors and wealthy donors) in shaping how the Sri Lankan public understands palliative care, and who has access to information about palliative care. As a result, certain aspects, such as palliative care centres, were strongly promoted despite areas of incompatibility with Sri Lankan palliative care needs, whereas the less powerful voices of patients and families were sidelined. This study highlights the importance of including relevant voices in the Sri Lankan palliative care discourse, improving access to palliative care information in Sri Lanka, and considering how palliative care should be adapted to the Sri Lankan context.

OP69 CONSUMER DISSATISFACTION IN A SPECIALIST PALLIATIVE CARE SERVICE

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Background Satisfaction with specialist palliative care is generally high; however, dissatisfaction remains underexplored and may reveal important gaps in care delivery. In community settings, unmet needs in communication, symptom management and psychosocial support can negatively impact both patient and caregiver experiences, particularly at end of life and during bereavement. Evaluating dissatisfaction as a distinct outcome may provide more nuanced insights than aggregate satisfaction scores alone. Identifying areas of dissatisfaction is essential for improving the quality and responsiveness of care.

Aim To determine the proportion of dissatisfied responses in a specialist palliative care service using FAMCARE-2 survey responses and analyse the distribution of dissatisfaction across the four domains: management of physical symptoms and comfort, provision of information, family support and patient psychological care.

Methods A single-centre, prospective cohort study was conducted at St Vincent's Private Hospital Brisbane's Community Specialist Palliative care service. FAMCARE-2 surveys were distributed to patients, caregivers and bereaved caregivers across public and private funding models between 2016 and 2024. Quantitative analysis of 'dissatisfied' and 'very dissatisfied' responses was performed across the tool's four domains. Free-text comments were thematically analysed to further explore areas of dissatisfaction.

Results The total survey response rate was 32% and of the 1133 surveys returned, 59 contained dissatisfied responses (5%). Dissatisfaction was highest among bereaved caregivers (6%), compared with patients (4%) and caregivers (3%). Across all survey items, dissatisfied responses were low ($\leq 2\%$) and distributed across all four domains. On further analysis of the 59 surveys, the item that registered most dissatisfaction was 'emotional support provided to family members' with 33% of responses being dissatisfied/very dissatisfied.

Thematic analysis of the 31 free-text dissatisfied responses identified consistent drivers of dissatisfaction. These included limited availability and responsiveness of the care team, inadequate emotional and bereavement support, suboptimal symptom management, and insufficient communication regarding prognosis and the dying process. These findings are consistent with existing literature highlighting communication and emotional support as key determinants of caregiver experience.

Conclusion While overall satisfaction was high, a small but clinically meaningful proportion of dissatisfaction persists, particularly among bereaved caregivers. Dissatisfaction is primarily associated with deficits in communication, emotional support and service accessibility and underscores the importance of good communication and psychosocial support in end-of-life care. Assessing dissatisfaction as a distinct outcome complements traditional satisfaction measures and provides actionable insights for targeted quality improvement in palliative care services.

OP70 DEVELOPING A 'LAST 1000 DAYS' FRAMEWORK IN AGED CARE: INTEGRATING FRAILTY, REABLEMENT, END-OF-LIFE CARE AND VOLUNTARY ASSISTED DYING INTO CLINICAL GOVERNANCE

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Older people are entering residential aged care later in life, often with advanced frailty, multimorbidity and increasing clinical complexity. Traditional models tend to respond to deterioration once it occurs, rather than shaping the final phase of life with clarity, intention and person-centred care. This creates a gap between what matters to people and how care is delivered.

This presentation outlines the development of the 'Last 1000 Days' framework within OneCare, a not-for-profit aged care provider in Tasmania. The framework is emerging as a practical, system-wide approach to recognising the final two to three years of life as a distinct clinical phase. It brings together frailty identification, reablement, palliative and end-of-life care, and governance into a single, coherent model, aligned to contemporary reform and strengthened standards.

The framework is structured around four pillars. First, earlier identification of frailty through standardised screening and risk stratification to enable timely and proportionate care. Second, embedding reablement to maintain independence and function for as long as possible. Third, strengthening palliative and end-of-life care, including advance care planning and voluntary assisted dying, ensuring care reflects individual goals and preferences. Fourth, the use of clinical dashboards and data to identify risk, predict trajectories and support proactive decision-making.

A central principle is that reablement and end-of-life care are not competing priorities. They sit on the same trajectory and should be delivered in parallel. Early implementation highlights the importance of strong governance, workforce capability, multidisciplinary collaboration and structured clinical triggers to support timely conversations.

This developing model reflects a clear intent. To move from reactive care to planned care. To protect what matters most in a person's final years. And to provide a structured, scalable approach that supports dignity, choice and quality across the aged care journey.

OP71 GRIEF AND ART: HONORING THE GRIEVING PROCESS THROUGH CREATIVE EXPRESSION

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This presentation introduces Expressive Art Therapy as an effective clinical approach for supporting individuals experiencing anticipatory grief and bereavement, including those who are dying and their grieving family members. Participants will explore the foundational principles of Expressive Art Therapy and examine how creative modalities can support emotional expression, meaning-making, coping, and connection throughout the grief process.

The presentation will highlight the therapeutic use of visual art, writing, movement, music, and symbolic expression in end-of-life and bereavement care. Practical strategies for integrating expressive arts interventions into clinical settings will be discussed, with attention to ethical and client-centered practice considerations. Clinical case examples will illustrate the application of expressive arts approaches across diverse grief experiences and care settings.

By combining theory with practical application, this session aims to provide clinicians with accessible tools for supporting clients navigating loss, transition, and emotional processing at the end of life.

Learning Objectives

1. Describe the core principles of Expressive Art Therapy and its clinical application in supporting anticipatory grief and bereavement.
2. Identify expressive arts modalities and interventions appropriate for individuals who are dying and their grieving family members.
3. Apply expressive arts techniques in clinical practice through the development of ethically sound, client-centered strategies for grief-focused therapy.

OP72

IMPLICATIONS OF HIGH RISK PHARMACOGENOMIC VARIANTS FOR SYMPTOM MANAGEMENT PRESCRIBING IN PALLIATIVE CANCER CARE

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Background Patients receiving palliative care experience high symptom burden and are particularly vulnerable to adverse drug reactions and therapeutic failure. Many commonly used symptom management medications rely on cytochrome P450 (CYP450) enzymes for metabolism, yet the impact of inherited differences in these enzymes on medication safety and effectiveness in palliative cancer care remains poorly characterised.

Objectives To determine the prevalence of CYP450 metaboliser phenotypes that indicate a need for altered dosing or alternative medications for commonly prescribed symptom management drugs in an advanced cancer palliative care cohort.

Methods We conducted a multicentre, prospective, longitudinal cohort study evaluating medication use and pharmacogenomic profiles of 52 adults with advanced cancer over a 7 day period. Genotypes were translated into metaboliser phenotypes using established clinical guidelines. Patients were classified as high risk if they carried a phenotype requiring guideline recommended dose modification or alternative therapy. High risk patients were further classified as at risk if they were concurrently prescribed a medication with actionable CYP450 guidance. All actionable variants were drug metabolising enzyme gene variants.

Results High risk pharmacogenomic phenotypes were highly prevalent: 86.5% of participants carried at least one high risk phenotype, and 54% carried two or more. CYP2C19 accounted for the greatest burden of high risk phenotypes (54%), corresponding to 12 commonly used medications across selective serotonin reuptake inhibitors, tricyclic antidepressants, and proton pump inhibitors. Overall, 13.5% of patients were classified as at risk, having both a high risk phenotype and exposure

to a medication with actionable genotype guided prescribing recommendations.

Discussion This study demonstrates that clinically actionable CYP450 variation is widespread in palliative cancer care, with the majority of patients carrying high risk phenotypes relevant to frequently used symptom management medications. The presence of high risk phenotypes in combination with real time prescribing highlights the limitations of trial and error medication selection in a population with limited time to achieve symptom control. These findings underscore the potential for pharmacogenomic guided prescribing to reduce therapeutic failure, minimise avoidable adverse effects, and improve the reliability of symptom relief.

Conclusion High risk CYP450 phenotypes are common in patients receiving palliative care for advanced cancer, and a meaningful proportion are exposed to medications for which genotype guided prescribing is recommended. This foundational evidence supports the integration of pharmacogenomic testing into routine palliative care pathways to enhance medication safety and optimise symptom outcomes.

OP73

A NATIONAL PHARMACOEPIDEMIOLOGIC STUDY OF RAPID-ONSET OPIOIDS FOR ADVANCED CANCER IN AUSTRALIA, 2013–2025: RARELY USED, INTENSIVELY DOSED

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10.1136/spcare-2026-ANZSPM.71

Background Nearly half of all breakthrough cancer pain (44%) is reported as incident pain which is linked to greater functional disruption. Rapid onset opioids (ROOs) have a pharmacokinetic profile which may better match the rapid peak and short duration of incident pain. This study characterises national ROO utilisation in Australia over 13 years compared to other immediate release opioids.

Methods This population based study used a 10% random sample of Australians through the Pharmaceutical Benefits Scheme (PBS) from 2013–2025 of people who used immediate release opioids in their last 6 months of life and had cancer treatment. Three rapid onset opioids (ROOs) were PBS listed and included: oral transmucosal fentanyl citrate (OTFC), fentanyl sublingual tablets (FST), and fentanyl buccal tablets (FBT). Descriptive statistics summarised prescribing frequency and oral morphine equivalent daily dose (OMEDD). Daily dose was obtained by dividing the tablet dose and number prescribed by number of days per month.

Results In total, 343,580 people were prescribed immediate release opioids. Median dose reduced over the 13-year period from 10mg (IQR 5,28) in 2013, reducing steadily to 7mg (IQR 4,16) in 2025. Median overall dose for ROOs was 200mcg (IQR 81,448mcg) compared to 8mg (IQR 4,19) for non-ROOs.

In total, 14,790 people received ROOs (4.5%). Since all three ROOs became available in year 2016, ROO use was proportionally greater compared to when only OTFC was available. FST was the commonest (66%; n= 9,690), followed by OTFC (27%; n=4,050) and FBT (7%; n=1,050).

Discussion/Conclusions ROO use has almost doubled since new formulations were added in 2016. Yet its use remains rare (4.5%) despite recommendations for incident pain. Median

equianalgesic ROO dose was higher than other immediate-release opioids, whereas non-ROO doses have reduced slightly over 13 years. Key drivers of rare ROO use and reasons for relative high dosing warrant further investigation.

OP74 IMPACT OF HYDROMORPHONE SLOW-RELEASE DISCONTINUATION ON OPIOID PRESCRIBING: A RETROSPECTIVE ADVANCED CANCER COHORT STUDY

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Background Hydromorphone slow release (SR) tablets were withdrawn from the Australian market in 2023, removing a key long acting opioid option for people with advanced cancer. The consequences of this supply interruption for opioid utilisation, dose requirements, and prescribing patterns in specialist palliative cancer care are not well understood.

Objectives To determine how the discontinuation of hydromorphone SR affected the utilisation and dosing of alternative slow release opioids in a large quaternary cancer centre.

Methods We conducted a retrospective cohort study comparing opioid prescribing patterns across two 12 month periods: 01 November 2021–01 November 2022 (pre discontinuation) and 30 April 2023–30 April 2024 (post discontinuation). Inpatient and outpatient prescribing data were analysed for adults with incurable advanced or metastatic cancer who first presented during the study periods. The primary outcome was change in prescribing frequency of individual SR opioids. Secondary outcomes included differences in oral morphine equivalent daily dose (oMEDD), demographic characteristics, and adjusted fold changes in median oMEDD and prescribing frequency.

Results A total of 2,856 patients were included (n=1,475 pre; n=1,381 post). Following hydromorphone SR withdrawal, notable shifts in opioid utilisation occurred. Methadone prescribing increased (aOR 1.42, p=0.07), accompanied by a doubling of median daily dose (45 mg vs 22.5 mg; p=0.005). Morphine SR use declined significantly (aOR 0.69, p<0.001), yet median daily oMEDD increased by approximately 20% (95% CI 1.01–1.37), indicating higher dose requirements among those continuing morphine. Tapentadol (aOR 1.40, p=0.01) and buprenorphine (aOR 1.37, p<0.001) were prescribed more frequently, without associated dose escalation. These changes reflect a redistribution of opioid selection rather than direct substitution at equivalent doses.

