

and 12/145 requiring recurrent intermittent urinary catheterisation. 60/145 patients had seizure plans, 13/145 had dystonia and agitation plans and 6/145 patients had hypothalamic instability plans. 55/145 admissions had an underlying mental health diagnosis.

Discussion Many patients admitted to the AYAH had a neurodegenerative or neurostatic condition with significant admissions for elective respite. 7 patients have died, all from cancer. This review highlighted the importance and availability of clinical psychology and psychiatry support given that 38% of our admissions had a mental health diagnosis. Nursing requirements between patients varied widely and could be very intensive. This information may be useful to those looking at setting up similar services in the future.

OP-30 A REASON TO LIVE: HOW ADOLESCENT AND YOUNG ADULT PALLIATIVE CARE MADE A YOUNG MAN A FIGHTER

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Background/Rationale The Manly Adolescent and Young Adult Hospice (AYAH) was developed by NSW Health to provide specialized support to adolescents and young adults (AYAs) aged 16–30 with life-limiting illnesses. This case review focuses on Bodhi, an 18-year-old transgender male with hereditary spastic paraplegia, who presented to AYAH for multiple admissions (Spray, 2024). The review explores the importance of multidisciplinary psychosocial involvement throughout palliative care and the progression towards end-of-life care. Bodhi and his family have provided permission to discuss his case to highlight the importance of AYA palliative care awareness.

Methodology Bodhi first presented to AYAH as a 17-year-old young man with significant low mood, emotional lability, a history of suicide attempts, and suicidal ideation. These concerns were exacerbated by physical symptoms of nerve pain and functional dystonia. He regularly ruminated on seeking Voluntary Assisted Dying (VAD) upon turning 18. To support Bodhi and his family, integration between community and inpatient care was essential for a seamless transition. Regular handovers and involvement in Bodhi's clinical formulation were reflected, discussed, and disseminated through weekly multidisciplinary meetings, which were then communicated to external facilities.

Impact on Practice The psychological case review was conceptualized using a Contextual Schema Therapy framework, an integrative model combining aspects of cognitive, behavioural, and psychodynamic therapies to identify gaps in Bodhi's care. The identified gaps were:

1. Poor pain management
2. Significant existential distress
3. Distress around themes of feeling 'defective.'

These concerns were gradually addressed during Bodhi's respite and symptom management admissions through a combination of medical and psychosocial interventions.

Psychological input focused on addressing individual existential distress using tools such as Voicing My Choices (Samson-Daly et al., 2023). The Clinical Psychologist utilized

Acceptance and Commitment Therapy (ACT) to help Bodhi identify goals and accomplish bucket list tasks. Coordination between AYAH Clinical Psychology, social work, psychiatry, and grief counselling ensured a seamless transition of care and provided Bodhi and his family with a sense of purpose as his disease progressed.

Discussion (Lessons Learned, Future Direction) This case illustrates the importance of addressing both physical symptoms and psychological distress within AYA palliative care. By developing a relationship with Bodhi through multiple admissions, he was able to reframe his psychological distress and gain a sense of agency over his medical condition. As a result, Bodhi declined pursuing VAD and chose to die peacefully at home with the support of community palliative care. His legacy continues through his surviving family.

REFERENCES

1. Spray T. (2024, March 19). Hospice helping the young. *North Side Living*. <https://northsidelivingnews.com.au/milestone-for-hospice/>
2. Samson-Daly UM, Zhang M, Evans HE, McLoone J, Wiener L, Cohn RJ, Wakefield CE. Adapting the voicing my choices advance care planning communication guide for Australian adolescents and young adults with cancer: appropriateness, acceptability, and considerations for clinical practice. *Cancers* 2023;15(7):2129.

OP-31 PALLIATIVE MEDICINE IN AUSTRALIA AND NEW ZEALAND: THE BIRTH OF A NEW DISCIPLINE

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Background Contemporary Palliative Care arose in the mid-20th century, initially in the UK, in response to health care that was increasingly aimed at treatment and cure, but with a correspondingly decreasing focus on addressing patient and family suffering, particularly at the end of life. In Australia and New Zealand, Palliative Care Services developed later; Palliative Medicine was only formally recognized as a specialist discipline in the early 2000's.

My PhD research explores the social history of these developments through the experiences and insights of the first cohort of doctors designated as Palliative Medicine Specialists by the Royal Australasian College of Physicians (RACP).

Study objectives

1. Document the experiences of the first cohort of doctors, the RACPs 'Foundation Fellows', who became Palliative Medicine Specialists in Australia and New Zealand.
2. Analyze and interpret the social history and development of Palliative Medicine in Australia and New Zealand.
3. Seek an informed insight into what might be of most benefit for the future of palliative practice in a rapidly changing health care and social environment.

Methods Narrative Inquiry, consisting of an Electronic Survey posted to all RACP Foundation Fellows, and a series of 25 Narrative Interviews conducted in person or via Zoom, and analyzed inductively according to Narrative Methodology.

Results Survey response rate 39%, of whom 58% agreed to be interviewed.

Analysis of demographic data.

