

Poster Presentations

P01

The needs of caring relatives in relation to advance care planning

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Background: Relatives of patients in need of care and of those who are seriously ill assume a variety of tasks. The aim of this study is a systematic review on needs, chances, risks and barriers of care giving relatives regarding advance care planning (ACP).

Methods: Qualitative and quantitative studies were identified through Pubmed, EMBASE, PsycINFO und CINAHL searches. In order to take into account that qualitative and quantitative studies were included, data were thematically synthesized.

Results: In total 37 studies met inclusion criteria, including 24 quantitative- and 13 qualitative studies. Most studies originated from the USA (46%). Thematically, the studies can be divided into four different categories: "Attitudes towards ACP" showed that, even though relatives experience some uncertainty about the meaning of ACP, they mostly agree with the necessity of it. "Decision Conflicts" revealed that the level of congruence between relatives and patients is not given in many cases. Regarding the "Effectiveness of ACP" several studies highlighted the importance to consider family dynamics in the ACP process. Different "Barriers for ACP" were found, including a lack of knowledge and awareness about ACP and difficulties regarding the timing of ACP discussions.

Conclusion: Although being an important group in the realm of ACP, as relatives are often also surrogate decision makers in case of incapability of decision making, studies on their attitudes and experiences are relatively rare and their knowledge seems quite limited albeit a perceived need for timely and appropriate ACP.

P02

Serious Illness Conversation Guide implementation and customisation of the guide for New Zealand

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Background: In New Zealand, clinicians are not routinely taught to have effective and compassionate conversations with consumers about what matters to them nor are they taught to use that information in partnership with consumers to plan and deliver care that matches that. New Zealand District Health Boards recognised the need to enhance the clinical communication skills of their workforce and tasked the Health Quality & Safety Commission with designing and delivering training to enhance the clinical communication skills of the non-palliative care workforce. As a first step, the Commission has been working with Ariadne Labs to bring the Serious Illness Conversation Guide tool and training to New Zealand. With the differences in the culture of the United States and New Zealand, the Serious Illness Conversation Guide needed to be adapted to the local environment.

Method: In August 2018, three codesign workshops were held with 43 consumers and clinicians. At the workshops participants were asked to work together to consider the language and words used in the guide and to suggest alternative wording for the prompts they felt did not feel comfortable to say or hear.

Results: A number of key themes emerged from the workshops – the language felt too stiff and formal, the tone was paternalistic, the guide left people feeling talked at and not partnered with, the language needed to be simplified, the doctor should not be "worried".

The input and suggestions from the workshops were synthesised and an Aotearoa version of the Guide developed.

P04

Kia Korero : Let's Talk - New Zealand ACP Campaign 2019

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The first public facing advance care planning campaign in New Zealand will feature the diverse voices of people at different stages of life and wellness, incorporating Māori, Pacific, Asian, Pakeha (European) and LGBGTQI communities. It begins with the story of kuia (elder) Māori woman, Keri Kaa who is in the last phase of life. The campaign, Kai Korero, Let's Talk, recognises the indigenous people as tangata whenua (the first people of the land), and aims to reflect the diversity of the communities we work with.

It will be launched with digital stories from February to April 2019, through social media such as Facebook, Instagram and Twitter. This is in response to our stakeholder engagement with Māori communities who have adapted quickly to digital resources. Māori is an oral culture and pūrakaū (storytelling) is an essential part of knowledge sharing.

It is also likely that print elements such as posters will be developed, and there will be a strong public relations component focusing particularly on Māori and Pacific media.

We hope the campaign will inspire people to have a conversation with their loved ones and their doctors about what matters to them if they become unwell, to discuss what kind of care they would or wouldn't want and to write down what is important to them.