Discussion The discontinuation of hydromorphone SR was associated with increased methadone utilisation and substantially higher methadone doses, alongside greater prescribing of tapentadol and buprenorphine. These findings highlight the susceptibility of palliative care prescribing to medication supply disruptions and suggest that clinicians may shift toward opioids with more complex pharmacology when preferred options become unavailable. The observed rise in methadone use underscores the need to reconsider its role in routine practice and to strengthen clinician training in its safe and effective prescribing. Broader analyses using national datasets are warranted to understand system wide impacts and to inform policy strategies that safeguard access to essential opioids for symptom management in advanced cancer.

OP75 A FACILITATED STRUCTURED APPROACH TO ESTABLISH A COLLECTIVE PURPOSE STATEMENT TO ADVANCE PALLIATIVE CARE IN THE ASIA PACIFIC REGION: THE CYNTHIA GOH FELLOWSHIP INITIATIVE

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Background As palliative care continues to expand globally, there is an increasing need to develop leaders capable of navigating complex healthcare systems and advancing the integration of palliative care within mainstream health services. The need for such leadership is particularly pronounced in the Asia-Pacific region, where health systems are characterised by substantial variability in resources, infrastructure, and service development.¹ Persistent health inequities, uneven distribution of palliative care services, and diverse sociocultural contexts present significant challenges to ensuring timely and equitable access to care. The Cynthia Goh Palliative Care Fellowship (CGF) aims to identify and develop the next generation of palliative care leaders in the Asia-Pacific region, creating a regional fraternity that will advance the development of palliative care in the region. We aim to describe a structured, facilitated approach undertaken to co-create a collective purpose statement to guide regional leadership action for upstreaming palliative care.

Methods A facilitated participatory design approach was employed by the second batch of eight CGF Fellows representing their respective sectors (countries) to co-create a collective purpose statement which will form the basis of a collaborative project.

Results Facilitated by an expert leadership coach, eight CGF (Batch 2) fellows from diverse health systems convened to co-create a collective purpose statement that will drive their collaborative project to advance palliative care in the Asia-Pacific region. From inspiration to ideation, the process was underpinned by Simon Sinek's 'Golden Circle - Start with why' framework² and built on the upstreaming palliative care framework developed by the Batch 1 fellows. A structured multi-step process was conducted, including contextual macro and micro analysis (PESTLE, McKinsey 7S respectively) and strategic assessment (SWOT) of potential options.³ Data were derived from facilitated discussions and group reflections. These were then considered within the context of stakeholders and hierarchy of roles. Thematic convergence was achieved through guided facilitation to develop a shared purpose statement.

Discussion Through the facilitated, structured and iterative process described, a collective purpose statement was generated to guide and underpin the collaborative work to co-develop a person-centred leadership framework to upstream palliative care and to ensure timely and equitable access across the

Asia-Pacific region. This methodological approach provides a means to triangulate key ideas and themes from a diverse group of leaders from varied resource and sociocultural settings to form a collective statement – which may be beneficial in other leadership development initiatives. Future work will focus on evaluating and refining this framework, which seeks to guide contextualised region-specific interventions to achieve intermediate and long-term outcomes.

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OP76

NUTRITION SCREENING PRACTICE AND DIETITIAN REFERRAL PATTERNS IN A PALLIATIVE CARE UNIT: AUDIT OF THE MALNUTRITION SCREENING TOOL USE

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Background Screening patients for malnutrition risk is part of the national clinical care standards.¹ Nutrition screening is important to identify patients at risk of malnutrition as well as those who would benefit from nutritional interventions and support.²

Nutritional screening tools such as the Malnutrition Screening Tool (MST) have been validated for use in acute hospital settings. The MST is also used in some palliative care settings, although nutrition screening in palliative care services occurs inconsistently. The MST risk stratifies a patient's malnutrition risk as low, moderate or high based on recent weight loss and appetite change. High-risk patients should be referred to a dietitian.

Conducted in the context of a larger study seeking to co-design a nutrition screening approach in a palliative care unit (PCU), we aimed to evaluate the use and effectiveness of the MST as a nutritional screening tool in the PCU setting.

Methods We conducted a retrospective clinical audit of MST use and effectiveness in the Wantirna Health Supportive and Palliative Care Unit, an adult inpatient PCU. The medical records of 150 consecutive admissions from January to March 2025 were reviewed. We excluded patients who did not have the MST completed on admission or had an incorrectly completed MST. A senior dietitian determined appropriateness of dietitian referral and potential for dietetic input for patients not referred. Data collected was reported descriptively.

Results 74/150 patients had a correctly completed MST. 74 patients (males: 41; 55%) were included with a median age of 76 years (interquartile range (IQR) = 65-85). 16 (16/74; 22%) patients were determined as low-risk for malnutrition, 52 (52/74; 70%) moderate-risk, and 6 (6/74; 8%) high-risk.

39/74 (53%) patients were referred to the dietitian, with the majority (37/39; 95%) retrospectively deemed as appropriate referrals. Clinical judgement from medical, nursing or allied

health staff was the most common trigger for referral (24/39; 62%). Only 6/39 (15%) referrals were initiated because of MST score on admission. 14 (14/35; 40%) of those not referred were identified as potentially benefitting from dietetics input.

Discussion The MST as a nutrition screening tool in the PCU setting is of questionable value. Although all patients in the high-risk category were appropriately referred, most dietitian referrals were generated independently of patients' MST score.

Conclusion Our findings suggest MST in isolation may be inadequate in identifying patients who require dietitian input, and that a flexible multi-prong approach to nutrition screening is necessary to better match dietitian referrals with patients' nutritional needs.

The results from this audit will inform next steps in co-designing a tool that endeavours to streamline the approach to nutrition screening, optimise dietitian referrals and improve patient-centred outcomes in this setting.

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OP77

VOLUNTARY ASSISTED DYING IN AN INPATIENT PALLIATIVE CARE UNIT: A 3-YEAR RETROSPECTIVE AUDIT OF PREVALENCE, CLINICAL CHARACTERISTICS, AND OUTCOMES

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10.1136/spcare-2026-ANZSPM.75

Objectives To identify the number of patients dying by Voluntary Assisted Dying (VAD) over a 3-year period in a specialist palliative care unit (PCU), and to assess demographics, symptoms, function, prognosis, and cognitive status.

Design Retrospective chart audit.

Setting 20-bed specialist PCU in metropolitan Queensland, in the 3-year period after VAD was made available on 1st January 2023.

Main outcome measures Number of patients referred to VAD service, and number who died after administration of VAD. For patients using VAD, outcomes included symptom severity as assessed by Palliative Care Outcomes Collaboration (PCOC) scores, prognosis estimates, and documented concerns about delirium/cognition.

Results Of 450 people who died in the PCU during the study period, 57 had contact with the VAD service and 26 died through VAD. The proportion who received VAD referral did not change over time (11.0%, 12.6%, and 14.4% for 2023, 2024, and 2025; $p > 0.05$ for all), but VAD deaths were significantly higher in 2025 (2.8%, 5.7%, and 8.9% respectively; $p = 0.013$ for 2025 compared to 2023). There were no significant trends in palliative phase and measures of physical function. On the day of their death, most patients (60-70%) were in the stable phase, with a median Australian-modified Karnofsky Performance Scale score of 30 ('almost completely bed-fast'). Physical and psychological suffering for most patients and families was assessed as mild or absent, with no significant trends over time. Concerns were documented about cognition for 4

patients who died by VAD, with no statistically significant trend over time.

Conclusions The number of patients using VAD increased over time, in line with overall trends in VAD usage throughout Queensland over the same period. Symptom burden at the time of VAD administration was generally mild, suggesting factors beyond physical or psychological distress may drive VAD uptake. A minority of patients underwent VAD while their treating palliative care team documented concerns around their decision-making capacity, which may warrant further study.

OP78 HOME-BASED GOALS OF CARE: ENHANCING COMMUNICATION AND DECISION-MAKING IN THE COMMUNITY

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Background The Goals of Care processes and documentation are increasingly embedded within acute hospital settings and are gaining traction in residential aged care across Victoria. However, there remains a gap in structured, accessible medical treatment planning for patients receiving care in the community, including those supported by Community Palliative Care services and within the disability sector. To address this need, a Home-Based Goals of Care Medical Treatment Plan was developed to facilitate clear communication of patient preferences and clinically appropriate treatment decisions in non-hospital settings. This initiative recognises the complexity of delivering goal-concordant care in the home, where multiple providers may be involved.

Objective To describe the development, structure, and clinical utility of a Home-Based Goals of Care form, and to highlight its role in improving communication, supporting shared decision-making, and guiding treatment in community-based care.

Methods The Home-Based Goals of Care form was developed through extensive multidisciplinary consultation, including engagement with community clinicians and ambulance paramedics, to ensure usability across care settings. Recognising that the Goals of Care processes may be unfamiliar outside hospital environments, the form incorporates an explanatory cover page designed for patients, families, and general practitioner (or specialist) providers. The document clearly outlines key treatment decisions, including explicit instructions regarding cardiopulmonary resuscitation (CPR), hospital transfer, and limitations of care. In response to specific risks identified in the disability sector, the form includes guidance on the management of airway obstruction, ensuring that basic life-saving interventions such as choking relief are not inadvertently withheld. The form is intended to function as a practical, immediately actionable medical treatment plan that can be readily interpreted by all providers involved in a patient's care.

Outcome The Home-Based Goals of Care form addresses a critical gap for patients who are unable to complete an Advance Care Directive (ACD), whether due to time constraints, cognitive impairment, or the burden associated with advance care planning discussions. While ACDs are valuable in documenting patient preferences, they do not alone constitute a complete treatment plan, as they lack clinical context and medical assessment. The Goals of Care process integrates patient values,

goals, and preferences with medical assessment of prognosis, treatment options, and medical feasibility. This shared decision-making approach results in a clear, documented plan that can guide care.

The form has demonstrated utility in supporting outpatient and community-based clinicians to make consistent, goal-aligned decisions, particularly in urgent situations. It enhances communication across care interfaces, reduces ambiguity regarding escalation of care, and provides reassurance to patients, families, and providers. Importantly, it serves as a 'care now' plan in situations where formal advance care planning is incomplete or not feasible.

Conclusion The Home-Based Goals of Care Medical Treatment Plan represents a practical and scalable approach to improving patient-centred care in the community. Currently approved for use within Northern Health, it has significant potential for broader implementation across Community Palliative Care services and other community care settings, supporting timely, coordinated, and goal-concordant care for patients at home.

OP79 MAPPING HOME-BASED PALLIATIVE CARE NEED IN RURAL CENTRAL INDIA

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Introduction Health for all cannot be ensured without first ensuring palliative care for all. Access to palliative care is limited in India, especially among the most vulnerable. Those truly left behind are the bed-bound and those who are unable to visit a healthcare facility. For India to address the problem of access, we must understand first what the true need is in its predominantly rural population. There are limited surveys that have mapped the need through community-based surveys in both rural and urban settings, with palliative care need varying from 1.1 to 6.1 per 1000 population. No community-based surveys have been done for Central India. This includes the underdeveloped state of Chhattisgarh, with its extreme marginalisation and poverty, and especially for its predominantly tribal regions such as Surguja. Moreover, most surveys have identified the general need for palliative care, but not specifically home-based palliative care.

Chhattisgarh grapples with significant healthcare challenges. Sangwari, a not-for-profit organisation, has been providing Comprehensive Primary Health Care in Surguja district since 2021. Palliative care is one of its prime foci of work since the beginning.

Our primary objective was to determine the need for home-based palliative care and to understand the demographic, socio-economic, and clinical aspects as well as the impact of illness on the lives of the people.

Methods A door-to-door survey was done for a population of 17981 in 4420 households in 27 villages from December 2025 to January 2026. Palliative care screening was done by integrating a 2-item structured questionnaire into the elaborate demographic survey, namely: Is there a member in your family who has been bed-bound for 3 or more months or is dependent on others for self-care? For those who screened positive, a team of palliative care trained doctors confirmed this through home visits.

Results A total of 175 people screened positive of which 109 needed home-based palliative care. The need for home-based palliative care was 6.06 per 1000 population or 24.6 per 1000 household. Average age was 61.3 years, 52% women, 89% illiterate and 58% were farmers prior to their current condition. Neurological illnesses (39%) were the highest diagnosis category, stroke being the primary contributor. 75% of the people had an ECOG functional score of 3/4 and an average Barthel Index of 44.5.

