

Abstracts of the 9th World Research Congress of the European Association for Palliative Care (EAPC)

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can take several forms. The documents demonstrate those issues of most prominence in the palliative care field over time. They are therefore one way to understand the global development of palliative care. In most cases however there is little evidence of follow up or impact assessment of palliative care ‘declarations’.

Abstract number: FC54

Abstract type: Oral

Comparison of Care Use in the Last Three Months of Life among the Elderly in Three Countries

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Background: There is a lack of international comparisons concerning care utilisation, and formal (paid) and unpaid care costs, including at the end of life

Aim: To determine and compare the formal and informal care used in the last three months of life by elderly patients who had accessed specialist palliative care in three countries.

Design: A mortality follow-back survey.

Setting: 3 countries: UK (London), Ireland (Dublin) and USA (New York City and San Francisco).

Data collection: Postal survey using self-completion questionnaires including the Client Services Receipt Inventory, sent to bereaved caregivers of patients aged ≥ 65 who accessed specialist palliative, plus extraction of patient record data.

Methods: Care costs (formal and unpaid) were calculated, combining service use and unit costs in each country. Lost productivity was measured by the proportion of carers who had stopped/reduced work and by the days off work for 3 months before and after patient’s death.

Results: 721 questionnaires were returned. Patients were: 53% women; mean age 79.9; 46% with cancer; 68% living with someone else; and mean number of carer 2.7. 70% of patients had been inpatients; 34% in ICU, 64% visited ER or A&E, 65% used ambulance services. In the community, 74% saw a doctor; fewer nurse contacts in the USA than UK and Ireland, although more social service use. Weekly total hours of informal care varied by city (e.g. 176 in SF versus 212 in NYC), but composition was similar. 30% of

carers stopped/reduced work with 3 weeks off before and/or after death. Substantial formal and unpaid care costs per patient for 3 months were identified: for example, in London £10,623 and £8,087 respectively.

Conclusions: Formal and unpaid care varied across the cities, although similar unpaid care was volunteered. Unpaid care was not negligible, and unpaid carers often reduced or stopped working and this also adds to societal costs.

Palliative care organisation and health care services II

Abstract number: FC55

Abstract type: Oral

Palliative Care at the Front Door - Improving the Recognition of Palliative Care Needs of Patients Attending an Irish Emergency Department

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Background/aims: Many patients with life limiting illnesses attend the Emergency Department (ED) because of worsening symptoms that cannot be controlled in an outpatient setting and are admitted to hospital without assessment by a Palliative Medicine (PM) service.

Early engagement with PM services in an acute hospital setting leads to better outcomes.

“The Three Rs of integrating Palliative Care and Emergency Department Care” is an initiative supported by the Emergency Medicine and Palliative Care Programmes. This project was designed and undertaken in a large Dublin teaching Hospital.

Our aim was to improve the recognition of palliative care needs of patients attending an Irish Emergency Department.

Methods: New guidelines and systems for the early identification of patients with palliative care needs were introduced in the ED. A new tool - P.A.U.S.E. was developed to identify patients not known to PM. The patient administration system in the ED was modified to “flag” patients known to the Hospital’s PM Service. PM Education for doctors and nurses in the ED was augmented by the daily presence of the PM team in the ED. Referrals to PM were

audited for two months before and after these interventions. Data was analysed using SPHINX software package.

Results: During the baseline period, 61% of all referrals to the PM Service were admitted to the hospital via the ED, but only 6 patients (10%) were referred and seen while in the ED. Following the introduction of the new guidelines and systems, 54% of all referrals (91) patients were admitted via the ED, 46 of whom (51%) were referred and seen while in ED, a 5 fold increase.

Conclusion: The introduction in the ED of specifically designed referral guidelines to PM services leads to a significant increase in early referrals and enhanced delivery of service.

Abstract number: FC56

Abstract type: Oral

Responding to Urgency of Need In Palliative Care: Initial Stages in the Development of a Decision Aid for Palliative Care Triage

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Background: Demand for inpatient and community-based palliative care (PC) services is increasing and transparency of decision-making around priority of service response is required, yet no valid or reliable PC triage tools currently exist.

The aim of this study was to identify factors health professionals considered salient when triaging PC needs and determine the relative importance of these, in order to inform the development of an evidence-based clinical decision-making tool.

Methods: This study used a mixed-method sequential design.

Stage 1 involved exploration of prioritization factors using semi-structured focus groups with purposively sampled PC and generalist clinicians from metropolitan and regional Victoria, Australia. Transcripts were subjected to deductive thematic analysis.

Stage 2 consisted of an online discrete choice experiment involving PC health professionals across Australia

and the United Kingdom, whereby participants compared the urgency of multiple pairs of randomly generated clinical cases to establish the relative importance of the triage factors derived from Stage 1.

Results: Focus groups (n=20 health professionals) revealed the factors considered important to determine urgency, such as problem severity, caregiver distress and mismatch between the level or complexity of care needs and the capacity of the care environment. Performance status was reported to be less important when considered in isolation. Challenges associated with the triage process and the implementation of a decision aid were highlighted. The discrete choice experiment established the relative weightings for the triage factors.

Conclusions: Indicators of urgent PC needs are complex, dynamic and contextual. The results of this study have important implications for the development of a decision aid to enable a standardised approach to ensuring equitable, efficient and transparent PC service allocation.

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Part 1: Mapping Complexity of Needs in Palliative Care: A Qualitative Study of Stakeholder Perspectives

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Background: Until now complexity in palliative care has largely been described in terms of four care domains (physical, psychological, social and spiritual). A more comprehensive, yet standardised way to report complexity has not been established.

Aim: To describe the full range of complexity of needs in palliative care and the interrelationships between components.

Study design/methods: Face-to-face semi-structured interviews with UK stakeholders across palliative care settings, purposively sampled by geographical location, background and experiences of models care. Vignettes were used to elicit discussion of complexity. Techniques to enhance trustworthiness were informed by COREQ guidelines. Framework analysis was conducted, with data handled in NVivo. Complexity components were mapped