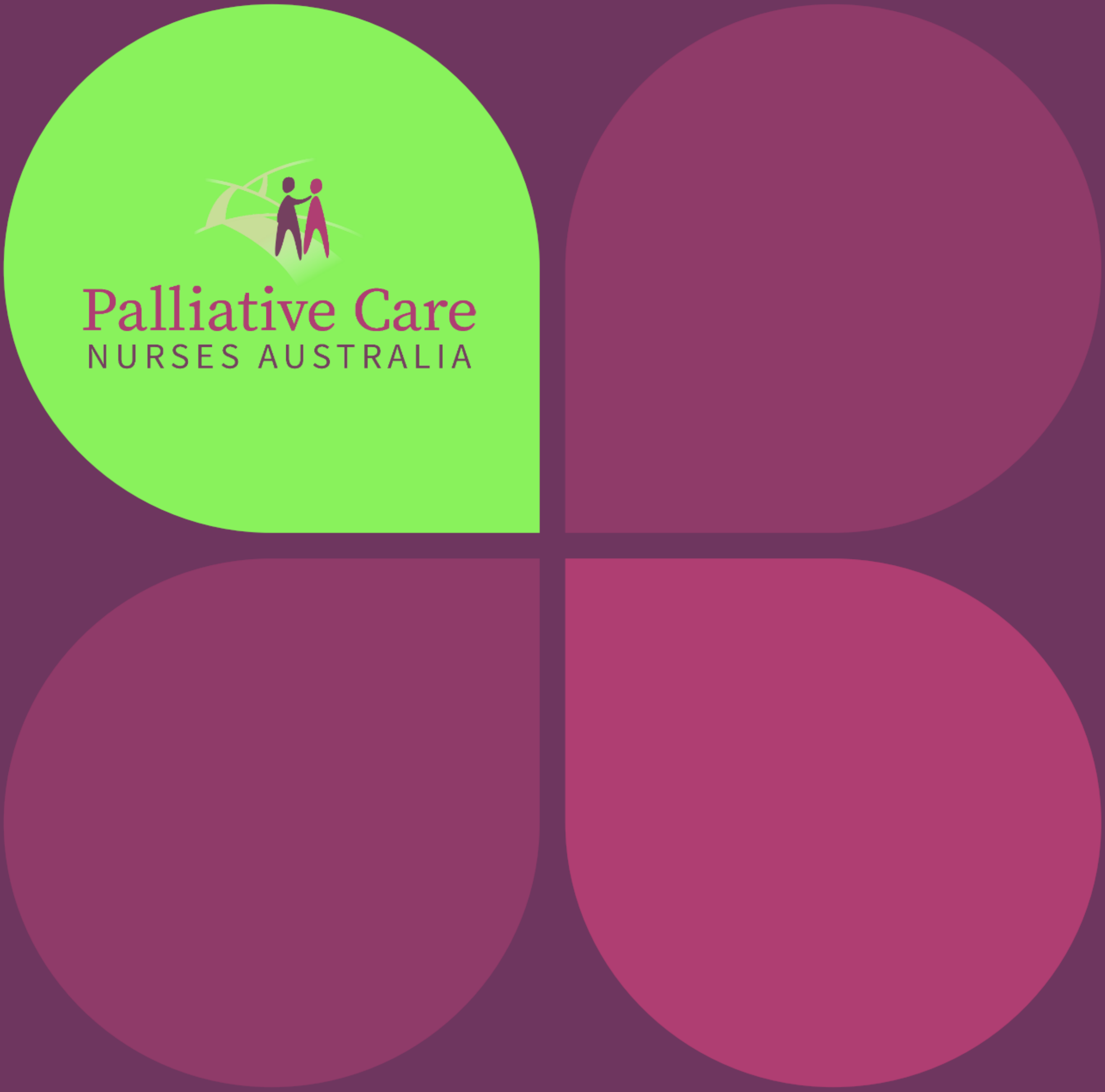
# PALLIATIVE CARE NURSES AUSTRALIA

## BIENNIAL CONFERENCE 2024



***Clinical Excellence, Connection and Culture – The Art of Palliative Care Nursing***

31 Jul – 2 Aug 2024 | Novotel on Collins | Naarm/Melbourne & Online

# Decision-making theory at end of life

Ms Tricia O'Connor[1], Professor Catherine Paterson[1], Professor Karen Strickland[3], Associate Professor Joanne Lewis[4], Dr Jo Gibson[5]