Discussion The need for home-based palliative care in rural Surguja is exceptionally high given the nascent health system stretching to provide care for infectious and Non Communicable Diseases. Moreover, with the high level of dependency and neurological illnesses, there is a community-level need for physiotherapy and rehabilitation which is largely missing. High level of dependency also translates to significant caregiver burden. Most caregivers are women.

Conclusion This community-based survey helps estimate need for home-based palliative care in similar areas and is a first of its kind. India has a huge task on its hands, which can be addressed by strengthening palliative care as part of the Comprehensive Primary Health Care at the grassroots. The national program must also prepare itself to provide for the rehabilitation needs and enormous burden of care.

Poster Presentations (PP)

PP1 A DECADES-OLD WINNING FORMULA: CONTINUOUS SUBCUTANEOUS INFUSIONS (CSCI) AND DRUG COMBINATIONS IN PALLIATIVE CARE

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10.1136/spcare-2026-ANZSPM.78

Background/Objectives Continuous subcutaneous infusions (CSCI) underpin symptom control at end of life, yet contemporary evidence describing real-world practice is scarce. Despite major advances in therapeutics, it remains unclear whether CSCI prescribing has evolved over time. Historical UK and Irish surveys (1992, 2001) reported up to 29 drugs used in CSCIs, with most clinicians combining two to four medications per infusion (Johnson et al., 1992; O'Doherty et al., 2001).

To evaluate current CSCI prescribing practices in a New Zealand hospice, including drug selection, combinations, and the use of pre-filled CSCIs (PFCSCI), to inform a planned national survey.

Methods A retrospective review of clinical records for all patients referred to Mary Potter Hospice between 1 June 2024 and 31 May 2025 was undertaken. Data on CSCI use, PFCSCI, and medications prescribed were collected and analysed descriptively.

Results Of 619 patients referred, 431 (70%) died during the study period. CSCIs were used in 344 patients (56%), with 87 (25%) receiving PFCSCI exclusively in the community.

Eighteen drugs were used in CSCI combinations, predominantly administered over 24 hours. Most infusions contained two or three drugs; fewer included four, and only one included five.

Opioids were the most frequently used medications (morphine 50%, fentanyl 29%, oxycodone 16%, methadone 5%), with relatively low median doses (morphine 25 mg, oxycodone 30 mg, fentanyl 0.3 mg, methadone 20 mg). Sedative and antiemetic agents commonly used included midazolam (82%; median dose 15 mg), levomepromazine (37%; median dose 26 mg), haloperidol (30%; median dose 1.5 mg), and metoclopramide (9%; median dose 30 mg).

Dexamethasone was rarely included in CSCIs (2%), typically at low doses (0.5–1 mg) for site irritation. When used for symptom control, it was more commonly administered as a once-daily subcutaneous injection (14%), with a median dose of 4 mg.

Octreotide (1%; median dose 550 micrograms), famotidine (3%; median dose 40 mg), and levetiracetam (4%; median dose 2000 mg) were used infrequently; in these cases, a second CSCI was required.

Two syringe drivers were required in 23 patients (7%), and 39 (11%) received a concurrent fentanyl patch.

Discussions CSCI prescribing patterns remain strikingly unchanged from those reported over three decades ago, highlighting a remarkably durable model of care. While newer or substitute medications are used, overall drug diversity appears reduced.

Clinical Implications This study provides contemporary, real-world evidence that longstanding CSCI prescribing practices remain effective and widely applicable. However, reduced drug diversity and increasing use of PFCSCI underscore the need for national standardisation, updated compatibility guidance, and prospective evaluation to optimise safe, consistent, and evidence-based end-of-life care across Aotearoa New Zealand.

These findings also have relevance for clinical decision-making in the context of assisted dying assessments. Concerns are occasionally raised that initiation of CSCI may reduce patient alertness and potentially impact assessment eligibility. However, the relatively low median doses of sedative medications observed in this study suggest that, in routine practice, CSCIs are unlikely to significantly impair alertness when used appropriately.

PP2 EXAMINING ADVANCE CARE PLANNING PRACTICES: A DESCRIPTIVE STUDY OF ACP TRACKER UTILIZATION

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Background Advance care planning (ACP) is a well-established practice that improves alignment of care with patient preferences, reduces decisional burden on families, and may decrease non-beneficial interventions and healthcare related costs at the end-of-life. Despite decades of study and promotion of the benefits of ACP, uptake remains low particularly in hospital inpatients. In Queensland, the ACP Tracker, a platform embedded within the integrated electronic medical record (ieMR) provides a statewide platform for accessing ACP documents and recording ACP-related activity.

Aims This study aimed to describe the prevalence of formal ACP documentation and patterns of ACP Tracker utilisation across two hospitals. Secondary aims were to examine associa-

tions of ACP Tracker utilisation with patient age, specialty, and in-hospital mortality.

Methods A retrospective descriptive study was conducted of all adult inpatient admissions (>24 hours) at Nambour General Hospital and Sunshine Coast University Hospital, Queensland, Australia, between March 2023 and February 2024. Demographic and ACP-related data were extracted from Queensland Health electronic systems. Outcomes included ACP document prevalence, document type, ACP Tracker utilisation (frequency, timing, and user group), and associations with age and mortality. Descriptive statistics were used, with group comparisons performed using chi-square, Mann–Whitney U, and Kruskal–Wallis tests as appropriate. Statistical significance was defined as $p \leq 0.05$.

Results A total of 38,899 admissions (26,841 patients; mean age 62.9 years; 53.2% female) were analysed. Overall, 5.1% of admissions had at least one ACP document recorded. Prevalence increased with age, reaching 9.7% in patients ≥ 75 years and 14.6% in those ≥ 91 years ($p < 0.001$). Enduring Power of Attorney documents were most common (48.4%), followed by Advance Health Directives (27.5%) and Statements of Choices (23.2%).

The ACP Tracker was accessed in 36.3% of admissions (mean 0.97 launches per admission), with significantly greater use in older adults (<75 years: 0.68 vs ≥ 75 years: 1.47 launches per admission; $p < 0.001$). Most launches occurred within 72 hours of admission. Nurses accounted for the highest proportion of ACP Tracker use (36.5%). ACP Tracker comments were recorded in only 1.6% of admissions. Among patients who died during admission (1.7%), 69.4% had ACP Tracker activity, yet only 10% had an ACP document present.

Discussion and Implications Despite frequent interaction with the ACP Tracker, formal ACP document prevalence remains low, including patients who die during hospital admission. These findings highlight a gap between ACP recognition and formal ACP document completion, which could represent missed opportunities to align care with patient preferences. Strengths include the large, multi-specialty cohort and detailed analysis of system utilisation. Limitations include restriction to two hospitals and inability to assess the quality of ACP discussions.

Future efforts should focus on improving translation of ACP activity into formal documentation through workflow integration, targeted clinician education, and system-level supports within the iEMR.

PP3

INCREASED COLLABORATION BETWEEN A HOSPICE AND A MĀORI HEALTH AND SOCIAL SERVICE PROVIDER FOLLOWING JOINT DELIRIUM RESEARCH

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In 2020–2021 four researchers from two Aotearoa/New Zealand hospices (Te Omanga Hospice, Lower Hutt and Wai-puna Hospice, Tauranga) teamed with a Māori researcher (Tu Kotahi Māori Asthma and Research Trust, Kōkiri Marae, Lower Hutt) and two academics (Sydney and Auckland) to study the feasibility of researching non-pharmacological delirium prevention measures in hospice settings.

One of the key themes of this study was the importance of whakawhānau (building meaningful relationships) which was as important for the relationships between the researchers themselves as for whānau (patients and families). An unforeseen and beneficial outcome of this research has been the increased collaboration between one of the hospices (Te Omanga) and the Māori health and social service provider (Kōkiri Marae).

PP4

WARD-BASED PALLIATIVE HIGH-FLOW NASAL OXYGEN: SHOULD IT BECOME STANDARD PRACTICE?

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10.1136/spcare-2026-ANZSPM.81

Background High-flow nasal oxygen therapy (HFNO), also referred to as high-flow nasal prong therapy (HFNP), is increasingly used to manage refractory dyspnea in patients with advanced cancer and other life-limiting illnesses. Compared with conventional oxygen delivery systems, HFNO delivers heated, humidified oxygen at high flow rates, improving oxygenation while allowing patients to speak, eat, and interact more comfortably than with mask-based non-invasive ventilation.

A recent systematic review and meta-analysis by L. Hentsch evaluated HFNO in adults with cancer and persistent dyspnea. HFNO was associated with significant improvement in dyspnea compared with conventional oxygen delivery systems (standardized mean difference -0.60 , 95% CI -1.02 to -0.17). Benefit appeared greatest in hypoxemic patients, while evidence for non-hypoxemic patients was less convincing. However, the overall quality of evidence was low, with substantial heterogeneity and risk of bias.

Earlier phase II work by David Hui and colleagues in patients with advanced cancer demonstrated that HFNO improved dyspnea scores and oxygenation similar to, or better than, bilevel positive airway pressure (BiPAP), while often being better tolerated.

Observational studies from oncology and palliative care settings suggest HFNO is commonly used:

- in patients unsuitable for intubation,
- during transition from active treatment to comfort-focused care, and
- to facilitate symptom relief at the end of life.

Despite these proposed benefits, many palliative care physicians report limited confidence in prescribing HFNO, and many palliative care units lack the resources to provide this intervention. Until recently, HFNO delivery was generally restricted to intensive care settings; however, policy changes in a tertiary Sydney hospital now permit HFNO use on oncology and general ward environments.

Given the limited real-world data describing HFNO use in palliative oncology populations, we propose a retrospective observational study examining the use of palliative HFNO in patients admitted to the oncology ward.

Methods We will conduct a retrospective chart review of all patients who received palliative HFNO on the oncology ward between April 2025 and April 2026. Based on preliminary estimates, approximately 20 patients will be included.

Collected variables will include:

- patient demographics,
- cancer diagnosis,
- indication for HFNO,
- average flow rates and inspired oxygen percentages on commencing
- documented improvements in symptoms
- use of opioids simultaneously
- duration of HFNO therapy,
- death on HFNO
- documented adverse events or treatment limitations.

The primary aim of the study is to describe patterns of HFNO use in palliative oncology patients and explore its role in symptom management and end-of-life care on the oncology ward to better inform and encourage other departments to adopt this as a palliative care intervention.

PP5

PROVIDING OUTPATIENT PALLIATIVE CARE FOR PATIENTS WITH NON-MALIGNANT DIAGNOSES: A PILOT EVALUATION

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10.1136/spcare-2026-ANZSPM.82

Background Patients living with non-malignant diseases experience multiple symptoms and palliative care needs (Quinn et al., 2020). They comprise a significant proportion of people requiring palliative care but receive palliative care at lower rates than those with cancer. As the Australian population ages, with rising burden of chronic non-malignant diseases, there will be increasing demand for palliative care.

Objectives By comparing the symptom burden, functional status, and frailty of clinic patients with non-malignant versus malignant diagnoses, this preliminary data will inform and refine the non-malignant illness stream clinic model.

Methods A weekly palliative care clinic at Maroondah Hospital, Eastern Health, Melbourne, Australia, commenced in November 2025 to support patients with non-malignant diagnoses, staffed by a Palliative Medicine Physician and an Advanced Trainee. Quality Assurance approval (QA25-088-120897) was received to implement a clinic database to facilitate quality assessment and longitudinal outcome monitoring. Data are collected at every patient contact including baseline patient characteristics. Palliative care needs are monitored using a modified Edmonton Symptom Assessment System (ESAS), functional status with Australia-modified Karnofsky Performance Status (AKPS), and frailty by Clinical Frailty Scale (CFS). Data has been analysed using descriptive statistics.

Results Between 13/11/2025-20/04/2026, 44 patients attended clinic. Of these, 56.8% (25/44) have a primary non-malignant diagnosis, the majority being respiratory disease. The median age of the non-malignant group was 78 years (interquartile range (IQR) 67-86 years) vs 76 years (IQR 58.5-84.5 years) for the malignant group. Most appointments (67.3%) occurred in-person; telehealth (32.7%) was predominantly used for follow-up appointments.

