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

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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?

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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