[1]Flinders University, Adelaide, Australia, [2]Clare Holland House, Canberra, Australia, [3]Edith Cowan University, Perth, Australia, [4]Avondale University, Sydney, Australia, [5]University of Canberra, Canberra, Australia

## Biography:

Tricia is a PhD candidate at Flinders University with a particular interest in the care needs of the unresponsive dying patient and how nurses make decisions. She is the 2022 recipient of the ANMC Vivian Bullwinkel Award. Tricia has worked as a registered nurse and midwife in various roles across Australia and overseas, as well as in the tertiary education sector. Tricia currently works as a specialist palliative care nurse at Clare Holland House hospice, Canberra, and has done so for over 15 years.

## Abstract:

Caring for the dying is a multidisciplinary team (MDT) model of care, with nurses providing the most direct patient care. Providing end-of-life care to meet the person-centred needs of individuals and families is complex and relies on effective clinical decision-making (CDM) skills. Little is known about how healthcare professionals (HCPs) inform complex decisions for care intervention when the patient is unresponsive at end of life. The cognitive continuum theory (CCT) has been used to examine CDM in healthcare.

This systematic review aimed to critically synthesis empirical links between theory, research, and practice to address the following questions: how has the CCT been used in research, and to what extent has it been integrated in research processes and clinical practice?

Methods: A systematic review was undertaken searching five databases from inception. A range of key concepts were mapped to each electronic database. Pre-eligibility screening criteria were applied, and methodological quality appraisal was conducted. A meta-aggregative synthesis was conducted using Joanna Briggs methodology.

Findings: Five synthesised findings related to the CDM processes were informed by the CCT. These included: CDM varied depending on the decision-making capacity of the individual HCP, their level of experience, availability of decision tools, access to senior staff and peers, and availability of resources such as time and staffing. The visibility of the CCT was variable, with only two studies rigorously applying the CCT to all stages of the research.

Discussion: This review identified a gap in providing a person-centric approach to CDM. This finding was dependent on multifactorial considerations which impacted individual HCPs. Complex DM should be safely embedded in the MDT to sustain the team and improve patient care. Further education and support is needed, particularly in the context of the unresponsive dying. Impacts of time, resources and workplace culture on CDM need to be addressed.

# Embedding Palliative Care in Residential Aged Care Facilities – One Year On

Mrs Carmen Sanchez[1], Ms Kathy Lark[1], Ms Michelle Leung-Cheng[1], Ms Usha Gurung[1], Ms Christine Najjar[1]

[1]Calvary Healthcare Kogarah, Kogarah, Australia

## Biography:

Michelle Leung-Cheng began her career in Intensive Care Nursing. She is actively involved in quality improvement initiatives that enhance palliative care access for underserved communities.

Usha Gurung, originally from Nepal. Special interest lies in educating aged care workers and raising awareness about palliative care within her minority community. Driven by a desire to give back, she seeks to enhance her skills and knowledge through continuous learning.

Christine Najjar, originally from Lebanon recognises the importance of education. She strongly believes in bridging the gap between aged care and palliative care in residential aged care facilities to better serve the elderly population.

## Abstract:

Background: The Royal Commission Aged Care Quality and Safety 2021 identified palliative care education is lacking in the aged care workforce and the prevalence of individuals with complex care needs in residential aged care (RAC) has surged from 10% to 53 % in the last decade. Addressing this critical gap, Calvary Health Care Kogarah, has undertaken a transformative initiative known as the 'Embedding Palliative Care in RACF' project.

This project, situated across 57 RAC facilities, drawing upon the expertise from Community Palliative Care Team (CPCT) to share their expertise in providing face-to-face evidence-based palliative care education within RACFs in the last twelve months.

Aim:

- Evaluating the impact of the 'Embedding Palliative Care in RACF' project one year on
- To assess the sustainability within CPCT
- To identify lessons learned

Measure:

- Review and evaluate the education survey responses.
- Explore the level of interest in on-going palliative care education among those working in RACFs.
- Identify gaps in both presenter delivery and participants understanding.