AKPS at initial visit was similar between groups, with both having a median score of 60 (IQR 50-60 vs IQR 60-70 for non-malignant and malignant groups respectively). Median

CFS in the non-malignant group was 6 (IQR 5-6) vs 5 (IQR 4.5-6) in the malignant group.

Comparing initial ESAS, median total modified ESAS score was 46/110 (IQR 29-60.3) vs 39.5/110 (IQR 17.3-50.3) for non-malignant and malignant groups respectively. The commonest symptoms reported in the non-malignant group were reduced wellbeing (reported by 18/18 patients, median ESAS score 5/10 (IQR 4-8)), tiredness (17/18, median ESAS 6 (IQR 4-8.3)), and appetite problems (17/18, median ESAS 5 (IQR 2.8-6.3)). In the malignant cohort the commonest symptoms were tiredness (14/16, median ESAS 6/10 (IQR 2.8-8)) and appetite problems (14/16, median ESAS 4 (IQR 1-6.5)).

Discussion Our data highlight that people living with advanced non-malignant diseases have significant palliative care needs and frailty. The next phases of development will include the additions of a palliative care pharmacist and nurse navigator to provide integrated multidisciplinary care.

The considerable needs captured by routine monitoring provide impetus to develop innovative, sustainable models to support integration of timely palliative care for the non-malignant disease cohort.

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PP6

PILOT PROJECT: IMPLEMENTATION OF A STRUCTURED PATIENT/FAMILY EXPERIENCE FEEDBACK PROCESS TO DRIVE QUALITY IMPROVEMENT IN A SPECIALIST PALLIATIVE CARE UNIT.

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Background and Rationale The palliative care unit at Werribee Mercy Hospital is a dedicated specialist palliative care inpatient unit. Between July and December 2025, the unit recorded 177 discharges, including 36 patients discharged home. These patients had an average length of stay of 10.6 days, with a maximum stay of 30 days.

During admission, patients frequently underwent medication titration, changes in functional status, equipment provision and escalation of care needs. Many were discharged home with new medications, altered opioid regimens, oxygen therapy, mobility aids or community supports. To better understand patient and family experiences following discharge home, the unit implemented a structured patient/family feedback process to inform quality improvement activities.

Methods Over a two-month pilot period, patients discharged home received a structured follow-up telephone call from senior nursing staff within one week of discharge. A brief feedback tool explored symptom management, discharge processes, communication, inclusion in care discussions, and areas for improvement. Both qualitative and quantitative data were collected. Responses underwent descriptive and thematic review to identify recurring strengths and improvement opportunities.

Results Ten structured discharge feedback calls were completed. Overall experience ratings ranged from 8–10/10.

Common positive themes included effective symptom management, clear communication, and feeling included in care discussions. Several patients and families described improved comfort and confidence managing at home following medication adjustments, opioid titration, oxygen initiation, and equipment provision during admission.

The feedback process also identified several quality improvement opportunities. Recurring themes included improving discharge communication, clarifying follow-up pathways, and ensuring patients and families better understood medication changes and community supports after discharge. Environmental concerns including ward temperature and bed comfort were also identified.

A small number of patients deteriorated or died shortly following discharge, reflecting the clinical complexity and acuity of the patient cohort.

Discussion and implications

This pilot demonstrated the feasibility and clinical value of a structured post-discharge patient/family feedback process within a specialist palliative care unit. The initiative generated meaningful patient experience data while identifying actionable quality improvement opportunities relating to discharge communication, medication understanding, transitional care processes and environmental comfort.

The project has informed refinement of the feedback tool and development of further quality improvement activities, including strengthening discharge communication processes and post-discharge support pathways. Structured patient and family feedback may provide an important mechanism to support person-centred quality improvement in inpatient palliative care services.

PP7

EXPERIENCES OF ASSISTED TELEHEALTH FOR MEDICAL REVIEW IN COMMUNITY PALLIATIVE CARE: A RETROSPECTIVE COHORT REVIEW

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10.1136/spcare-2026-ANZSPM.84

Background and Rationale Telehealth is increasingly used in palliative care and has recognised benefits in improving access, reducing travel burden, and supporting care at home. However, limitations are also well described, including digital divide, variable video quality, and challenges performing functional and observational assessments remotely. Clinicians frequently report lower confidence managing complex or deteriorating patients through standard telehealth due to reduced physical examination and non-verbal assessment cues.

Assisted telehealth (ATH), where a nurse is physically present with the patient to facilitate assessment, communication and technology use, may mitigate these limitations while retaining the accessibility and efficiency benefits of telehealth. This retrospective pilot study examined the use, characteristics and outcomes of ATH medical review compared with face-to-face

(FTF) review in a metropolitan community palliative care service.

Methods A retrospective cohort review was conducted using routinely collected clinical data from Mercy Palliative Care, a community palliative care service in metropolitan Melbourne, Australia. Patients receiving either ATH or FTF medical review during January–February 2026 were included.

Collected variables included patient demographics, diagnosis category, functional status (AKPS), palliative care phase, total Problem Severity Score (PSS), worst symptom severity score, and hospital utilisation. Post-review outcomes included change in symptom severity within seven days, admission within seven days, place of death, and achievement of preferred place of death. Phase-adjusted comparisons were performed between ATH and FTF cohorts.

Results Twenty-seven ATH reviews (24 patients) and 28 FTF reviews (27 patients) were analysed. Cohorts demonstrated comparable acuity, with approximately 67% of patients in the deteriorating phase and high mortality (~75–80%).

Both ATH and FTF medical reviews were associated with improvement in symptom burden within 7 days. Mean reduction in total Problem Severity Score was greater in the ATH cohort compared with the FTF cohort (−1.9 vs −1.1). Mean reduction in worst symptom score was also greater following ATH review (−2.7 vs −1.8).

Phase-adjusted analysis demonstrated comparable or greater improvement in worst symptom scores with ATH across all phases, including stable (−2.0 vs −1.6), deteriorating (−2.7 vs −1.8), and terminal phases (−3.0 vs −2.7).

ATH reviews required substantially less clinician time compared with FTF review (mean 28 minutes vs 112 minutes including travel). Home death occurred more frequently following ATH review (54% vs 41%), while achievement of preferred place of death remained high in both groups (79–85%).

Discussion and Implications This pilot study suggests that assisted telehealth can provide symptom outcomes comparable to face-to-face medical review in community palliative care, including among deteriorating patients. The presence of an on-site nurse may address known limitations of standard telehealth by supporting physical assessment, functional review, environmental assessment and communication. ATH also demonstrated substantial efficiency advantages through reduced clinician travel time while supporting home-based end-of-life care.

Further work is required to better define the patient groups most suited to ATH. This pilot study provides an initial result that ATH is effective even in patients with advanced illness and informs future studies examining the broader clinical trajectories of these cohorts. Future work should explore factors influencing ATH suitability and outcomes, including subsequent medical and nursing encounters, medication changes, escalation of care, and longitudinal healthcare utilisation following review. Better understanding these downstream interactions may help identify which patient characteristics and service factors contribute to successful ATH outcomes and clarify the role of ATH within community palliative care management.

PP8 ABSTRACT WITHDRAWN

PP9 GOING HOME ON TIME (GHOT): A QUALITY IMPROVEMENT PROJECT AIMED AT STREAMLINING WORKLOAD IN A SPECIALIST PALLIATIVE CARE CONSULT TEAM

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10.1136/spcare-2026-ANZSPM.85

Background Burnout is an occupational phenomenon conceptualised by chronic workplace stress, affecting mental and physical health as well as professional efficacy.¹ This is particularly relevant for specialist palliative care clinicians who are frequently exposed to suffering and complex end-of-life issues. Other known risk factors include high workload, poor work-life balance, work inefficiency and inadequate staffing.² Within the Specialist Palliative Care Service (SPCS) Inpatient Consult Team at Launceston General Hospital, Tasmania, increasing clinical demand and administrative workload has resulted in frequent overtime to maintain safe patient care and comprehensive handover. Recognising and addressing known risk factors early may prevent or mitigate the risk of burnout.²

Objectives The Going Home On Time (GHOT) quality improvement project aimed to evaluate workflows and implement strategies to enable the SPCS Inpatient Consult Team to leave work on time. The aim was for all team members to finish by 17:00pm at least 80% of the time.

Methods Baseline GHOT rates and workflow data including daily ward round duration, documentation time, staffing levels, patient load, and referral numbers were collected. Using an A3 problem solving framework,³ workflow mapping and detailed root-cause analysis with a fishbone diagram identified key drivers: documentation processes, ward round efficiency, and process standardisation. A series of interventions were introduced, followed by re-audit cycles to evaluate their impact.

Results Baseline GHOT rate was 26%. Initial interventions focused on streamlining documentation responsibilities and reducing duplication, resulting in a temporary improvement with GHOT rate $\geq 80\%$ for three weeks before declining, coinciding with rotational registrar turnover. A second intervention phase targeted further documentation simplification and workload distribution strategies, including a 'divide and conquer' ward round approach. While some measures improved efficiency, others were impractical due to unmodifiable operational constraints, staff factors such as staff turnover or absence, or hospital-wide infrastructure including delayed implementation of an electronic medical record (EMR). Overall, GHOT rates improved compared to baseline but remained below the 80% target. Subsequent analysis revealed increasing patient loads and referral rates despite static staffing resources and infrastructure.

Discussion Despite successful optimisation of modifiable factors such as streamlining documentation processes and clinical time management, the GHOT project did not achieve the target rate. Structural limitations, particularly workforce capacity and absence of EMR, combined with increasing clinical demand,

were the predominant barriers to achieving sustained improvement. This project demonstrated that workflow optimisation alone is insufficient in the context of increasing service demand that exceeds available resources. Ongoing data collection will inform a potential business case for increased staffing to support safe, sustainable service delivery and improve staff well-being.

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PP10 DIFFERENCES IN O₂ RELATED OBSERVATIONS IN PATIENTS WHO RECEIVED PLEURODESIS AND PATIENTS WHO RECEIVED A PLEURAL DRAIN, FOR THE MANAGEMENT OF MALIGNANT PLEURAL EFFUSION

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10.1136/spcare-2026-ANZSPM.86

Background Pleural drain insertion and endoscopic pleurodesis are common procedures for the management of Malignant Pleural Effusion (MPE).

Aim To compare oxygen (O₂) saturations and supplementation requirements between pleural drain insertion and endoscopic pleurodesis.

Method A retrospective review was conducted of patients with malignant disease who underwent either procedure at St Vincent's Hospital Sydney between 2019 and 2022.

Results 74 procedures were analysed. 60 pleural drain insertions (Drain Group, 81.1%), and 14 endoscopic pleurodesis surgeries (Pleurodesis Group, 18.9%), were performed across 57 patients (61.4% male; median age 72 years). The groups were demographically comparable. Baseline minimum O₂ saturations on room-air were lower in the Drain Group (median 92.5% versus 95.0%; $p=0.031$). The Pleurodesis Group showed higher maximal supplementation needs (median 7 versus 2L/min, $p<0.001$) and maximal supplemented O₂ saturations (median 100% versus 98.5%, $p<0.001$), primarily within 24-hours post-procedure. However, more than 24-hours post-procedure, both groups achieved comparable median room-air O₂ saturations of $\geq 93\%$ and median minimal supplementation requirements of 0L/min. A higher proportion in the Pleurodesis Group experienced severe pain within 24-hours post-procedure (57.1% versus 10.0%, $p<0.001$).

Conclusion Pleurodesis was associated with greater short-term O₂ requirements and more severe pain. However, both procedures achieved comparable oxygenation outcomes at later assessment.

**PP11 COMFORT OVER CURE: LESSONS FROM A CASE OF
END-STAGE KIDNEY FAILURE IN SYSTEMIC SCLEROSIS**

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Palliative care involvement in chronic, life-limiting illness can be particularly complex when patients remain on life-sustaining treatments such as haemodialysis. Systemic sclerosis (SSc) is associated with high symptom burden, multi-organ complications, and an unpredictable disease trajectory, making timely palliative care integration essential. This case illustrates the role of palliative care in end-stage kidney failure (ESKF) secondary to SSc, with a focus on refractory symptom management and supported decision-making around dialysis withdrawal following an acute deterioration.

