

Oral Presentations

OP-1 **EXAMINING TELEHEALTH MODALITIES AND CONSULTATION INTERVENTIONS IN PALLIATIVE CARE: OUTCOMES FROM AN INNOVATIVE RAPID PALLIATIVE CARE IN REACH DIVISION (RAPID) PROGRAM DEVELOPED DURING THE COVID-19 PANDEMIC**

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Background Palliative care patients undergoing transitions between hospital and home settings encounter significant challenges. The Rapid Palliative Care In reach Division (RAPID) program was implemented to facilitate this transition during the COVID-19 pandemic. This study examines the utilisation of telehealth modalities and their associations with consultation interventions within the RAPID program.

Methods A retrospective clinical audit was conducted using electronic medical record data from patients seen by the RAPID palliative care service at Monash Health between October 2020 and March 2022. Data included patient demographics, Palliative Care Outcomes Collaboration (PCOC) phase, consultation modalities, and interventions initiated. Descriptive statistics were employed to summarise the demographic characteristics and statistical analysis included t-tests, chi square/Fisher tests, and Mann Whitney U tests where appropriate.

Results This study included 206 patients who collectively participated in 722 consultations, with 76.2% conducted via telephone, 18.6% via video, and 5.2% in person. Among them, 128 patients were from the Community cohort, involving 426 consultations, while 78 patients were part of the Hospital in the Home (HITH) cohort, with 296 consultations. Patients admitted to HITH exhibited prolonged lengths of stay and a heightened frequency of interventions compared to those discharged to community services. Notably, patients of non-English speaking backgrounds (NESB) exhibited a higher incidence for receiving video and in person consultations. The mean age of patients for video and telephone consultations was 69.4 years, while for in person reviews, it was younger at 64.1 years ($p=0.028$). Comparing video to telephone consultations revealed that video consultations were significantly more likely to involve the commencement or escalation of medications (41% vs 23%, $p<0.001$), alteration of management plans (26% vs 8%, $p<0.001$), provision of advice or education (28.4% vs 18.6%, $p=0.042$), and referrals to other healthcare providers (30% vs 17%, $p<0.001$). Subgroup analysis based on patients' PCOC phase at the time of consultation demonstrated significant differences in medication increases and altered plans for both the Stable and Deteriorating phases. Additionally, more referrals to other healthcare providers via video consultations were observed in the Stable phase compared to telephone consultations. However, no disparities in intervention frequency between modalities were noted in the Unstable and Terminal phases. Furthermore, the involvement of the RAPID program facilitated direct admissions to inpatient palliative care units for 10 patients and direct readmissions to medical units for 14 patients, thereby circumventing Emergency Department presentations.

Conclusion The RAPID program demonstrates the importance of specialised palliative care services in transitional care. While

telephone consultations predominated, video consultations were associated with higher intervention frequencies, especially for patients in the Stable and Deteriorating phases. Incorporating video components may enhance intervention rates however further research is needed to validate these findings and explore their impact on patient-specific outcomes, thereby optimising telehealth services in palliative care.

OP-2 **PALLIATIVE CARE NEED AND MANAGEMENT IN A TERTIARY AUSTRALIAN EMERGENCY DEPARTMENT**

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Background Patients frequently present to the emergency department (ED) in their last year of life; improving goal-directed care and symptom management for these patients is important to promote patient dignity and autonomy and to reduce costs to the healthcare system.

Aims To determine the current proportion of patients presenting to a tertiary ED who have palliative care (PC) needs, and rates at which key indicators of good PC, particularly goals of care (GOC) clarification and symptom management, are documented.

Methods A retrospective case note analysis was undertaken across five different weekdays between April and June 2023 at a single tertiary Australian ED. The electronic medical record for adult ED presentations was reviewed and patients with PC needs were identified using the Supportive and Palliative Care Indicators Tool [www.spict.org.uk] and other clinical indicators. Case notes of patients with PC needs were screened against objective measures of good PC in the ED.

Results 108 patients were identified with PC needs over five days (12% of adult presentations) - of these, 87 (81%) were admitted and one patient died in ED. A further 14% died during subsequent hospital admission and 46% within 6 months. Seventeen patients (16%) were known to specialist PC prior to presentation. Of admitted patients, 24% were referred to the PC consult team. None discharged from ED were referred despite there being no formal barrier to this.

Whilst 72% of all admitted patients had a resuscitation status documented, only 10 patients (9%) had a documented comprehensive GOC discussion. For those bedbound at baseline, aged 90+, and those deteriorating with cancer, 27%, 21% and 13% had this conversation documented, respectively. Of admitted patients in these groups, 5%, 37% and 44% had their ceiling of care lowered during admission.

Pain scores were documented by nursing staff for 86% of patients; 48% had any mention of pain in medical notes. A third of patients with ongoing pain scores ≥ 7 were markedly under-prescribed analgesia, with a median time of four hours to any opioid analgesia for those charted it. More than 60% of patients with regular background opioid and 50% with regular benzodiazepine missed at least one dose. Documented assessment and management of other symptoms was scant.

Fourteen patients had documented wishes that they were not for life prolonging measures. Six of these (43%) received life-prolonging measures, nine (64%) were admitted with an average length of stay of 7.2 days (range 1–16), with seven of these admitted patients (78%) being listed for medical emergency team calls.