Results: Preliminary findings suggest promising improvements in confidence in delivery of palliative care and that an overwhelming 94% of participants expressed a keen interest in receiving further palliative care education. The most requested topics include recognizing end of life signs and symptoms, managing deterioration, and communicating with distressed families.

The information suggests a need to reassess the delivery method as participants found traditional PowerPoint presentations less engaging. Consequently, an education session on presentation skills has been organised for the specialist palliative care nurses, and interactive workshop formats will be adapted as the new educational approach.

Conclusions: By incorporating these adjustments, the phase two of ‘Embedding Palliative Care in RACF’ project can enhance its educational impact, making the learning experience more enjoyable, relevant, and accommodating to the unique circumstances of the aged care workforce.

# End of Life Care Audits. How do they help?

Mrs Megan Day[1], Mrs Grace Edwards[1]

[1]Sydney Local Health District, Camperdown, Australia

## Biography:

Megan is the Transitional Nurse Practitioner Palliative Care for the Sydney Local Health District. She has worked in Palliative and End of Life Care for over 7 years and Haematology for over a decade. She is a strong patient advocate and believes all patients should have access to quality palliative and end-of-life care. Megan is passionate about early integration and equitable access to specialty palliative care. Megan has worked closely with the Respiratory Care team, providing advice and complex symptom management for patients, championing Advanced Care Planning. Megan is currently establishing Integrated Palliative Care clinics across Sydney Local Health District.

## Abstract:

Background: An audit of end-of-life care in Acute Hospital Settings to evaluate care against Elements 1-5 of the Australian Commission on Safety and Quality in Healthcare’s (ACSQHC) Essential Elements for Safe and High-Quality End-of-Life-Care. With most deaths in Australia occurring in hospitals, it remains important for the clinical care provided to patients to be constantly evaluated and improved. Recent research into bereavement indicates the care and conversations provided to families and carers at end of life has a significant impact on their bereavement experience.

Aims: To establish baseline data of care provided to patients at end of life to help inform and prioritise education planning to meet the needs of staff, patients and families/carers and advise on the implementation of a tool to best assist clinicians in the recognition of dying.

Methods: A retrospective audit of 10 percent of the deaths in Sydney Local Health district was completed at random from a one-year period from January to December 2023; utilising the Australian Commission on Safety and Quality in Healthcare (ACSQHC) end-of-life audit tool.

Results: Early results indicate that there are opportunities for staff to improve recognition of patients in the last year of life, or at risk of deterioration and that with the right tools and education, there is potential to improve clinical care of patients as well as empower staff to have earlier advance care planning discussions and better communication with patients, families and carers at end of life.

Conclusion: End-of-life audits are essential to evaluate care, highlight the needs of staff, develop and plan education and to assist when implementing a standardised framework to help clinicians recognise patients at risk of dying. End of life audits play a crucial role in improving patient outcomes, informing clinical care and ongoing education planning to meet the ever-changing needs of staff.

# Improving end of life care for residents of residential aged care facilities: The i-matter project

Ms Mia Taylen-Smith[1], Professor Deborah Parker[2], Professor Liz Reymond[3]

[1]Queensland Health, Brisbane, Australia, [2]University of Technology, Sydney, Australia, [3]Queensland Health, Brisbane, Australia

## Biography:

Mia is a Nurse Practitioner. She has worked across the continuum of palliative care including inpatient, outpatient, community, hospice, state-wide support teams and the RACF environment. She found a love of mentoring while rolling out a project aimed at improving end-of-life care in aged care facilities and has turned this into a passion working towards a Doctorate in Philosophy at the University of Technology. She is currently working with the SPACE team who in-reach 24/7 into local RACF's providing specialist palliative care to the residents/families and support and mentorship to staff.

## Abstract:

Background: Care demands within Australia's Residential Aged Care Facilities (RACFs) are set to double by 2040. The 2018 Productivity Commission report on end-of-life care found that the care residents currently receive is often suboptimal. In 2018 the Royal Commission into Aged Care Quality and Safety made it clear that substandard care in Australia's aged care system was unacceptable. The need for change provided the impetus for I-matter Project.

Aims: To improve the provision of P&EoLC in RACFs by the development, implementation and evaluation of a complex intervention in the RACF setting.