Exploration of interviewees' motivations, their values, and their struggles and achievements.

Developing a narrative of discipline development for Palliative Medicine.

Implications The discipline is still in a relatively early stage of its development and integration within the health care system. The social world in which it does its work is changing, with new needs and challenges continually reshaping the health care landscape.

The research delineates those values and practices which remain important and should be retained to benefit future palliative practice.

OP-32

SUPPORTING CHOICE FOR END-OF-LIFE CARE AT HOME: A THREE-YEAR REVIEW OF THE RESPONSIVE ACUTE PALLIATIVE INTERVENTION AND DECISION ASSISTANCE (RAPID ASSIST) PROGRAM

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Background Many Australians report a preference for end-of-life care at home however, due to both individual and system barriers, often only a small proportion can safely do so.¹ The RAPID Assist program² was established in 2016 to meet the urgent palliative care needs of community patients by facilitating timely support in the home environment. The model consists of a multidisciplinary outreach service, covering a 30km radius of the health services precinct in Parkville Victoria, providing acute specialist palliative care.

Objectives To evaluate the efficacy of the RAPID Assist program in providing timely, coordinated care to support people to die at home.

Methods The RAPID Assist program operates during business hours, delivering care via home visits (residential aged care facilities (RACF) and private residences), telehealth and in-hospital consults. The team comprises clinical nurse consultants, an occupational therapist, and palliative medicine specialists. Collaborative partnerships with Hospital in the Home (HITH), Residential InReach (RIR) and Community Palliative Care services (CPCS) enhance coordination and continuity of care. Data was collected prospectively for patients referred to RAPID Assist between March 2021 and March 2024. Cohort demographics, referral sources/reasons, nature of interventions, community service linkage and outcomes are reported descriptively.

Results During the study period, 988 people were referred to the RAPID Assist program with 804 referrals accepted and reviewed by the service. The main referral sources were HITH and RIR (53.5%) with a large proportion for residents in aged care facilities (66.8%). The primary cause of deterioration on referral was predominantly due to non-malignant causes (60.5%). The primary indications for referral were symptom management (38.5%) and admission to CPCS (29.5%). Most referrals (61.8%) received a same day review, delivered mainly via face-to-face consultation (61.9%) providing multifaceted interventions, and with an average of 1.4 contacts per referral. Most people (78%) indicated a preference to die at home, either in their RACF (61.7%) or private residence (16.3%), and of the 723 who are known to have died during the study period, 77.0% died in their preferred location. Service demographics and outcomes are provided in Table 1.

Discussion The results support RAPID Assist as an effective service model enabling more people living with advanced illness with complex and urgent palliative needs to remain at home. Further research is needed to assess patient and caregiver experience, psychosocial needs, and quality of life.

Conclusion RAPID Assist is an effective service providing timely and coordinated support to optimise hospital-to-home transitions and meet the urgent palliative care needs of patients in the community, to allow more people to die in their place of choice.

REFERENCES

1. Pinto S, Lopes S, de Sousa A, Delalibera M, Gomes B. Patient and family preferences about place of end-of-life care and death: an Umbrella Review. *Journal of Pain and Symptom Management* 2024;**67**(5):e439-e452.
2. Le BH, Marston C, Kerley C, Eastman P. Facilitating the choice of dying at home or in residential care with the implementation of a palliative care rapid response team in a cancer centre and general hospital. *Palliat Med.* 2019 Apr;**33**(4):475–476.

OP-33

CONSTRUCTING A QUEENSLAND PALLIATIVE CARE RESEARCH TELETRIAL NETWORK

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The recent establishment of the Australian Teletrial Program, funded by the Australian Government, facilitates the creation of trial clusters, with regional, rural, and remote sites connected to an urban primary research site via telehealth. In April 2024 the first Australian palliative care research teletrial network became active in Queensland, providing access to clinical trials for symptom control in advanced disease to all Queenslanders regardless of location. This transforms the scope of clinical trials and reduces health inequity.

A strategic implementation framework was used to construct the network, with a focus on collaboration and resource acquisition. Partnerships were established with relevant stakeholders such as the Queensland Regional Clinical Trials Coordinating Centre. Ethics and governance approval, grants, care pathways, supervision plans for research nurses, trial drug, and couriering services were obtained or created. Clinical Trial Research Agreements were negotiated with each of the fifteen Queensland Hospital and Health Services (HHS's). The first of these was signed in April 2024, allowing the teletrial network to operate in the Queensland Central West HHS. Several more HHS's will shortly become active, with a goal of eventually involving all Queensland HHS's. Ongoing training, mentoring and support is provided.

Currently the network is being used to recruit to a clinical trial of medicinal cannabis for the relief of symptoms in patients with advanced cancer. Interested patients are referred by their usual palliative care team and, if eligible, participate in telehealth reviews in their home or at their local health service over a four-week period. Patients, carers, clinicians, and researchers are being invited to participate in qualitative research assessing the barriers, challenges, and experience of the teletrial network.

The successful construction of a Queensland palliative care research teletrial network has presented challenges due to geographical distance, the involvement of multiple health services