

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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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.

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OP-33

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

and organisations, and local resource constraints. The difficulties that we have encountered, and the strategies that we have employed to resolve them, act as a model that other states and services can use in constructing their own teletrial network. Additionally, the qualitative data that we are collecting concerning stakeholder experience of the teletrial network will guide future use and ensure its sustainability, thereby transforming the scope of clinical palliative care trials in Queensland and reducing health inequity.

OP-34 EMPOWERING END-OF-LIFE CHOICES: FIVE YEAR EVALUATION OF AN INNOVATIVE MODEL OF INTEGRATED PALLIATIVE CARE FUNDED BY A PRIVATE HEALTH INSURER

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10.1136/spcare-2024-ANZSPM.34

Background Recognising patients' preferences and enabling them to die in their preferred place is a critical aspect of effective palliative care delivery. It is crucial to recognise that not all patients wish to die at home. Everyone's end-of-life preferences are unique. Therefore, the decision about where to receive end-of-life care should be based on the patient's individual preferences and needs, made in consultation with healthcare providers and carers.

Objectives The primary aim of this study was to evaluate whether patients in the Bupa Palliative Care Choices Program (BPCCP) at St. Vincent's Private Hospital Brisbane (SVPHB) achieved their preferred place of death over five years. Secondary aims included assessing patient and carer satisfaction with the support provided by BPCCP in achieving these preferences.

Methods This study employed a single-centre, prospective cohort design and surveyed patient and carer experiences. The study population included patients admitted to the SVPHB Community Specialist Palliative Care Service (CSPCS) from August 1, 2016, to July 31, 2021, who were eligible for BPCCP (prognosis of six months or less and were insured under Bupa Private Health Insurance).

Data on the patients' demographics, preferred place of death, and actual place of death were collected from electronic patient records. Patient and carer satisfaction was measured using the FAMCARE-2 survey, a validated tool assessing satisfaction in symptom management, information provision, family support, and psychological care.

Results A total of 779 patients were admitted to BPCCP over the five-year period. The cohort had a median age of 77 years, with 50.3% male, 49.7% female. The majority (81.3%) had malignant diseases, predominantly lung cancer, while 18.7% had non-malignant conditions such as cardiovascular disease. Out of the 608 patients who died during the study period, 39.5% died at home, 40.1% in an inpatient palliative care unit, and 20.4% in an acute hospital setting. Of the 558 patients who stated a preferred place of death, the majority of BPCCP participants preferred to die at home (53%), and overall, 85.7% achieved their preference. Specifically, 79.0% of those who preferred to die at home, 91.5% who preferred to die in an inpatient palliative care unit, and 100% who preferred an acute inpatient setting achieved their goal.

Discussion The study found that 85.7% of BPCCP participants died in their preferred place, indicating a high level of success in aligning end-of-life care with patient preferences. Common barriers to achieving the preferred place of death included acute medical events, active treatment requirements, carer stress, and sudden deterioration. The high satisfaction rates from the FAMCARE-2 survey highlighted the program's effectiveness in managing symptoms, providing information, and supporting families and caregivers.

Conclusion The BPCCP demonstrated the potential to significantly improve access to high-quality palliative care and support patients in achieving their end-of-life preferences. The program's success underscores the importance of integrated care models and partnerships between healthcare providers and private insurers to facilitate patient-centred end-of-life care. Future research should explore similar models across different regions and settings to further validate these findings and improve palliative care delivery.

OP-35 DESCRIPTION OF AN EARLY, INTEGRATED PALLIATIVE CARE CLINIC FOR PATIENTS WITH SYSTEMIC SCLEROSIS AND THEIR CAREGIVERS

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10.1136/spcare-2024-ANZSPM.35

Background Systemic sclerosis, also known as scleroderma, is a complex, multi-organ disease which causes substantial and progressive fibrosis of the skin and internal organs, including the heart and lung. It is an uncommon disease, associated with early onset of significant and persistent symptoms, impaired quality of life, and shortened lifespan. International guidelines recommend early, integrated palliative care for patients with advanced cardiopulmonary disease such as heart failure, and interstitial lung disease, as this care can improve patient, caregiver and health care outcomes. However, there is no evidence examining the role of palliative care in systemic sclerosis. St Vincent's Hospital Melbourne has piloted a clinic of early, integrated palliative care for patients with advanced systemic sclerosis.

Aim This study aims to describe the model of care provided within the clinic, by describing the tasks completed by the palliative care physician for each patient over the course of their palliative care reviews.

Methods This pilot program was conducted at St Vincent's Hospital Melbourne. Triggers for referral to the clinic included patients with a high symptom burden, physician-perceived poor prognosis, or who requested advance care planning or future care discussion. Descriptive data quantified the care provided at each review.

Results Between 06/07/23 and 16/05/24 twenty-four patients received 51 clinic reviews (61% face to face, 31% phone, 8% telehealth). Nineteen patients identified a primary caregiver, and caregivers attended 22/51 (43%) of reviews. The median patient age was 67 years (range 19–87), and 58% were female. 54% of patients had diffuse disease subtype, with the median time since systemic sclerosis diagnosis 9.5yrs (range 0–40). Most patients had limited function, with a median Australia-modified Karnofsky Performance Status of 60 (range 40–80). Non-pharmacological symptom management was discussed with 83% of patients, and