Methods: A three-phase sequential explanatory mixed methods project, to measure the effect of a complex intervention– collectively termed the I-matter project.

Results: Twenty-eight RACF's, with 521 nurses participated in the intervention. The project resulted in improved capacity for RACFs to provide P&EoLC. Evidenced at an organisation level by an increase in education ($p = .002$); palliative care case conferences ($p=.008$); use of EoLC pathway ($p=.002$) outcomes and establishing palliative care working parties ($p=.002$). Organisational support supported an increasingly educated workforce with nurses reported an increase in P&EoLC knowledge/skill. The impact of this in resident outcomes with increased documenting P&EoLC preferences increasing ($p= \leq .05$) and concordance with dying in place of choice ($p=0.04$) and a reduction in unwanted/unnecessary hospital admissions ($p= .001$).

Conclusion: EoLC outcomes for residents of participating facilities have significantly improved throughout the project. P&EoLC must become core business within RACFs. To do this quality education and support of nursing staff is required. A complex intervention that is flexibly delivered in RACFs is capable of transforming the P&EoLC provision available to residents of RACFs.

# Influences shaping clinicians’ monoclonal antibody and immune checkpoint inhibitor preparation and administration practices: Systematic review

Mrs Angela Ballard[1,2], Dr Carla Thamm[1,3], Ms. Thea Ogle[1], Professor Jane L. Phillips[1]

[1]Queensland University of Technology (QUT), Brisbane, Australia, [2]Federation University, Berwick, Australia, [3]Flinders University, Bedford Park, Australia

## Biography:

Angela Ballard, a part-time Ph.D. candidate at Queensland University of Technology (QUT), initially trained in New Zealand before moving to Australia in 2002. With over 20 years of experience as a registered nurse, Angela also holds a master's degree in advanced nursing and a post-graduate certificate in oncology nursing. With a passion for cancer care, Angela has held positions such as cancer clinical nurse educator in both oncology and haematology clinical environments. Now, along with her Ph.D. studies, Angela currently works as a full-time nurse lecturer at Federation University, helping to shape the future generation of nurses.

## Abstract:

Background: Over the past 30 years, monoclonal antibodies and immune checkpoint inhibitors have greatly improved cancer survival outcomes and quality of life, positioning them as potential replacements for conventional chemotherapy.  Little is known about the long-term risks and impact of repeated exposure to these agents for clinicians preparing and administering them. This is especially relevant for cancer nurses, who, in addition to administering these agents, are occasionally tasked with preparing monoclonal antibodies within the ward or outpatient environment.

Aim: To identify influences shaping clinicians' awareness of safe handling, their current practices, and the recommended practices for those preparing and administering monoclonal antibodies and immune checkpoint inhibitors.

Methods: This systematic review was reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). Six electronic databases were searched to identify peer-reviewed studies reporting empirical evidence on the practices of clinicians administering monoclonal antibodies and immune checkpoint inhibitors published between 2012-2022. Eligible articles were extracted into Covidence. Quality was assessed before a narrative synthesis identified patterns, trends, and relationships within and across included studies, allowing for descriptive and analytical themes to be generated.

Results: Of the 6543 identified articles, 141 were eligible for review, with four included. Two main themes emerged: 1) The lack of international consensus on the exposure risk of Monoclonal Antibodies and Immune Checkpoint Inhibitors, and 2) Clinician education is vital but challenging to implement without robust evidence about the secondary exposure risks of these novel agents.

Conclusion: A lack of consensus creates uncertainty about the hazardous nature of monoclonal antibodies and immune checkpoint inhibitors. These results in various risk reduction strategies during preparation and administration and inconsistent professional development. Protecting the long-term health of clinicians necessitates consensus, however, without compelling evidence or international agreement on the hazardous drug classification criteria of these agents, this is challenging.

# Mercy Health Palliative Aged Care Collaborative Project

Mrs Kirsten Mitchener[1], Mrs Valerie Crane[1], Mr John Stafford[1]

[1]Mercy Palliative Care, Sunshine, Australia

## Biography:

Valerie Crane is the Aged Care/Palliative care Clinical Nurse Consultant (CNC) at Mercy Palliative Care (MPC) working collaboratively with residential (RiR) at Werribee Mercy Hospital conducting Clinical needs rounds.