P05

Implementation of a multi-modality education program in Australia

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Background: Despite the acknowledged importance of advance care planning (ACP), a barrier to uptake is appropriately skilled clinicians to have conversations. A literature review showed limited availability of education resources that considered the Australian context. This implementation project involved the development of education resources that facilitated scaffolding of learning, from novice to expert, and included online modules, clinician workshops and train the trainer workshops as part of a standardised program of education in ACP.

Methods: Nine online modules, education resources to enable clinicians to practice ACP discussions in workshops and training for facilitators to implement their own workshops were developed.

Results: From July 2017 to June 2018, 2656 people were registered on the learning management site and 1541 completed at least one online module. Feedback from the online evaluation identified that 99% of 4262 people rated their likelihood of recommending the module to colleagues as ≥ 5 out of 10. Seventy percent of the 144 people who attended the clinician workshops in the 12-month period specifically identified communication with patients and colleagues as the key area of learning for implementation. From 16 people who attended the two facilitator's workshops 6 have accessed the education resources and facilitated their own workshops.

Conclusion: This program considered the implementation of ACP education using a framework for learners to scaffold their knowledge. The suite of education resources provides a sustainable program of education by encouraging development of skills to the expert facilitator level. There is clearly a demand and interest in multi-modality learning.

P07

Advance Care Planning Reduces Healthcare Utilisation and Saves Cost

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Background: Advance Care Planning (ACP) is an important conversation that patients have with their care team to understand their medical condition and establish goals of care. Few studies, however, have investigated its impact on hospital resources. This study aims to determine the association between ACP and its effect on healthcare utilisation and cost.

Methods: 1343 patients from a tertiary hospital in Singapore completed either a General ACP or ACP – Preferred Plan of Care (PPC) from January 2013 to December 2017. Healthcare utilisation data was studied for each group pre- and post-6 months from ACP completion date. This included number of admissions, length of inpatient hospitalisation stay, attendance to the emergency department and specialist outpatient clinics. Total inpatient bill size was used as a marker of healthcare cost. Univariate analysis with paired T-tests was used to explore any significant difference in hospital utilisation rates between pre- and post-ACP in each group.

Results: 366 patients and 977 patients completed General ACP and ACP-PPC respectively. For ACP-PPC group, there was significant reduction in healthcare utilisation and cost (% Δ : 36-76%, $P < 0.05$). Whereas for General ACP group, the length of stay and inpatient bill size were significantly decreased.

Conclusion: ACP forms an integral component in patient care, especially for patients with more advanced diseases. Other than allowing patients to understand personhood and their goals of care, it serves as a platform to moderate healthcare utilisation. This study shows that ACP may reduce healthcare utilisation and cost.

P10

Advance Care Planning in Victorian Health Services: 2014- 2018 Survey Results and Evaluation

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Background: The Victorian Advance Care Planning Strategy 2014–2018 (the Strategy) was launched in March 2014.

The Strategy aimed to ensure all Victorians have the opportunity to express their preferences for future treatment and care and provided a clear framework Victorian public health services. The strategy set out four priority actions:

Enabling the person;

Increasing workforce capacity;

Establishing robust organisational systems; and

Ensuring an evidence base and quality approach.

Methods: A benchmarking survey was conducted in 2014 and a summative survey in 2018.

The surveys used the on-line survey administration tool - Survey Monkey (www.surveymonkey.com) with approximately forty questions across the four priority action areas.

Chief Executive Officers (CEO) at 84 publicly funded health services were contacted and asked to nominate one person from their health service, preferably with advance care planning experience, to complete the survey. There was over a 90% response rate.

Results: Survey results found:

significant increase in advance care planning programs;

strong and increasing level of health services' executive support;

an increase in the use of advance care planning alerts in clinical data;

increasing advance care planning education; and

organisational practice and policy improvements.

Conclusion: The results have confirmed the importance of a state-wide strategy and the development of state-wide

resources such as an advance care directive form template and the development of a common advance care planning barcode. This paper will explore the progress being made in public health services and identify the lessons learned, gaps and challenges for future policy development.

