OP-39 ENHANCING AND STRENGTHENING PALLIATIVE CARE SUPPORT IN RESIDENTIAL AGED CARE HOMES: THE RESPONSIVE ACUTE PALLIATIVE INTERVENTION AND DECISION ASSISTANCE (RAPID ASSIST) SERVICE

[1]Saskia-Aisha Marguccio*, [1,2]Kristie Ballagh, [1,3]Brian Le, [1]Andrea Jordan, [1]Patricia Perez, [1]Amy Noble, [1,3,4]Aaron B Wong. *[1]Parkville Integrated Palliative Care Service (Royal Melbourne Hospital and Peter MacCallum Cancer Centre), Parkville, Australia; [2]Barwon Health, Geelong, Australia; [3]Department of Medicine, University of Melbourne, Parkville, Australia; [4]Austin Health, Heidelberg, Australia*

10.1136/spcare-2024-ANZSPM.39

Background Residential aged care facilities (RACF) have high mortality rates, yet multifaceted challenges, including complexity of clinical needs, care fragmentation, staffing capacity and access to palliative care supports, impact on the quality of palliative and end of life care in this setting.[1] Timely palliative care engagement plays an integral role in reducing avoidable and unwanted hospital admissions, improving quality of life, and supporting preference-based care. Established in 2016, Responsive Acute Palliative Intervention and Decision Assistance (RAPID Assist) is an outreach service which aims to provide timely and responsive specialist palliative care support to bridge care gaps/transitions, address the urgent palliative care needs of RACF residents and establish timely linkage with community palliative care services (CPCS) to assist continuity of care.[2]

Objective To evaluate the effectiveness of RAPID Assist in providing aged care residents with palliative care in their preferred location, through analysing referral response/interventions, outcomes of service and congruence between preferred and actual place of death.

Methods A prospective cohort study of RACF residents referred to RAPID Assist between March 2021 and March 2024. Data was collected prospectively from electronic medical records and analysed descriptively.

Results Over the three-year period, RAPID Assist received and accepted 610 referrals (594 individual residents). Most residents referred were female (62.3%), and less than half (40.4%) were from culturally and linguistically diverse backgrounds. The main source of referrals was from outreach services (75.6%), with 60.8% of referrals reviewed on the same day. Service characteristics and outcomes are provided in table 1. The leading causes of deterioration upon referral were sepsis (28.2%) and dementia (17.5%). The most common referrals were for symptom control (50%) and to facilitate admissions to CPCS (27%). Five hundred and forty-one residents are known to have died following RAPID Assist review and most were able to die in their preferred location (87.8%). RAPID Assist facilitated 296 CPCS admissions, prevented 58 hospital presentations, aided 433 residents with symptom management and expedited 58 discharges from hospital over the 3-year period.

Discussion These results show that RAPID Assist provides a timely and effective intervention to bridge care transitions from hospital and in the community to address urgent palliative care needs of RACF residents. Despite the complex dynamic RACF environment, the service enables more residents to receive care and die in their location of choice. Exploring the experience and support of RACF staff and families may impart insights to enrich service delivery.

Conclusion Rapid Assist is a beneficial service that aids RACF residents in accessing timely palliative care to meet urgent

Abstract OP-39 Table 1 RAPID assist service demographics and outcomes

	2021–2024
Total Residents Referred and Accepted, N	594
Age (years), mean (SD)	88.0 (8.5)
Sex, N (%)	
Male	224 (37.7)
Female	370 (62.3)
Culturally and Linguistically Diverse, N (%)	
Yes	240 (40.4)
No	352 (59.3)
Unknown	2 (0.3)
Referral Source, N (%), Total Referrals to RAPID Assist = 610	
Hospital in the Home/Residential	461(75.6)
InReach†	54 (8.9)
Residential Aged Care Facility	1 (0.2)
Community Palliative Care Service	6 (1.0)
GP Family	1 (0.2)
Palliative Care Consult Team	25 (4.1)
Palliative Care Unit	8 (1.3)
Other Inpatient Units	33 (5.4)
Outpatient clinics	6 (1.0)
Other	15 (2.5)
Cause of Deterioration on Referral, N (%)	
Sepsis	172 (28.2)
Dementia	107 (17.5)
Cancer	79 (13.0)
Cardiovascular Disease	47 (7.7)
Other	205 (33.6)
Average Number of Contacts per Referral, N (range)	1.3 (0–6)
Primary Reason for Referral, N (%)	305 (50.0)
Symptom Management	165 (27.0)
Admission to Community Palliative Care Service	50 (8.2)
Clarification of care goals/planning	1 (0.2)
Admission Prevention Expedited	20 (3.3)
Discharge Family Distress	38 (6.2)
Follow-Up	14 (2.3)
Settling Visit	5 (0.8)
Psychosocial Support	5 (0.8)
Other	7 (1.1)
Outcome of Intervention*, N	432
Symptom Management	296
Expedited Community Palliative Care Admission	216
Clarified Advanced Care Plan/Goals of Care	124
Hospital Related Intervention	*58*
Hospital Presentation Prevented	*58*
Hospital Discharge Expedited Palliative Care Unit Admission Transfer to Emergency Department	*6* *2*
Preferred Place of Death, N (%)	
Residential Aged Care Facility	542 (91.2)
Hospital	8 (1.3)
Unknown	44 (7.4)

Actual Death Location, N (%)	
Residential Aged Care Facility	498 (92.1)
Palliative Care Unit	12 (2.2)
Other Hospital (Other inpatient units or hospitals)	2 (0.4)
Unknown	29 (5.4)
Congruence between Preferred and Actual Death Location, N (%)	
Yes	475 (87.8)
No	12 (2.2)
Unknown	54 (10.0)

*Each referral may have >1 outcome of intervention addressed by the RAPID service.
†Hospital outreach services: Hospital in the home is a bed-substitution model providing acute care in the home.
Resident InReach is a short-term consultative specialist service providing acute outreach support to residents in RACF.

needs, optimise outcomes, and ultimately supports residents to receive care and die in their preferred location.