MPC is the largest palliative care service in Victoria servicing the inner and western suburbs of Melbourne.

Val has worked as a CNC at MPC since 2018 and has extensive experience in community nursing with RDNS/Bolton Clarke. She is passionate about creating therapeutic relationships with clinical care providers in RACF's.

John Stafford is a Clinical Nurse Consultant for the Residential in Reach Service with over 26 years of nursing experience. Originally from the UK, John has spent the majority of his career in Emergency Departments. With 11 years in his current role, he has pursued further education in Emergency Nursing, Education, Project Management, and Management. John strives to be innovative in all areas of health care to drive best practice, bringing a wealth of knowledge and expertise to his position.

## Abstract:

Background: Identification by community palliative care service that referrals are not always appropriate for service or referred when patient is imminently dying.

Aims: Improve access and outcomes for end of life care of individuals residing in Residential Aged Care. Build capacity in Residential Aged Care facility staff (RACF) to identify deterioration in residents, referral to appropriate services and improved symptom management in the location of choice by the individual resident. Relationship building with General Practitioners (GP) providing care at RACF.

Methods: Mercy Palliative Care, Clinical Nurse Consultant (CNC) partnered with Residential In reach (RIR) service located at Werribee Mercy Hospital to target 13 residential aged care facilities located in the City of Wyndham. Face to face formal and informal education provided by both services by identified need from RACF. Implementation of Clinical Needs Rounds at identified facilities to build capacity.

Results: Improved identification and recognition of physical or cognitive decline of individuals. 5% increase in referrals to community palliative care service of individuals who are appropriate to receive palliative care. Engagement and improved relationship with staff at all facilities. Improved review of Goals of Care (GOC) and advance care planning discussion.

Conclusions: Recognition despite initial findings, further ongoing collaboration and relationship/capacity building is required. The unique partnership of Palliative Care and Residential in Reach has led to individuals remaining in their preferred place of choice with reduced presentations to Emergency Departments.

# Mercy palliative care unite – urgent need identification team evaluation

Mrs Jennifer Zerafa[1], Mrs Valerie Crane[1], Ms Deanne Layton[1], Mrs Arlene Miller[1], Mrs Kirsten Mitchener[1]

[1]Mercy Palliative Care, Sunshine, Australia

## Biography:

Jennifer Zerafa is a nurse unit manager at Mercy Palliative Care.

## Abstract:

Background: A need to respond to patient complexities by senior staff with a multidisciplinary approach was identified within Mercy Palliative Care.

Aim: To respond to unstable patients requiring a complex clinical and psychosocial response within a 24-hour timeframe.

Methods: Funding was obtained through Mercy Palliative Care growth funding and consultation was sought within the Mercy Palliative Care Leadership team, consisting of a Clinical Nurse Consultant, Medical and Allied Health team member.

A referral and exclusion criteria was established. A process was developed as to how UNITE patients would be identified and referred.

Education sessions were rolled out to staff.

A spreadsheet was devised to capture all visits attended documenting referral reason and outcomes. Visits commenced in March 2023.

Results: A recent data analysis was undertaken showing the following:

- Improved response to complex pain in patients in the unstable and deteriorating phase.
- Improved response to complex symptom management.
- Improved response to complex family dynamic situations.
- Improved multidisciplinary team communication and approach to patient goals of care.
- Majority of UNITE patients seen within a 24-hr period.
- Majority of UNITE patients died in their preferred place of choice.

Conclusion: The UNITE service highlights the need for a multidisciplinary team approach when a patient and/or carers experience increased severity or sudden change in symptoms. This includes distress related to complex clinical and psychological issues arising for some Mercy Palliative Care patients.

# Palliative care service structures and capacity vary across rural areas – state-wide service-level survey

A/Prof. Rebecca Disler[1], Dr Amy Pascoe[1], Dr Helen Hickson[2], Prof Julian Wright[2,3], Bronwyn Phillips[4], Dr Sivakumar Subramaniam[2,3], Dr Kristen Glenister[2], Prof Jennifer Philip[5], Prof Doranne Donesky[6], A/Prof Natasha Smallwood[1,7]