CG was a 74-year-old woman with ESKF due to systemic sclerosis, receiving in-centre haemodialysis for six months. Her comorbidities included recurrent scleroderma renal crisis, severe gastrointestinal dysmotility and severe peripheral vascular disease. She lived independently with her pets and relied primarily on two close friends, who acted as enduring powers of attorney. Prior to palliative care involvement, she had not completed formal advance care planning.

She was referred to palliative care in August 2025 due to significant and escalating symptom burden, including severe lower limb pain, nausea, diarrhoea, fatigue, and intractable pruritus. Pain management proved challenging due to mixed nociceptive, neuropathic, and ischaemic mechanisms, compounded by renal failure and gastrointestinal malabsorption. Neuropathic pain was treated with pregabalin. Escalating oxycodone requirements with limited benefit prompted opioid rotation to transdermal fentanyl to bypass unreliable oral absorption; however, analgesia remained inadequate. Systemic sclerosis-related skin thickening and impaired transdermal uptake were considered possible contributors. Methadone was introduced as an adjunct and became the most effective analgesic, offering advantages relevant to palliative prescribing in ESKF, including minimal renally cleared active metabolites, limited dialyzability, and efficacy in complex pain states through μ -opioid agonism and NMDA antagonism. Intractable pruritus was managed with mirtazapine, improving sleep, while nausea responded to haloperidol. Fatigue was addressed as multifactorial, with supportive counselling and energy conservation strategies.

Palliative care also addressed treatment burden and goals-of-care alignment. Early in the therapeutic relationship, a resuscitation plan was completed, and dialysis frequency was reduced to better balance benefit with quality of life. Two months later, CG was admitted with a necrotic hallux wound and sepsis, with concern for calcific arteriopathy. Major amputation was recommended for infection control; however, she was high risk with likely loss of independence. Palliative care facilitated multidisciplinary meetings across nephrology, vascular surgery, and other teams, ensuring consistent communication and supporting CG to make values-based decisions. Ultimately, she chose comfort-focused care and withdrew from dialysis. During her terminal admission, methadone and pregabalin were further titrated and later transitioned to continuous subcutaneous hydromorphone infusion for end-of-life comfort. She was transferred to a specialist palliative care unit and died peacefully five days later, surrounded by her friends and her pets.

This case highlights the importance of early palliative care integration in SSc and ESKF, not only at end of life but through-

out the trajectory of progressive symptom burden. It demonstrates the role of palliative care in complex analgesia (including the utility of methadone in renal failure), management of distressing non-pain symptoms, reduction of dialysis treatment burden, and coordinated communication to ensure that life-prolonging therapies remain proportionate and goal-concordant.

**PP12 RAPID ANALGESIA WITHOUT OPIOIDS: INHALED
METHOXYFLURANE FOR ACUTE PAIN IN PALLIATIVE
CARE — A PROSPECTIVE AUDIT**

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Background Acute procedural and volitional incident pain is common in palliative care and often requires rapid-onset analgesia. Conventional options such as opioids require titration and may be delayed in onset or poorly tolerated. Methoxyflurane is a volatile inhalational anaesthetic licenced for the relief of pain for surgical procedures and trauma-associated pain, in a conscious and cooperative patient.^{1,2} In 2023, the Tasmanian Health Service approved its use for rapid, short-term self-controlled analgesia for acute procedural or incident pain during inpatient palliative care.³

Aim To evaluate effectiveness, safety, and patient acceptability of inhaled methoxyflurane in palliative care.

Methods From 2024 to 2026, a prospective audit evaluated inhaled methoxyflurane for moderate-to-severe acute procedural or volitional incident pain. Patients were recruited via palliative care referrals or within an inpatient palliative unit. Eligible participants had poor response to prior analgesia or experienced pain precluding essential procedures like radiotherapy. Under supervision, patients self-administered methoxyflurane (3 mL) intermittently via a handheld inhaler. Nursing staff and patients were educated on correct inhaler technique to optimise drug delivery. Collected data included demographics, diagnosis, procedure type, and pain characteristics (mechanism, type, location). The primary outcome was the global medication performance assessment based on patients' rating of effectiveness. Baseline pain score, treatment-related pain, percentage pain reduction, adverse effects, and willingness to reuse the device were recorded. Patient effectiveness and satisfaction were evaluated on Likert scale (1 = lowest, 5 = highest).

Results An audit of 20 episodes across 14 patients (mean age 75; five female) evaluated methoxyflurane use. Pain types were procedural (70%), volitional incident (15%), and mixed (15%). The most common indication was pain during transfer and positioning for radiotherapy. In 18 episodes, patients received their usual breakthrough analgesia plus inhaled methoxyflurane. In 95% of episodes, patients rated methoxyflurane as moderately to highly effective, and those patients would use it again. There was a clinically meaningful reduction in pain ($\geq 30\%$) in 95% of episodes. Onset was rapid. Side effects were of minor severity and were unpleasant odour (n=1), unpleasant taste (n=1), dizziness (n=1), cough (n=1), and sedation (n=1).

Discussion Methoxyflurane was an effective and well-tolerated option for short-term acute pain in selected palliative care

patients. Its rapid onset and ease of administration make it particularly useful for procedural and volitional incident pain. It may also ensure procedural analgesia while optimum opioid dose is being established. It requires staff education to ensure correct use.

Limitations

- Small sample size
- Single-centre audit
- Short-term outcome assessment only

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PP13

ENABLING HOME WITH GRACE AND DIGNITY: EARLY SUCCESS OF A RELIABLE HARMONISED COMPASSIONATE DISCHARGE MODEL

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Background and Aim Many patients approaching end-of-life prefer to spend their final days at home, but compassionate discharge from acute hospitals is often challenged by fragmented workflows, caregiver anxiety, equipment delays, and uncertainty regarding financial coverage and after-death arrangements. The NUH Harmonised Compassionate Discharge (ComD) Pilot was developed as a coordinated end-to-end pathway to enable safe, timely and dignified discharge home for patients nearing end of life. A key pillar of the pilot was the partnership between NUH, insurers, home hospice providers and community partners to remove logistical and financial barriers for families.

Problem Identified Using Ishikawa Diagram Prior to the pilot, discharge planning for end-of-life patients relied on multiple independent referrals, resulting in delays and inconsistent service responsiveness, particularly during weekends. Families also faced uncertainty regarding affordability and timeliness of home hospice support, equipment rental, care aides and certification of cause of death (CCOD) service at home, contributing to prolonged hospitalisation despite limited acute care needs.

Key Actions Introduced Using PDSA Cycle The pilot introduced a harmonised operational model involving NUH, insurers, home hospice, equipment vendors, care aide providers and mobile CCOD partners. Insurers support reduced out-of-pocket concerns and improved confidence among families and clinicians to proceed with discharge planning.

Importantly, the workflow was developed in close consultation with trained palliative care doctors, nurses and community palliative care partners to ensure that the model was clinically practical and applicable in real-world settings. Their guidance strengthened discharge readiness criteria, medication planning, equipment requirements and caregiver support arrangements.

A no-rejection agreement with home hospice ensured all referred cases were accepted, including weekends. Same-day home visits or teleconsultations were arranged where possible. Flexible equipment arrangements, skilled care aides and fixed-

rate CCOD services with defined service level agreements further strengthened operational reliability.

A ComD Care Bag and Caregiver Guide were intentionally designed to provide both practical and emotional support, equipping families with essential caregiving items, guidance and reassurance during the transition home.

Early Results and Observations Between November 2025 and March 2026, 14 patients benefitted from the ComD pathway. The pilot achieved 63 inpatient bed days saved, with vacated beds reassigned within an average of 3.7 hours. Families reported improved confidence and reduced caregiver stress due to structured home support and financial assurance arrangements. Estimated net system savings after accounting for home-based care costs was S\$83,736.

Beyond operational outcomes, the programme enabled patients to spend their final days in the familiarity of home, surrounded by loved ones with greater comfort, grace and dignity. Families shared that the coordinated support and financial assistance allowed them to focus more on meaningful time together during the last mile.

Lessons Learned & System Impact The pilot demonstrated that ComD requires not only clinical readiness, but also strong operational coordination, financial assurance and reliable community partnerships. Integrated payer-provider-community collaboration can improve patient experience, optimise acute bed utilisation and support more sustainable end-of-life care delivery aligned with patient preferences.

PP14

THE ROLE OF SMOKING CEREMONIES IN END-OF-LIFE CARE FOR ABORIGINAL PATIENTS AND COMMUNITIES IN PROVIDING CULTURALLY SAFE, PATIENT-CENTRED CARE IN WESTERN SYDNEY

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Background The practice of smoking ceremonies at end of life for Aboriginal people is steeped in cultural traditions. These practices can include smoking a person pre-death, as well as post-death, as a form of cleansing and to send off the spirit(s) to the Dreamtime. While there is anecdotal evidence that smoking ceremonies occur in hospitals in Western Sydney, the impact on Aboriginal communities has not been formally evaluated. This research aimed to investigate the cultural significance and impact of smoking ceremonies for providing culturally safe end-of-life care in a hospital setting. In doing so, the findings may inform the implementation of policy with appropriate cultural governance.

Methods This study employed a parallel mixed-methods design. Ten interviews were conducted with Aboriginal community members and staff with lived experience of end-of-life smoking ceremonies in Western Sydney hospitals. Interview questions explored what smoking ceremonies are, how they are used at end of life, and whether participants believed this practice to be appropriate. Interview transcripts were analysed using thematic analysis.

Quantitative data extracted from de-identified Electronic Medical Records were used to describe Aboriginal patients who received end-of-life care in Western Sydney between 1 January 2020 and 31 December 2024. Variables included: Aboriginal

and Torres Strait Islander status; age; hospital facility; sex; presenting clinical problem; specialty of discharge; diagnosis-related group; primary diagnosis; care type; and length of stay. Quantitative data were analysed using descriptive statistics.

Results Thematic analysis identified eight key themes: cultural and spiritual significance of smoking ceremonies at end of life; cultural practice as patient-centred care; healing and emotional wellbeing; process and communication; barriers and challenges; connection and community; impact on staff; and continuity of cultural practices. Participants consistently described smoking ceremonies as integral to culturally safe end-of-life care, supporting spiritual wellbeing, family and community connection, and appropriate grieving processes. There was unanimous agreement that smoking ceremonies represent best practice in patient-centred care for Aboriginal people and should be embedded as a routine component of end-of-life care within hospital settings.

Between 2020 and 2024, deaths of Aboriginal patients occurred across three hospitals in Western Sydney. Of these patients, 97 (51%) received acute care and 95 (49%) received palliative care at end of life. The cohort comprised n=99 (52%) males and n=93 (48%) females. These findings demonstrate that a substantial proportion of Aboriginal patients die within acute hospital environments, highlighting the importance of culturally safe end-of-life practices that can be delivered across care types.

Conclusions Smoking ceremonies are a cultural practice of profound spiritual significance at end of life and serve as a vital grieving tool for Aboriginal people. Western Sydney hospitals have facilitated this practice through consultation and guidance from Aboriginal community members and staff to ensure cultural needs are met. Enabling cultural practices such as smoking ceremonies within hospital settings creates culturally safe spaces for Aboriginal patients and their families to grieve appropriately.

PP15 A DOSE OF GRIEF: DEATH EDUCATION FOR MEDICAL STUDENTS

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Introduction/Background Australia's ageing population has led to increased death and dying. Many medical students and trainees report feeling underprepared and unsupported whilst caring for ageing and dying patients, likely due to persistent gaps in death education within Australian medical curricula. This lack of preparation contributes to poorer experiences for patients and their families at the end-of-life, as well as negative mental health impacts for trainees. A Dose of Grief aims to increase death literacy, and compassionate care within the medical workforce, thereby enhancing the quality of end-of-life experiences for all Australians.

Methods The project will commence with an online, national, cross-sectional survey of Australian medical students designed to assess experiences and perceived preparedness regarding death education in medical training. Survey items consist of Likert style scales, multiple choice and rank order, with the inclusion of two validated tools (Death Literacy Index and Death Anxiety Beliefs and Behaviours Scale). Findings will be analysed quantitatively to identify key gaps and educational priorities. These

findings will inform the design of a pilot education program to be delivered across select Australian medical schools.

Results/Evaluation Survey data encompasses themes including personal background information, formal educational experiences, and the perceived quality thereof, and self-reported preparedness for death and dying encounters. This information will be used to evaluate Australian medical student's knowledge of end-of-life care, to design a purpose-built program by medical students for medical students as they transition into the role of junior doctors.