REFERENCES

1. Rawlings D, Damarell R, Chakraborty A, Devery K, Tieman J. Rapid review of the literature on end-of-life care in aged care and community settings. Sydney: ACSQHC; 2022.
2. Le Brian, 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. *EAPC*. 2019;**33**(4).

OP-40 IMPROVING LINKS BETWEEN RESIDENTIAL IN REACH AND COMMUNITY PALLIATIVE CARE TO PROVIDE OPTIMAL CARE TO RESIDENTIAL AGED CARE RESIDENTS

[1,2,3]Scott Reeves*, [4]Yvonne Cartwright, [4]Zi Yi Low, [1]Lisa Candia. [1]*Banksia Community Palliative Care, Melbourne, Australia*; [2]*Monash Health, Melbourne, Australia*; [3]*Monash University, Melbourne, Australia*; [4]*Northern Health, Melbourne, Australia*

10.1136/spcare-2024-ANZSPM.40

Background Both Residential In Reach (RIR) and Community Palliative Care (CPC) are involved in the provision of end-of-life and symptom-based care for Residential Aged Care (RACF) patients, however, it is not always clear which service is best placed to provide care in a specific situation. Banksia CPC provides specialist palliative care services to residents of the Northeast suburbs of Melbourne. Northern Health RIR provides specialist RIR services to RACFs in an overlapping region. Confusion in which service to call may result in duplication of care, or delayed access to the most appropriate care. Our project aimed to transform existing models of care to improve palliative care provision for our joint patient cohort.
Methods We developed a multiple intervention strategy to improve the service integration of the Northern Health RIR and the Banksia CPC teams to optimise care of deteriorating patients in our region. This included, 1) Regular meetings between RIR and CPC staff to discuss referrals and any clinical concerns, and 2) a simplified referral document for utilisation where RIR are involved, to streamline referral to CPC. It also included direct interventions within our local RACFs such as, 1) A flow chart for RACF staff to understand which service is most appropriate to call in the event of a deterioration, and 2) Joint palliative care needs rounds – attended by both RIR and CPC which focused on supporting RACF staff in identifying patients in need and ensuring appropriate service referral.
Results During our initial project period, 66 patients were jointly managed. We found that regular meetings created clinical relationships which enabled discussion of complex clients to identify the best service provider. We conducted 6 joint palliative care needs rounds which identified deteriorating patients prior to crisis situations and allowed conversation between the two services to determine the appropriate action and gain the best outcomes.
Discussion We observed an increase in referral of patients with specialist palliative care needs from RIR to CPC. RIR and CPC provide complementary but discrete skillsets. Whilst RIR offers a rapid response to acute decline, prescribing of medications and goals of care discussions in the palliative space, it lacks capacity for ongoing palliative support. CPC provides specific palliative management, including emotional and psychosocial support for residents, their families and the ACF staff, and oversight of complex palliative symptoms, requiring interventions such as continuous infusions (syringe drivers).

Our project challenges traditional models of care, to improve care provision and broaden access to palliative care services. Through collaboration between RIR and CPC, we continue to explore strategies to identify deteriorating patients in RACF proactively, to enable prompt delivery of clinical care. Following this project, Both Northern Health and Banksia are exploring similar collaborations with our other regional partners.

(Approval was gained from NH Research Department for presentation of this data.)

OP-41 DELIVERING END-OF-LIFE CARE IN RESIDENTIAL AGED CARE FACILITIES – HOW CAN GPS WORK ALONGSIDE SPECIALIST PALLIATIVE MEDICINE PROVIDERS TO OPTIMISE CARE DELIVERY?

Jordan Crawford*, Atish Manek, Grant Russell. *Monash University Department of General Practice, School of Public Health and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Melbourne, Australia*

10.1136/spcare-2024-ANZSPM.41

Background Australia has an ageing population. Older Australians frequently require medical services in their later years, including palliative care at end-of-life. Previous studies have illustrated that the role of the general practitioner (GP) in a community palliative care setting can require considerable coordination.[1] It may also be associated with high levels of uncertainty as GPs must navigate who is responsible for providing various aspects of care for an older person.[1] For individuals aged 85 years and older, residential aged care facilities (RACFs) are the most common place of death, a setting in which GPs already provide the majority of primary care services.[2 3] There is therefore, increasing need for an interdisciplinary model of palliative care delivery, where GPs provide end-of-life care alongside community and hospital-based palliative care services.[4] Despite growing demand for such service delivery, little is currently known about the experience of Australian GPs working in this setting, and the way they interact with other services when delivering end-of-life care to RACF residents.
Aim/Objectives The aim of this project is to better understand the way in which GPs deliver end-of-life care in the RACF setting. It also aims to explore GP's interactions with