[1]Monash University, Melbourne, Australia, [2]Department of Rural Health, The University of Melbourne, Shepparton, Australia, [3]Goulburn Valley Health, Shepparton, Australia, [4]Murray Primary Health Network, Bendigo, Australia, [5]The University of Melbourne, Melbourne, Australia, [6]Department of Physiological Nursing, University of California San Francisco, San Francisco, USA, [7]Department of Respiratory and Sleep Medicine, The Alfred Hospital, Melbourne, Australia

## Biography:

Assoc/Prof Disler is an Australian Research Council Discovery DECRA Fellow from Monash University. Through her research, she leads improvement in access to care and models of care for people living with advanced chronic disease, particularly in rural settings. Rebecca is funded by a prestigious ARC Fellowship to address end-stage chronic disease in rural Australia. As Fellow of the American and ANZ Thoracic Societies, Convenor of the Symptom Support and Palliative Care group for ANZ Thoracic Society, and as a Cochrane review author, her work has been included in several international and national guidelines, including NICE UK and global GOLD strategies.

## Abstract:

Background: Despite clear benefit from palliative care in end-stage chronic, non-malignant disease, access for rural patients is often limited due to workforce gaps and geographical barriers.

Aim: This study aimed to understand existing rural service structures regarding the availability and provision of palliative care for people with chronic conditions.

Methods: A cross-sectional online survey was distributed by email to rural health service leaders. Nominal and categorical data were analysed descriptively, with free-text questions on barriers and facilitators in chronic disease analysed using qualitative content analysis.

Results: 42 (61.7%) rural health services were included, most were public (88.1%) and operated in acute (19, 45.2%) or community (16, 38.1%) settings. 17 (41.5%) reported an on-site specialist palliative care team, primarily nurses (19, 59.5%). Nearly all services (41, 95.3%) reported off-site specialist palliative care access, including: established external relationships (38, 92.7%); visiting consultancy (26, 63.4%); and telehealth (18, 43.9%). Perceived barriers in chronic disease included: lack of specific referral pathways (18; 62.1%); negative patient expectations (18; 62.1%); and availability of trained staff (17; 58.6%). Structures identified to support palliative care in chronic disease included: increased staff/funding (20, 75.0%); formalised referral pathways (n=18, 64.3%); professional development (16, 57.1%); and community health promotion (14, 50.0%).

Conclusions: Palliative care service structure and capacity varies across rural areas, and relies on a complex, at times ad hoc, network of onsite and external supports. Services for people with chronic, non-malignant disease are sparse and largely unknown, with a call for the development of specific referral pathways to improve patient care.

# Parental Bereavement and Community within a Perinatal Palliative Care Setting

Ms Montana Allen[1], Ms Kelly Oldham[1]

[1]Hummingbird House, Brisbane, Australia

## Biography:

Kelly Oldham is a researcher at Hummingbird House.

## Abstract:

Current models for perinatal palliative care merge aspects from adult and child palliative care, such as pain relief and multi-sensorial comfort, combining these with additional emotional factors, such as maternal bonding and memory making. However, many models fail to capture the community aspect that Hummingbird House brings to perinatal palliative care and its influence on bereaved parents.

The purpose of the current research was to expand on existing perinatal palliative care models to include the important community aspect that Hummingbird House considers, as well as review parental experiences within a communal perinatal palliative care context. Empirical literature was sourced from Google Scholar and textbooks. Furthermore, immersion into the clinical and therapeutic service provided by Hummingbird House increased understanding and experience surrounding perinatal palliative care and parental bereavement within a community. In this case, immersion included conversations with grief and bereavement specialists in addition to palliative care specialists, observing clinical meetings and music therapy sessions, and attending a remembering ceremony held by Hummingbird House.

The final model described was flexible and holistic, able to be modified to fit individual parental experiences and desires. It included a community aspect to appeal to the ways in which parents and families grieve within different social contexts, as well as other important aspects such as integrative and comprehensive care. Future perinatal palliative care services may use this model as a guide for assisting parents and families both inside and outside the hospice facility, as it considers community to be a blanket that deeply influences bereavement.

# Pilot Study: The use of Virtual Reality (VR) Head Mounted Devices in Inpatients receiving Palliative Care

Mrs Rebecca Palmer[1], Doctor Paul Lam[1]

[1]Nepean Blue Mountains Local Health District, Blue Mountains, Australia

## Biography:

Rebecca Palmer has been a Registered Nurse for over 30 years.

