

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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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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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

pharmacological management in 88%. A change in disease directed management was enacted for 46% of patients, while 42% of patients were referred for further investigation(s). Psychosocial/spiritual assessment and support was provided for 96% of patients. Discussion of formal community supports was common (71%), with 46% of patients requesting referral for supports. Serious illness communication was offered to all patients and accepted for diagnostic/illness discussion by 88% of patients, while 58% engaged in a prognostic discussion. The majority of patients had an advance care planning discussion (83%); 38% of patients completed an advance care directive, 46% completed a medical power of attorney, and 8% had a voluntary assisted dying discussion. Interdisciplinary discussion was prominent, with 83% receiving informal multidisciplinary discussion, and 33% formal multidisciplinary discussion. 17% of patients accessed palliative care unit for admission, while 29% were under community palliative care, and two (8%) patients died.

Discussion This is first integrated palliative care clinic for systemic sclerosis described internationally. This clinic provided attention to symptom management alongside interdisciplinary discussion, and disease orientated care. Patients accepted the opportunity to discuss their illness and plan for their future. Further research is planned to evaluate the outcomes of the clinic, and understand the patient, caregiver and health care perspectives of this model of care.

OP-36 VOLUNTARY ASSISTED DYING (VAD) AND PALLIATIVE CARE IN QUEENSLAND

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Introduction Voluntary assisted dying (VAD) became enacted in Queensland January 1st, 2023. VAD gives eligible people diagnosed with life-limiting conditions, who are suffering intolerably and dying, an additional end-of-life choice allowing them to choose the timing and circumstances surrounding their death. Implementation is still in an iterative phase and there is much to learn: baseline demand is unknown and the relationship between VAD and palliative care services is embryonic. These and other considerations need careful research to ensure optimal outcomes for those seeking VAD, their significant others and related services' development. The Queensland VAD Support and Pharmacy Service (QVAD SPS) was established to support all eligible Queenslanders seeking VAD and those involved in their care. This presentation concerns aspects of the activity of QVAD SPS.

Aim To commence exploration of VAD in Queensland and the volume of VAD patients simultaneously accessing Specialist Palliative Care Services (SPCS).

Methods 2023 data related to numbers of individual VAD enquires, patients requiring linkages to local VAD Authorised Practitioners (APs), statewide prescriptions received and dispensed and numbers of APs writing prescriptions were extracted from the QVAD SPS REDCap data repository. A prospective consecutive case series of patients referred to the Director QVAD SPS between 3/01/2023 and 8/05/2024 was conducted. Deidentified data including patient demographics, public/private health status, eligibility for VAD and SPCS involvement were collected as was feedback regarding the

relationship between palliative care and VAD services. Quantitative data were analysed using descriptive statistics.

Results In 2023, QVAD SPS assisted with 3,835 individual enquires; 62% from people seeking information or referral for VAD: 153 Queenslanders were unable to access an AP through their local area and were assisted by QVAD SPS.

QVAD SPS dispensed 888 prescriptions (O961 received), equating to 36% higher activity than was modelled: over 1/3 of requests (302) were for immediate supply; 89% of self-administration substance deliveries and 94% of practitioner administration substance deliveries occurred on the requestors' preferred date or sooner. At end 2023 there were 181 APs: 25% had written 93% of VAD prescriptions, 98 have never prescribed.

The case series comprised 97 patients: median age 71 years (range 28- 90), 38 females, 35 resident in the South-East corner of Queensland, all eligible for VAD and nearly 80% (77) were current SPCSs' patients. Feedback indicated that the relationships between SPCS and VAD services were non-standardised.

Discussion In Queensland the demand for VAD is increasing and has surpassed modelled expectations, especially in regional areas. Further, while the number of trained APs is relatively high, the active workforce is limited, which may impact accessibility in the future. Interestingly, although the case series only relates to a single AP, it appears many patients are linked with SPCSs at the time of referral for VAD.

Importantly, the relationship between VAD services and SPCSs is not yet standardised. Potentially, this can lead to inequity for palliative patients wishing to access VAD, communication challenges between patients and service providers and carer stress before and after a VAD death.

OP-37 THE ROLE OF SPECIALIST IN-REACH TEAMS IN PROVIDING PALLIATIVE CARE: THE IMPART (IMPROVING PALLIATIVE CARE IN RESIDENTIAL AGED CARE USING TELEHEALTH) TRIAL

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Background Residential aged care facilities (RACFs) are high-mortality settings and the provision of high-quality palliative and end-of-life care is crucial for residents due to their limited life expectancy, medical comorbidities, frailty and complex care issues.

Residential In-Reach programs (RIR) provide care, consultation, referral, education and support for clients and care providers in RACFs. They assist staff to develop their clinical skills and knowledge, and ensure care is delivered at the right place and time, thereby helping to prevent avoidable hospital presentations. They provide expertise in many aspects of care, including palliative/end-of-life support and advance care planning.