do not meet the referral criteria for a specialist palliative care service.

I would present on the shared care GP-NP clinic we have established, specializing in Aged Residential Care. With our daily practice dealing with dementia using a palliative care lense, we can improve patient outcomes and family experience. .

Summary This presentation will talk directly to advancing palliative care practice outside of the hospice setting, to improve the outcomes for the patients and populations we serve. It will be thought provoking and motivating to encourage a desire to grow our practice.

P-7 DEVELOPMENT OF A BEREAVEMENT SUPPORT MODEL AT AUSTIN HEALTH

Sarah Charlton*. *Austin Health, Heidelberg, Australia*

10.1136/spcare-2024-ANZSPM.55

Bereavement support encompasses the experience of family members and friends on a continuum, including the anticipatory, expectant, death and post-death periods. It is an essential element of high-quality end of life care (DHHS, 2016). Austin Health cares for approximately 1400 people per year who die as inpatients. We thank the North and West Palliative Care Consortium for funding this initiative.

We have developed an evidence-based bereavement support model to ensure a systematic approach to identifying and supporting the bereavement of families and carers of Austin Health patients. The model has a focus on sustainable bereavement support utilising existing resources (including community palliative care services when available) and targeting clinical resources to those in most need. The model includes a bereavement risk assessment tool, consumer resources, and the use of the validated Brief Grief Questionnaire (Shear et al., 2005). Consumers were an integral part of the steering committee.

Prior to death, the Bereavement Risk Assessment tool identifies factors contributing to both resilience and risk (based on Neimeyer et al., 2012). At the time of death, the patient's next of kin is allocated to either 'universal' or 'specialist' follow-up. Usual psychosocial assessment and care is provided at all times.

All next of kin are sent a bereavement card, hand-written and posted by volunteers, with information on supports available.

The specialist stream adds a telephone call to the next of kin from a trained clinician (most commonly a social or spiritual care worker) at about 12 weeks post death. At this point, the Bereavement Risk Assessment is repeated.

If ongoing risk of complicated grief is identified, a further telephone call is undertaken at 6 months. The Brief Grief Questionnaire is then used to formally screen for complicated grief. Usual psychosocial care is provided at both these time points, but if more support is required then the person is advised to seek external supports as appropriate, for example via their general practitioner.

The model has been implemented on the Palliative Care Unit and is being scaled up across the hospital. It has been well received by staff and bereaved families.

REFERENCES

1. Department of health and human services (DHHS) 'Victoria's End of Life and Palliative Care Framework A guide for high-quality end of life care for all Victorians'; 2016.
2. Shear K, Frank E, Houck PR. Treatment of complicated grief: a randomized control trial. *The Journal of the America Medical Association* 2005;**293**(21):2601–2608.
3. Neimeyer RA, Burke LA. Complicated grief and end of life: risk factors and treatment considerations. In counselling clients near the end-of-life. J.L. Worth (ed.), pp.205–224. New York: Springer Science.2012

P-8 IMPLEMENTATION OF A RAPID RESPONSE TEAM IN HOME PALLIATIVE CARE TO REDUCE INTERRUPTIONS IN HOME VISITS BY HOME CARE NURSES

Winnie Choo*, Poh Heng Chong, Zhi Zheng Yeo, Miao Lan, Xu Fen, Jodie Sin, Tan Joo Eng. *HCA Hospice Care, Singapore, Singapore*

10.1136/spcare-2024-ANZSPM.56

Background HCA Hospice (HCA) is Singapore's largest home hospice care provider, serving 3,600 patients annually. Patients with life-limiting illnesses with an estimated prognosis of less than a year are either seen in a day-care center, or visited at home at regular intervals by nurses, doctors, medical social workers and allied health workers.

The nurses are contactable by external stakeholders such as family members or other healthcare workers by phone during office hours on weekdays from 8.30am to 5.30pm. Phone calls after office hours are received by a call team of a nurse and doctor. The daily duties of a palliative home care nurse during office hours include calling patients to check symptom control, scheduling their visits and multi-disciplinary meetings. During home visits, they take history from the patient and family, perform physical examinations, perform procedures like the changing of feeding tubes and hold conversations with patients and other stakeholders.

Incoming calls during office hours were postulated to cause interruption and disruption to their work, leading to distraction, inefficiency, burnout and staff attrition. A team of four nurses and one doctor were assigned to be first responders to incoming phone calls to the home care nurses. This team receives phone calls that were diverted from the nurses. Phone calls from 30 home care nurses were diverted to the triage nurse team during office hours. The team was equipped with the necessary skills and knowledge to assess and address patient needs over the phone. Call diversion protocols were established to ensure timely and appropriate routing of calls to the triage team. If clinically warranted, the team would make video consultations or make home visits to the patient to manage the patients. Prior to this survey, the effectiveness of this system and its impact on the home care nurses was not studied.

Method Call logs and case notes between Nov 2023 – Apr 2024 are analysed to describe the frequency of calls and the outcomes following MediHELP support. Nursing staff were surveyed about their experience of work having diverted their calls. Qualitative and quantitative data are integrated to produce findings.

Results Preliminary data analysis found a reduction in the number of interruptions and stress experienced by home care nurses following the rapid response team's implementation. It remains to be seen if this system allows home care nurses to allocate more time and attention to direct patient care.

Conclusion The introduction of a rapid response team in a palliative home care service was effective in reducing