Rebecca has worked in Supportive & Palliative Care in the hospital, hospice, outpatient clinic, and community setting.

Rebecca completed her Masters in Nurse Practitioner in 2020.

## Abstract:

Background: Patients admitted under palliative care often present to hospital due to escalating symptom issues and this may include loss of function due to disease progression.

These circumstances may prevent patients from travelling and visiting “bucket list” locations or from returning to places that have personal meaning for them.

Immersion in a virtual environment can improve wellbeing by providing the opportunity to virtually “visit” places important to the patient, enabling them to forget that they are in hospital, and a distraction from unpleasant symptoms.

Aim: To assess the feasibility of providing inpatients who are receiving palliative care with an enjoyable and novel experience using a VR Head Mounted Device.

To find out if there were common themes for places that this patient population would like to visit in VR.

Method: Recruitment of inpatients known to the Palliative Care Service with a life expectancy of < 12 months.

Patients’ experiences of time spent in VR recorded through qualitative semi-structured interviews. Symptom assessment before and after the VR experience using the Edmonton Symptom Assessment System – Revised Version (ESAS-R), but this study is not designed to be sufficiently powered for statistical significance.

Results: 8 out of 9 patients enjoyed the experience.

Patients requested either holiday destinations they had previously visited or “bucket list" places. The locations requested were very diverse.

Conclusion: It is feasible to use VR Head Mounted Devices to provide novel and enjoyable experiences for inpatients receiving palliative care.

A large content library is needed to cater to the diversity of patient preferences.

Future research should include studies that are sufficiently powered to assess for statistically significant impacts on symptoms.

# Saving the Subcutaneous Cannula Site

Mrs Grace Edwards[1], Mrs Natividad Miles[1]

[1]Sydney Local Health District, Camperdown, Australia

## Biography:

Grace Edwards works for the Sydney Local Health District.

## Abstract:

Calciphylaxis is a rare and poorly understood disease with a high morbidity and mortality rate. Currently there are no treatment guidelines with mortality 50% at 6 months. Calciphylaxis is more common in patients with end-stage renal failure where pharmacological pain management is difficult due to the high risk of toxicity.

Aims: To present our experience in pain and symptom management, highlighting the role of palliative care, kidney supportive care (KSC) and the multidisciplinary team in the care and management of these patients.

Methods: A case presentation of a patient with End-Stage Kidney Disease (ESKD) who was on haemodialysis and had a previous history of renal transplant. This patient had multiple risk factors for calciphylaxis and extended lengths of stay in hospital. The patient developed classic calciphylaxis wounds which progressed quickly. In addition to painful wounds, calciphylaxis patients develop numerous calcium deposits in the skin making the insertion and management of subcutaneous cannula difficult. As calciphylaxis patients deteriorate and require stronger opioids the maintenance of these subcutaneous sites is imperative to adequate symptom management.

Results: Calciphylaxis patients are complex and require a multifaceted approach to symptom management including the ongoing care of subcutaneous cannula sites. Input from the entire multidisciplinary team including KSC and palliative care is required ensuring patients receive safe and effective clinical care.

Conclusion: The combined efforts of the KSC and specialist palliative care teams resulted in good symptom management highlighting the need for a multidisciplinary and multifaceted approach to improve patient QoL. Early involvement of the KSC team or specialist palliative care can help address these issues in addition to providing advice on appropriate symptom and subcutaneous cannula management. It is important to emphasize that palliative care is not equivalent to EOLC, and that good advance care planning is crucial given the poor prognosis associated with calciphylaxis.

# What percentage of residents were identified as needing palliative care using the pacop profile tools

Bronwyn Arthur[1], Laura Bryce[1], Alanna Connolly[1], Stephen Moule[1]

[1]PACOP (Palliative Aged Care Outcomes Program), University of Wollongong, Wollongong, NSW Australia

## Biography:

Bronwyn Arthur works for the Palliative Aged Care Outcomes Program at the University of Wollongong.

## Abstract:

Calciphylaxis is a rare and poorly understood disease with a high morbidity and mortality rate. Currently there are no treatment guidelines with mortality 50% at 6 months. Calciphylaxis is more common in patients with end-stage renal failure where pharmacological pain management is difficult due to the high risk of toxicity.

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