Discussion It is anticipated the evidence will reaffirm a lack of comprehensive education around death, dying and end-of-life care. Furthermore, we suspect to find correlations between self-reported death anxiety and unpreparedness. With this research we aim to work towards embedding death education within Australian medical training and contribute to a wider cultural change of open discussion regarding ageing, death and grief.

PP16 METHOXYFLURANE INHALER FOR SINGLE EPISODE CANCER-RELATED INCIDENT PAIN IN PALLIATIVE CARE PATIENTS: THE FLARE FEASIBILITY STUDY PROTOCOL

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Background Incident cancer pain (IcP) is a predictable, often severe, transient exacerbation of pain that occurs despite relatively stable and adequately controlled background pain. It may be triggered by voluntary or involuntary movements, care activities, or procedures. In palliative care, examples include malignant wound dressing changes, personal hygiene and positioning for radiotherapy. Incident cancer pain is frequently distressing for patients and difficult to manage. Current pharmacological strategies for managing IcP commonly rely on breakthrough opioids, which may have an onset and duration that do not align well with the onset or the short, intense pattern of IcP. Methoxyflurane, a non-opioid analgesic delivered through a patient-controlled inhaler, has rapid onset and short duration of action, making it potentially well-suited for managing the transient nature of IcP. While evidence in palliative care remains limited, previous studies have explored its application in painful burn dressings, including in the paediatric population, as well as an analgesic agent for bone marrow biopsy in Australia.¹⁻³

Objectives The FLARE study aims to assess the feasibility of conducting a clinical trial of methoxyflurane for single episode IcP in palliative care settings, with a particular focus on regional and rural populations.

Methods FLARE is a multi-site, single-arm feasibility study aiming to enrol 10 adults with advanced cancer known to a palliative care service scheduled to undergo a procedure or event considered likely to induce IcP. Participants will self-administer methoxyflurane via inhaler, under the supervision of a trained healthcare professional, immediately prior to, and during the painful incident. Methoxyflurane dosing will be limited to a maximum of two 3 mL ampoules per episode, with rescue analgesia available if required. Feasibility will be demonstrated

by recruitment of 10 participants across three sites within 12 months and completion of pre-specified study outcome measures and adverse event reporting for at least 80% of participants. Secondary outcomes include assessing the efficacy, tolerability, and safety of methoxyflurane as an analgesic for a single IcP episode. This includes measuring the worst pain during the episode with a 0–10 Numerical Rating Scale, completion of the procedure without the need for additional breakthrough analgesia, assessing sedation levels using the Pasero Opioid-Induced Sedation Scale, and evaluating adverse events according to NCI-CTCAE criteria.

Planned analysis The primary objective is to assess recruitment feasibility as set out above. Recruitment, completion of outcome measures, use of rescue analgesia, pain scores, acceptability ratings, sedation scores, and adverse events will be summarised and reported using descriptive analysis.

Implications By evaluating recruitment feasibility, intervention acceptability, outcome completion and safety monitoring, this study will inform the potential development of a Phase III Randomised Controlled Trial of methoxyflurane for IcP in palliative care. This will also have implications for enhancing IcP management including in regional and rural settings.

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PP17

DIAGNOSIS-ASSOCIATED DIFFERENCES IN CONTINUOUS SUBCUTANEOUS INFUSION USE AND END-OF-LIFE DECISION MAKING: MALIGNANT VERSUS NON-MALIGNANT DISEASE

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Background Continuous subcutaneous infusion (CSCI) is inextricably linked to supporting symptoms at the end of life. As populations age globally and more people live with advanced non-malignant illness, understanding diagnosis-specific end-of-life care patterns is increasingly important. However, differences in contextual factors related to CSCI initiation, symptom indications, and decision-making between patients with malignant and non-malignant disease remain poorly understood.

Objective The primary aim of this study was to compare the clinical and decision-making contexts of CSCI initiation between patients with malignant and non-malignant disease. Secondary aims included comparing medication use, initiation setting and the prevalence of acute infection between groups.

Methods This retrospective single-centre study included consecutive adults who died from 28 March to 31 July 2025 while admitted under the specialist palliative care service at Ipswich Hospital, Queensland, Australia, a facility serving a relatively socioeconomically disadvantaged catchment. Group differences

were compared and age-adjusted logistic regression was performed.

Results Among 122 patients, 63 (51.6%) had malignant disease and 59 (48.4%) had non-malignant disease. Patients with non-malignant disease were older (mean 70.9 vs 80.8 years, $p < 0.001$). Mean Socio-Economic Indexes for Areas (SEIFA) decile by home postcode was 3.03 (± 2.27), with no significant difference between groups. CSCI use was comparably frequent in patients with malignant and non-malignant disease (96.8% vs 94.9%, $p = 0.595$) and time from CSCI commencement to death was similar (median 2 days [IQR 1–8] vs 2 days [IQR 0.5–3], $p = 0.097$).

Primary indication for CSCI differed by diagnosis ($p = 0.001$): pain predominated in malignant disease (67.9% vs 37.5%), while dyspnoea (8.9% vs 25.0%) and agitation (8.9% vs 30.4%) were more common in non-malignant disease. CSCI initiation location differed by diagnosis ($p = 0.005$), with CSCI more often commenced in the palliative care unit in malignant disease (52.5% vs 26.8%). Acute infection was more frequent in non-malignant disease (17.5% vs 49.2%, $p < 0.001$).

Medication patterns also diverged in the initial CSCI, with higher benzodiazepine (64.4% vs 91.1%, $p = 0.001$) and anticholinergic use (11.9% vs 32.1%, $p = 0.008$) in non-malignant disease.

Documented family-only decision-making, defined as no recorded patient involvement in the decision to commence CSCI, occurred in 41.7% of patients with malignant disease and 77.6% of those with non-malignant disease ($p < 0.001$). Non-malignant disease remained associated with family-only decision-making after adjustment for age (OR 4.02, 95% CI 1.71–9.47, $p = 0.001$).

Discussion CSCI use was nearly ubiquitous in both groups, but the clinical and decision-making contexts markedly differed. In non-malignant disease, CSCI was more often commenced outside the palliative care unit, in the setting of acute infection, dyspnoea or agitation and with family-only decision-making documented. These findings suggest distinct diagnosis-associated patterns of CSCI initiation at the end of life. More broadly, they may support the case for context-responsive, stratified end-of-life care pathways in an ageing population, including those in relatively socioeconomically disadvantaged settings. Access to specialist palliative care consultation, coupled with reliable access to CSCI and essential medication wherever deterioration occurs, may be warranted. Future research should delineate how illness trajectory and decision-making capacity influence opportunities for anticipatory discussion and meaningful patient participation in non-malignant disease.

PP18

ADVANCE CARE PLANNING IN END-STAGE LIVER DISEASE: A MIXED-METHODS SYSTEMATIC REVIEW

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10.1136/spcare-2026-ANZSPM.94

Background Patients with end-stage liver disease (ESLD) have a high symptom burden, poor quality of life, and are at risk of decompensation events that lead to the loss of decision-making capacity. Unlike other organ failures (kidney, heart) there is no bridging therapy to transplantation, therefore many patients are usually close to death when this is considered appropriate, if at all. Despite this, patients seldom participate in Advance Care

Planning (ACP) to discuss and document their wishes for future care. Little is known about the potential benefits of ACP in this population.

Aims A mixed methods systematic review of qualitative and quantitative literature was carried out to examine current evidence for ACP in ESLD patients with regards to the impact on these patients' outcomes as aligned with the goals of ACP.

Methods Mixed methods systematic review (MMSR) following the Joanna Briggs Institute methodology, synthesising available qualitative and quantitative data.

Results Four relevant studies which investigated the use of ACP in ESLD were identified from 3671 that underwent initial screening. Quantitative data supported the acceptability of ACP in this population, as well as improved rates of Advance Directive (AD) documentation, and improvements in disease-specific knowledge. Goals of care were more likely to shift towards less aggressive interventions following ACP. End-of-life care (EOLC) was influenced through complex impacts on hospital and ICU length of stay, and overall low rates of death in acute hospital. Qualitative data supported the acceptability of ACP in this population, and benefits on caregiver perception of end-of-life care, as measured with the Quality of Dying and Death (QODD) questionnaire.

Conclusion ACP can assist patients living with ESLD and families to discuss and document informed choices about their EOLC, and thereby potentially receive goal-concordant care in a suitable location, with experiences of death that are less distressing for families.

PP19

THE IMPACT OF EMBEDDING PHARMACY EXPERTISE IN A REGIONAL SPECIALIST PALLIATIVE CARE SERVICE - BRIDGING GAPS IN MEDICATION MANAGEMENT FOR PATIENTS AND HEALTHCARE PROFESSIONALS

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In collaboration with the Pharmaceutical Society of Australia and supported by an Australian Government National Palliative Projects grant six sites across Australia trialled and reported on the impact of having a pharmacist embedded in a specialist palliative care service. The funding supported 0.2FTE (1 day per week) for a period of 12 months. WNSWLHD trialled a virtual model of care to optimise the geographical reach and equity of access. Structured digital interaction logs captured outcomes including encounter characteristics, clinical foci, activities performed, and perceived clinical benefit. Interactions were recorded on 80 occasions with healthcare professionals predominantly from a remote workplace but also on occasions face to face. These interactions supported Palliative Care Specialist Physicians (34%), General Practitioners (9%), Nursing (44%) and Community Pharmacists. The pharmacist undertook a broad range of activities predominantly strategies to optimise quality use of medicines, responding to medication related incidents and reviewing progress towards goals of care and identified medication barriers. Direct interactions with patients and/or carers were recorded on 26 occasions and included patients living with family or unpaid carers and in residential aged care facilities or living alone. Functional status indicated high care needs with approximately 54 % of interactions involving patients with an AKPS score <50 with

symptom distress a dominant feature of pharmacist involvement. Increased patient/ carer knowledge and confidence in palliative medicines was recorded in 88% of interactions with recommendations to initiate, cease or modify medicines occurring in nearly half of all interactions. At conclusion of the pilot anecdotal feedback was sought from healthcare professionals within the specialist palliative care team on their perceived benefit having had dedicated pharmacy expertise available in the team which reinforced the recorded outcome measures and the impact of this support on healthcare professionals wellbeing.

PP20

AN AUDIT OF SODIUM VALPROATE CONTINUOUS SUBCUTANEOUS INFUSION USE IN THE INPATIENT HOSPICE SETTING

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10.1136/spcare-2026-ANZSPM.96

Background Subcutaneous administration of medication is common in palliative care, especially when oral administration is impractical or ineffective. Most medications are not licensed for subcutaneous administration and are thus prescribed off-label. As off-label applications often lack evidence, informed consent and its documentation is essential. Sodium valproate is licensed for management of seizures and mania but is also used off-label for mood stabilisation, neuropathic pain and agitated delirium. There is some evidence for efficacy and tolerability of subcutaneously administered sodium valproate. The safety of prescription, tolerability, and quality of documentation within an inpatient Palliative Care Unit (PCU) will be assessed as part of a Quality Improvement (QI) project.

Methods We undertook a retrospective chart review of all patients treated with a sodium valproate continuous subcutaneous infusion (CSCI) at a PCU in the Australia Capital Territory (ACT) from 01/03/2023 to 30/08/2024. Patients were identified by generating an automated report via the ACT Health electronic medical record (EMR) for all prescriptions of 'sodium valproate' via CSCI. The PCU admission documentation was then searched manually and assessed for the safety, tolerability and quality of documentation for sodium valproate CSCI prescribing.

Results In 18 months, 16 patients were treated with sodium valproate CSCI in the PCU. Fifteen patients were on pre-existing oral sodium valproate prior to CSCI initiation with the remaining patient having a sodium valproate CSCI initiated for complex neuropathic pain. The majority of CSCI had sodium chloride as the diluent. Initial doses ranged from 600mg/24hr to 3000mg/24hr. Oral to subcutaneous conversion ratios were generally 1:1. CSCI duration ranged from 0.5 to 45 days with the median duration being four days. One patient suffered a cutaneous adverse drug reaction (ADR) 31 days after commencing CSCI, requiring insertion re-site but no further treatment. Documentation of consent was poor, with five patients having adequate consent documented for sodium valproate

CSCI, three patients having incomplete consent documentation, one patient whose capacity to consent was in doubt due to the presence of ongoing psychiatric symptoms, and 6 patients with no documentation regarding consent. None of the doc-

umentation mentioned the off-label nature of prescription or discussion of potential ADRs of sodium valproate CSCI.

