

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.

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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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10.1136/spcare-2024-ANZSPM.32

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

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CONSTRUCTING A QUEENSLAND PALLIATIVE CARE RESEARCH TELETRIAL NETWORK

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10.1136/spcare-2024-ANZSPM.33

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