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.

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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

community or hospital-based palliative medicine services, and opportunities for future service development.

Methods This study is currently in progress. It follows a qualitative study design, using a phenomenological approach to data collection and analysis. The study is set within RACFs in metropolitan Melbourne. GPs responsible for providing end-of-life care to patients within RACFs are to be recruited, and will each participate in a semi-structured interview. Interviews will be audio-recorded, transcribed and coded using NVivo. Data analysis will be conducted iteratively through a constant, comparative approach until thematic saturation is achieved.

Findings Recruitment and data collection are currently underway and will be completed by July. Preliminary findings will be presented.

Implications It is expected that findings from this research will highlight the current experiences of Australian GPs delivering end-of-life care to older Australians living in RACFs. Results will illustrate the ways in which GPs interact with various services, including community and hospital palliative care teams in order to provide quality end-of-life care within RACFs. Study findings may also indicate opportunities for service optimisation, with a view to cultivating high quality and effective palliative care services for Australia's ageing population in future.

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OP-42 INCIDENCE AND OUTCOMES OF FALLS IN AN INPATIENT PALLIATIVE CARE UNIT: A SINGLE-CENTRE RETROSPECTIVE STUDY

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Background Falls are the leading cause of hospitalisation and death due to injuries in Australia. Amongst hospitalised patients, falls are the most common safety incident and cause substantial concern among staff and families. Current Best Practice Guidelines for preventing falls in older people in Australian hospitals do not specifically address falls in palliative care settings. Identifying and managing falls risk in palliative care is crucial for maintaining healthcare standards and ensuring patient safety and quality of life.

Objectives The primary aim of this study was to determine the incidence of falls in an inpatient palliative care unit over a one-year period. Secondary aims included determining the outcomes of falls, characteristics of patients with falls, and the fall prevention interventions utilised.

Methods This retrospective cohort study examined falls by palliative care patients admitted to a 40 bed metropolitan palliative care inpatient unit (IPU) over a 12-month period. Falls were identified using the online incident reporting system and patient characteristics, falls risk assessment and prevention measures was obtained through the electronic patient records.

Results A total of 525 individual patients were admitted to the IPU for 613 episodes of care, representing 10,536 bed days. There were 61 falls by 51 individual patients, yielding an incidence of 9.7 and the rate of falls was 5.8 falls per 1000 bed days for all admitted patients.

Falls occurred throughout the day, with more falls between midnight and 08:00. Most falls (93%) were unwitnessed. Half of the falls resulted in no injury, while the most common injuries were skin tears/abrasions and haematomas. Serious injuries such as fractures occurred in 1.6% of falls. Of the patients who fell, 41% died within one week post-fall.

Falls risk assessment was completed for 97% of patients at the time of the fall. Fall mitigation strategies were in place for 93% of falls, including bed rails, alarms, increased observation, education, assistance with toileting, and grip socks. Six falls (10%) involved patient refusal of fall mitigation strategies.

Discussion The fall rate in the IPU was 5.8 falls per 1000 bed days, the lowest reported for inpatient palliative care units. Compared to similar studies, this study had a large sample size and provided comprehensive data on falls incidence, prevalence, and rates. Most falls did not result in serious injury, and falls prevention strategies were widely implemented. However, the refusal of mitigation measures by some patients highlights the need for interventions that respect patient autonomy and dignity.

Conclusion This study provides valuable insights into falls in inpatient palliative care units, reporting an incidence of 9.7% and a rate of 5.8 falls per 1000 bed days. Falls prevention strategies must balance patient autonomy with safety and quality of life. Further research is needed to assess the effectiveness of interventions and gather patient and staff perspectives on falls prevention in palliative care settings.

OP-43 LIVER SUPPORTIVE CARE – AN EMBEDDED SERVICE FOR CIRRHOTIC LIVER DISEASE AND HCC

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'Liver Supportive Care' is a multidisciplinary approach that integrates palliative care into the multidisciplinary team involved in the management of chronic liver disease, in order to improve the care of patients with chronic, end-stage liver disease with palliative care needs.

There is a growing body of evidence to support the integration of palliative care for patients with the growing burden of chronic liver disease and related complications, in particular patients with End Stage Liver Disease. Available evidence dictates that integration of health specialties with palliative care is associated with improved health outcomes including improved quality of life, quality of life care, decreased rates of depression, improved understanding of illness and improved patient satisfaction.[1-3]

We describe a new, embedded model of care at St George Hospital, Sydney. Patients who meet referral criteria (based on modified-SPICT criteria) with cirrhotic liver disease and/or HCC without curative intent, are referred to the Liver Supportive Care service. This encompasses a co-located clinic each week, with a Multi-Disciplinary team approach involving a