Conclusion The audit found that sodium valproate CSCI prescribing in the PCU was safe, well tolerated, and largely consistent with evidence. It further identified discussion of ADRs and documentation of consent as areas for improvement. This will be the focus of the QI activity. An education program will be devised, and consenting requirements will be included in a policy being generated, informed by the results of this audit.

PP21

NO REST FOR THE WEARY: CASE STUDIES OF COMPLEXITIES WITH RESTLESS LEGS SYNDROME MANAGEMENT IN AN OUTPATIENT SUPPORTIVE AND PALLIATIVE CARE SETTING

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Background Restless Legs Syndrome (RLS) is a frequently overlooked yet burdensome condition in palliative care. Patients receiving supportive and palliative care may be at increased risk due to multiple factors, including advanced age, renal impairment, iron deficiency, neurological conditions and use of potentially exacerbating symptom medications.^{1,2} RLS may coexist with other chronic or life-limiting conditions, contributing to complexities in overall management and significantly impairing quality of life.¹

Methods Two case studies describe patients with RLS contributing to overall symptom burden; complicating comorbidity management and symptom medication choice. Careful balancing of risks and interacting conditions was required to optimise their RLS control.

Results Case 1: 85-year-old woman with advanced connective tissue disease associated interstitial lung disease (ILD) complicated by pulmonary hypertension on a background of antisyndetase syndrome and RLS. Her ILD was managed by prednisolone monotherapy and long-term oxygen due to multiple immunomodulatory agents' intolerance. Her symptoms included chronic intermittent nausea, anxiety, abdominal and back pain, and insomnia due to RLS. Trials of various symptom management medications were poorly tolerated: gabapentin(confusion/fall), olanzapine/cyclizine(worsening RLS), ondansetron(constipation). Following hospitalisation, her RLS and symptom cluster was managed successfully with buprenorphine patch 5 microgram/hour weekly, domperidone 10mg q.i.d., clonazepam liquid 0.5mg nocte and nortriptyline 10mg nocte. Due to worsening breathlessness, her buprenorphine patch was rotated to controlled release morphine tablet 5mg BD with preserved symptom control.

Case 2: 75-year-old woman with ATTR amyloidosis(cardiomyopathy with conduction disease and polyneuropathy), depression(on venlafaxine), severe RLS with augmentation, obstructive sleep apnoea, falls, type 2 diabetes and aortic stenosis treated with transcatheter aortic valve implantation. Her RLS was severe; impacting on her quality of life, sleep (positive airway pressure therapy use compromised), mood and function. Previous treatments were not tolerated and/or ineffective - dopamine agonists(augmentation), gabapentinoids(mood disturbance), transdermal drug therapies(fentanyl, rotigotine - contact dermatitis), clonazepam(sedation), vitamin C/E/

iron(not effective). Antidepressant switch worsened depression with no RLS improvement. Balancing falls and sedation risk, her RLS control improved considerably following the introduction and uptitration of controlled release oxycodone/naloxone to 10/5mg midi and 40/20mg nocte, with oxycodone immediate release 5mg as needed, and maintaining pramipexole at a lower dose. Sublingual buprenorphine therapy rotation and adjunct bilateral peroneal nerve stimulation were discussed as potential future treatment options.

Discussion These case studies highlight the significant impact of RLS on overall symptom burden, function, mood and quality of life. Managing RLS alongside comorbidities, side effects, and drug interactions/tolerability and drug-disease interactions highlights the need for specialist outpatient supportive care.² The importance of close communication and coordination of care with patients' treating specialists and primary care providers is also paramount in supporting these patients.

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PP22

AUSTRALIA'S MEDICATION SHORTAGES IN PALLIATIVE CARE – A CALL FOR A MULTI-AGENCY RESPONSE

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Background Medications shortages threaten the delivery of safe and effective palliative care in Australia. These shortages now affect multiple medications essential for palliative care symptom management leading to consumer, pharmacy and prescriber impacts. A multi-agency response is necessary to facilitate coordinated and responsive action in navigating these challenges in order to maintain safe and effective symptom control for palliative care patients.

Methods Exploration of the key components that form a multi-agency response was undertaken in a multistakeholder palliative care consortium meeting followed by iterative refinement in a virtual roundtable format with pharmacy representatives from a national pharmacy peak body, hospital and community pharmacists, and frontline clinicians – facilitated by a statewide Palliative Care Community of Practice.

Impact on practice Medication shortages extend beyond opioid discontinuations and affect multiple other symptom medications in palliative care, with cascading impact on multiple levels. For consumers these include risk of destabilisation of symptom control, delays in accessing medications, adverse effects from substitute/alternative therapies, avoidable emergency presentations/hospitalisations and psychosocial distress.¹ Prescribers and pharmacists experience increasing administrative and clinical burden associated with sourcing alternatives, monitoring stock variability and navigating fragmented communication pathways.¹ Existing responses remain largely reactive.² Prompt notification to prescribers is essential as a significant downstream effect is noted at the community level.

We propose a multi-agency coordinated approach spanning national, statewide and local levels to improve real-time communication, documentation of medication shortages, stock planning and management of key palliative care medication shortages across both hospital and community settings.

Discussion Establishing effective communication between stakeholders is central to an organised response. This includes key players at a local, state and national scale. A coordinated multi-agency response and advocacy is essential to support real-time pro-active responses when patient's access to palliative care symptom medications is threatened. Infrastructure of a dedicated multi-agency response is required to coordinate timely communication and support in navigating this complex landscape, thereby ensuring care remains safe and effective.

Summary A multi-agency response, structured communication processes and effective care coordination form the cornerstone of bolstering our response to palliative care medication shortages.

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PP23

IMPACT OF COVID-19 PANDEMIC ON PALLIATIVE CARE DELIVERY FOR PEOPLE LIVING WITH DEMENTIA IN RESIDENTIAL AGED CARE: FACILITY MANAGER PERSPECTIVES

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Background and Aims Dementia is a progressive and terminal neurodegenerative condition which presents unique palliative care needs for those impacted.^{1,2} In Australia, most people living with advanced dementia die in residential aged care facilities (RACFs).³ During the height of the COVID-19 pandemic RACFs experienced a disproportionate burden of cases and mortality, as strict public health policies were put in place to limit transmission in this setting.^{4,5} We aimed to evaluate the perspectives of senior RACF staff (Facility Managers, Clinical Care Coordinators, Nurse Unit Managers and/or Directors of Nursing) regarding the impact of the COVID-19 pandemic on the provision of optimal palliative care for RACF residents with dementia.

Methods A cross-sectional survey was distributed to all Victorian RACF senior staff in online and paper format between November 14 2022 to January 22 2023. Ethics approval was obtained from the Alfred Health Human Research Ethics Committee (Project Number 428/22). Qualitative data from responses were analysed using inductive thematic analysis.

Results Of 762 RACFs contacted, 147 responses were received (19.3% response rate). Respondents were primarily Facility Managers (43.8%), followed by Care Coordinators (21.2%) and Directors of Nursing (17.1%). Three themes were identified

regarding the COVID-19 pandemic's impact on the provision of optimal palliative care for residents with dementia: social isolation, decreased access to external resources, and staffing uncertainty.

Conclusions Our respondents perceived that the COVID-19 pandemic and its resultant societal disruption had significant flow-on impacts for the dying experience of people with dementia in residential aged care. Although the height of the pandemic has subsided, the impacts on the RACF workforce and quality of care in the sector are ongoing.⁶ The learnings from this study hold implications for guiding optimal palliative care access and delivery in future outbreaks, particularly for residents with advanced dementia who experience a disproportionate impact from disruptions to care.

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PP24

UNDERSTANDING PLACE OF DEATH IN PATIENTS WITH SOLID ORGAN MALIGNANCIES – A RETROSPECTIVE COMPARISON OF DEATHS AT AN ACUTE HOSPITAL AND AN INPATIENT PALLIATIVE CARE UNIT

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Background Place of death is an important metric in the provision of end-of-life care (EOLC),^{1,2} however there is limited research exploring factors that affect place of death within hospital systems. Given many patients express a preference to die in specialised palliative care settings over acute hospitals,^{1,3} it is important to understand the factors that influence why deaths occur in each of these locations, as EOLC in inpatient palliative care settings has favourable outcomes over EOLC in acute hospitals.^{4,5} This study aimed to understand why patients received EOLC in each study setting.

Methods This was a retrospective cohort study conducted at the Tasmanian Health Service using the routinely collected data of patients with solid organ malignancies who died over a one-year period either while admitted under the Medical Oncology (MO) service at the acute Royal Hobart Hospital (RHH) or the Palliative Care (PC) service at the palliative care unit (PCU) in Hobart, Tasmania. Descriptive statistics were used to analyse data.

Results 292 patients were included in the study. 53 died while admitted under the MO service and 239 died while admitted under the PC service. The PC patients were more likely to avoid presenting to the Emergency Department, known to the community palliative care service for substantially longer, had their final palliative goals-of-care completed longer before death, and had substantially fewer medical investigations performed. Differences in the frequencies of several cancer types were seen between the cohorts. Most MO patients appropriately received EOLC at the RHH. The most common reason for MO patients not receiving EOLC in the PCU was unavailability of PCU beds.

Conclusions This study has highlighted several factors associated with a higher chance of receiving EOLC in a PCU compared to an acute hospital in patients with solid organ malignancies. Important differences in the frequencies of several cancer types were found between the study cohorts. While most MO patients appropriately received EOLC at the RHH there is scope to further improve utilisation of PCUs for these patients.

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PP25

REFRAMING PALLIATIVE CARE CONVERSATIONS: A CO-DESIGNED EDUCATIONAL APPROACH TO SUPPORTING TIMELY INTEGRATION IN CANCER CARE

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Background Cancer specialists provide high quality, complex care and have strong therapeutic relationships with patients and families. Within this context, conversations about referral to specialist palliative care play a critical role in shaping expectations, supporting shared decision making, and enabling timely access to additional supportive care. As cancer treatments evolve and prognostic uncertainty increases, cancer clinicians are required to navigate increasingly nuanced and emotionally complex discussions. Supporting skilled, confident communication is therefore central to strengthening timely, person - centred integration of palliative care.

Objective To describe the co design and development of an educational program that supports oncologists and haematologists to enhance communication skills for introducing and discussing palliative care alongside active cancer treatment.

Methods A multidisciplinary working group was convened by an engaged and experienced project manager with a background in healthcare. The working group comprised consumer repre-

sentatives, palliative care physicians, medical oncology, haematology and radiation oncology specialists and trainees. Relevant societies and colleges were contacted and invited to contribute. The Royal Australasian College of Physicians education design team were engaged to develop the resource. Through an iterative co design process, the group explored communication challenges commonly encountered across cancer services, including introducing palliative care in the setting of prognostic uncertainty and responding to patient and family emotions. Consumer input reinforced the importance of clear communication and discussing referral to palliative care in a timely manner.

Results The working group co-design process informed development of an accredited online Continuing Medical Education program tailored for adult cancer specialists and trainees. The course was designed to complement existing clinical expertise and support consistent, values - aligned communication across disciplines.

The course positions communication as a core clinical skill that underpins high quality cancer and palliative care. Educational content provides practical strategies to support clinicians in confidently introducing palliative care as a routine, needs based component of comprehensive cancer care. Key elements include structured approaches to framing palliative care alongside ongoing treatment, techniques for acknowledging uncertainty, and strategies for recognising and responding to emotional cues. Reflective components encourage clinicians to build on existing strengths, adapt communication to individual patient contexts, and maintain compassionate, patient - centred conversations.

Conclusion This initiative demonstrates a collaborative, multi-disciplinary approach to supporting communication excellence in cancer care. By enhancing common understanding between the disciplines and providing practical communication strategies, the course supports timely palliative care integration into cancer care while recognising and building on the high standard of care already provided by cancer specialists. The co-design process offers an effective approach to strengthening collaboration between oncology and palliative care services and promoting consistent, person - centred conversations across the cancer continuum.

PP26

USING THE AUSTRALIAN REFINED DIAGNOSIS RELATED GROUPS (AR-DRG) CASEMIX CLASSIFICATION TO DESCRIBE COMPLEXITY IN PATIENTS ADMITTED UNDER A SPECIALIST PALLIATIVE CARE SERVICE

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Background Specialist palliative care input is required for cases with greater complexity, but there is no consensus on how to define or measure complexity. While the Australian Refined Diagnosis-Related Groups (AR-DRG) casemix classification is not used to classify palliative care, this study explores whether its complexity indices can be used to measure the clinical complexity of palliative care.

Methods This study used the Diagnosis-Related Group (DRG) to describe complexity in palliative care patients admitted

under the specialist palliative care service at a metropolitan teaching hospital in Sydney over three years, from 2022 to 2025. The DRG casemix classification classifies episodes with a suffix ABCD or Z, with A being major complexity, B being intermediate and C being minor complexity. For the purposes of the study, we classified 'A' as major complexity, B and C as minor complexity and excluded D or Z (ungroupable). The study compared complexity using the DRG in patients admitted from the community to those admitted from the acute setting and examined the trends in complexity over the study period as measured over three years in 6 month blocks.

A single-centre cross-sectional study was undertaken using routinely collected data from the New South Wales Activity-Based Management Portal. Descriptive analyses were performed with medians and interquartile ranges reported. Further analyses used Chi-squared tests for categorical variables and logistic regression tests for comparison of complexity over time using Excel formulas. A p-value of 0.05 was considered statistically significant.

Results 1183 patients, 675 male and 486 female were analysed for this study. The median age was 77 years, with 49.5% having cancer as a principal diagnosis. Patients who were admitted from the acute setting had nearly twice the odds (Odds Ratio 1.78, 95% CI 1.39 - 2.27) of major complexity compared to those admitted from the community. No statistically significant change in complexity levels was observed over the study period.

Major complexity was significantly associated with younger age, with major complexity seen in 61% of patients under the age of 85 years compared with 53% of those 85 years and older (95% CI 48.3 - 57.8%).

Those in the unstable phase on admission were 40% more likely to have major complexity compared to those who were in a non-unstable phase (95%CI 1.13-1.76%, $p=0.003$).

Conclusion The DRG casemix system is potentially a useful tool to define and describe complexity of palliative care patients. However, it needs refinement as the DRG complexity system does not adequately account for other domains of palliative care complexity, particularly the psycho-social.

PP27

END OF LIFE CARE FOR RESIDENTIAL AGED CARE HOME RESIDENTS IN A REGIONAL AUSTRALIAN HOSPITAL

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10.1136/spcare-2026-ANZSPM.103

Objective Given evidence that patients and their families generally consider death at a patient's home preferable to death in hospital, this study aims to examine the patient specific characteristics and management of Residential Aged Care Home (RACH) residents who were admitted to and subsequently died in a regional Australian hospital.

Design Retrospective medical record review.

Setting Dubbo Base Hospital - Western NSW Health District Regional Australian Hospital

Participants 36 RACH residents aged >65 years who presented as patients to and died at Dubbo Base Hospital between January 2022-2024.

Main Outcome Measures Variables measured included demographics, medical history, current presentation, documentation, treatment measures, and cause of death.

Results Patients had a mean age of 85.5 years, an equal sex ratio, and at least one previous hospital presentation in the preceding year (83.3%). Most presented with pain (47.2%) or altered consciousness (41.7%). Pain relief, medical consultation, and end-of-life medications were infrequent pre-hospitalisation (36.1%, 38.9%, 0%). Advance Care Directives/Plans and RACH documentation accompanied patients in 55.6% and 52.8% respectively. Hospital treatments included end-of-life medications (83.3%), intravenous antibiotics (50%), and procedures (22.2%). Sepsis was the primary cause of death.

Conclusion We identified commonalities in patient specific circumstances and provided care amongst the study population. These commonalities reveal factors that may predispose RACH residents to hospital admission and consequent in-hospital death, including but not limited to: RACH staff feeling ill-equipped to manage medical decline especially when there is a lack of pre-hospital medical professional consultation; absence or late end-of-life care planning; and lack of patient documentation transfer to hospital. Awareness of these factors may encourage early recognition, continuity, and improvement in our care of this population. Upskilling may support nursing and local medical professionals in caring for RACH residents at end-of-life in the RACH rather than requiring transfer to hospital. Further research examining quality of end-of-life experience as perceived by families of RACH residents would inform best end-of-life practice in our region.

PP28

SILENCING THE PERSISTENT COUGH: SPEECH PATHOLOGY INTERVENTION IN PALLIATIVE CARE

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Coughing, an important protective reflex, can become a distressing symptom impairing daily function and quality of life.¹ For chronic cough, defined as lasting beyond eight weeks, there is a broad list of contributing causes to consider. Among adults receiving palliative care these may relate to their primary life-limiting diagnosis or to comorbid chronic diseases. As the cough persists, there are structural, inflammatory and neuro-modulatory changes perpetuating the cycle.¹ We present the case of an 81-year-old Mandarin-speaking female with metastatic pancreatic cancer who presented chronic cough refractory to pharmacotherapy, which ultimately responded to speech pathology intervention.

Our patient presented to an acute hospital with chronic, severe cough. It had been present for two months with persistent, forceful coughing fits interrupting conversation and disrupting sleep. There was no viral prodrome, and only small volumes of thick clear sputum were expectorated. Other medical history included gastro-oesophageal reflux disease (GORD), type 2 diabetes mellitus, hypertension and depression. Preliminary investigations excluded common respiratory viruses and bacterial pneumonia but showed progressive pulmonary metas-

tases with a large cavitating right-sided lesion. Multiple medications were trialled for symptom control. Among these were inhaled budesonide and salbutamol for possible inflammation and bronchospasm, dextromethorphan and oral morphine mixture as cough suppressant, paroxetine as an alternative SSRI, escalation of GORD therapy, a trial of antibiotic therapy and oral prednisolone, cessation of a longstanding ACE inhibitor and commencement of bromhexine and pregabalin. There was limited improvement and she was transferred for inpatient palliative care. At this time, she also requested voluntary assisted dying, in part due to the severity of her cough.

Further changes made on admission to the palliative care unit included referral to speech pathology. Our patient engaged in a comprehensive speech pathology assessment comprising a case history and 'Laryngeal Hypersensitivity Questionnaire' with an interpreter.² This indicated chronic cough in the setting of Irritable Larynx Syndrome (ILS) with laryngeal hypersensitivity.² Evidence-based intervention included education on basic vocal fold anatomy and the chronic cough irritation cycle alongside strategies to ward off coughing fits, including strong swallow with fluids or saliva substitute spray.³ Following two sessions, she was able to reduce the frequency and intensity of coughing episodes enough to sustain an hour-long conversation.

This case highlights the value of speech pathology assessment and intervention for chronic cough in the adult palliative care setting. In our experience, collaboration with speech pathology has enhanced interdisciplinary learning and empowered our patient to take back control of her cough.

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PP29

DO NUTRITION SCREENING PRACTICES AND DIETITIAN REFERRALS IN A PALLIATIVE CARE UNIT VARY BY ADMISSION GOALS OF CARE? A RETROSPECTIVE AUDIT

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10.1136/spcare-2026-ANZSPM.105

Background Patients admitted to an inpatient palliative care unit (PCU) have varied admission care goals, most commonly symptom management or end-of-life care (EOLC), which may impact the role of nutritional support and dietitian input.

Nutrition screening tools such as the Malnutrition Screening Tool (MST), which focuses on parameters including appetite change and recent weight loss, does not incorporate a patient's goals of care.

This audit aims to evaluate the use of the MST and dietitian referral patterns among patients admitted for symptom management and EOLC, respectively, in the PCU setting.

Methods We audited the medical records of 150 consecutive admissions from January to March 2025 in the Wantirna

Health Supportive and Palliative Care Unit (adult inpatients). We excluded patients who had an admission goal other than symptom management or EOLC. Appropriateness of dietitian referrals and potential for dietetic input for patients not referred were determined through chart review by a senior dietitian. Data collected was reported descriptively. The Fisher exact test was used to compare characteristics of patients based on admission goals of care.

Results 133/150 patients (68 females; 51%) met inclusion criteria. Median age at admission was 76 years (interquartile range (IQR) = 65–85). 103/133 (77%) patients were admitted for the clinical goal of symptom management, while 30/133 (23%) patients were admitted for EOLC.

The MST was completed on admission for 106 (106/133; 79.7%) patients. 20 (20/106; 19%) patients were determined as low-risk for malnutrition, 59 (59/106; 56%) were moderate-risk, and 27 (27/106; 25%) were high-risk.

However, only 65/106 (61%) MST scores were completed correctly.

Patients admitted for symptom management had higher rates of correctly completed MST compared to those admitted for EOLC (71% v 26%, $p < 0.001$) and were more frequently referred to the dietitian (47% v 10%, $p < 0.001$).

Two (2/30; 7%) patients admitted for EOLC were seen by a dietitian and another two were determined to have potentially benefitted from dietitian input. In comparison, 48 patients admitted for symptom management were seen by a dietitian (48/103; 47%), and another 20 had identifiable clinical need for dietitian input.

Discussion Patients admitted for EOLC were less likely to have a correctly completed MST on admission and were less likely to be referred to the dietitian. Incorrect MST completion may reflect staff training deficiencies and challenges in administering MST in EOLC patients. Whilst lower dietitian involvement in this cohort may reflect appropriate goal alignment, incorrectly completed screening and potential unmet need in symptom management admissions raise concerns about reliance on MST alone.

Conclusion These findings suggest that, without consideration of clinical context and goals, nutrition screening tools like the MST may not adequately identify patients who require nutritional intervention and support in the PCU setting. There is a need for a nuanced approach to deliver goal-aligned nutritional care and support.

PP30

ASSESSMENT OF BEREAVEMENT RISK AND THE ACCEPTABILITY AND FEASIBILITY OF A BEREAVEMENT SUPPORT SERVICE AT AN ACUTE TERTIARY HOSPITAL

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10.1136/spcare-2026-ANZSPM.106

Introduction Evidence-based guidelines identify bereavement support as an essential component of end-of-life care. However, no 'gold standard' approach exists, and structured models are often absent outside of Palliative Care Units (PCUs).^{1,2} This pilot project aimed to implement and evaluate a systematic bereavement support procedure within an acute hospital setting

and specifically compare needs across the Emergency Department (ED), Intensive Care Unit (ICU), and PCU to inform future workforce planning.

Methods We conducted a prospective study at an acute tertiary hospital in Victoria, Australia, from July 2024 to January 2025. Participants included next-of-kin (NOK) of decedents from the ED, ICU, and PCU. Risk screening was performed via decedent file reviews and clinical consultation using the Northern Health Bereavement Risk Assessment Tool (NHBRAT). We collected routine clinical and demographic data, and information regarding healthcare services use pertaining to decedents. Other data collected included bereavement risk level (low/medium/high), bereavement support provision, and external referrals. Quantitative analysis utilized descriptive statistics, t-tests, and logistic regression to identify risk factors.

Results Of 289 identified decedents, 227 were in PCU, 33 in ED, and 29 in ICU. Screening revealed the highest proportion of high-risk bereavement in the ICU (52%), followed by ED (48%) and PCU (31%). Our analyses showed that ICU deaths had 16 times higher odds of high-risk bereavement ($p < 0.001$), and ED deaths had 2.1 times higher odds ($p = 0.047$) compared to PCU. Each one-year increase in the decedent's age was associated with a 5.2% decrease in high-risk bereavement odds ($p < 0.001$). Gender, language, country of birth, cause of death,

and length of hospital stay were not significantly associated with bereavement risk level. Uptake of bereavement support provision was high; over 80% of high-risk NOK across all sites engaged with support. External referrals were highest for ICU (24%) and ED (12%) cohorts indicating an ongoing need for support for high-risk individuals.

Discussion & Conclusion Our study confirms that high-risk bereavement is significantly more prevalent in acute areas (ICU/ED) than in the PCU; and demonstrates acceptability and feasibility of a structured bereavement support procedure in these settings. While limited by its single-centre design, these findings provide a framework for targeted resource allocation and workforce planning. Implementing a systematic approach ensures that higher risk individuals are identified and supported; and staff dealing with bereaved NOK are also supported through clear pathways to experienced providers – thus addressing a critical gap in hospital-based end-of-life care.²

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