P11

Ideal and realistic advance decisions

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Background: The Patient Autonomy Law was passed on December 18, 2015 in Taiwan and will be valid on January 6, 2019. Advance care planning is the legal duty before signing an advance decision. As a medical center participating in the pilot study, we collect 99 advance decisions made after advance care planning. However, the 99 advance decisions looked the same because all the people refuse life-sustaining treatment and artificial nutrition and hydration. It's revealed a question that advance decision is too vague to be implemented under clinical scenario. This study will discuss how to make advance decision more useful in the clinical situations.

Method: Analysis the nature of advance decision by the factors which influence one's decision-making process.

Results: People tend to express a vague value rather than a precise decision about medical choices. Previous decisions may not be accurately used in complex and specific clinical situations. The decision supposed to be made rationally but patient has the emotional needs during the process of receiving information and making decisions. If the patient's mental capacity declined, whether the patient's critical interest is still the same is argued. Conflicts were found between the personality identity and the experiential interest sometimes.

Conclusion: Value-oriented advance decisions are intended to be acquired ideally. However, advance decisions are not a history book of value. It is simply a plan before death, a collection of treatment preference. Therefore, advance decisions need to be translated, weighed and clarified by health care providers while implementation.

P12

Assessing the usability of a web-based advance care planning education tool for adults: a pilot study

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Background: Our previous study suggested that elderly Japanese people find it difficult to discuss with family and healthcare professionals about end-of-life (EOL). To address this issue, we have developed a prototype for a web-based Advance Care Planning (ACP) education tool. This tool has five components: (1) EOL simulated experience program, (2) thoughts about EOL vignettes, (3) wishes about truth telling, (4) EOL care preferences, (5) my favorite life. We evaluated whether this online educational tool encouraged ACP for a sample of community-dwelling adults.

Methods: Ten participants (mean age: 63.8 years) were requested to use it for one month. Data was collected from the entries on the tool website, and a semi-structured interview was conducted later. The percentage of each completed ACP component was calculated. The qualitative data was analyzed by the thematic analysis. IRB approval was obtained from the researchers' institution.

Results: The highest percentage of completed ACP component was "EOL care preferences". Ways to foster ACP with the tool yielded four main themes: understanding of ACP, embarrassment due to ACP, my preferred procedure of ACP, and advantages and disadvantages of the web-based tool.

Conclusion: This tool encouraged the adults who had not previously considered ACP to recognize the importance of thinking about EOL, they are still healthy though. However, fostering ACP was connected to depression, depending on the individual's readiness in thinking of his own death. Hence, future research will be applied to improve this tool and make it more user friendly for a large number of the adults.

P13

Advance directives requesting euthanasia in the Netherlands

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The Dutch Termination of Life on Request and Assisted Suicide Act (WtI) came into force in 2002. Based on this act, euthanasia, although a criminal act under the Dutch Penal Code, is justified if performed by a physician complying with specified due care requirements. A review committee assesses in every case whether physician-assisted dying has been carried out in accordance with these requirements. If there is reason for doubt, the case is handed over to the Public Prosecutor who judges whether there are grounds for prosecution.

One of the current challenges in the Netherlands is the significance of an advance directive requesting euthanasia. Section 2 (2) of the WtI allows physicians to carry out euthanasia on patients lacking mental capacity based on an advance directive requesting euthanasia drawn up at a time the patient was still competent. The due care requirements apply 'to the extent allowed for by the actual situation'. Uncertainty exists about the interpretation of the wording.

This study examines the legal status and practice of advance directives requesting euthanasia, focusing on the question how the due care requirements can be met in case of advance directives concerning late stage dementia patients. The legislative history and case law offers advice how to assess the due care requirements but do not seem to provide enough guidance for a careful and practical application of the advance directive. The legal position of the advance directive requesting euthanasia is complex and in need of assessment.

P15

Talking about healthcare decisions with end-of-life patients: what do nurses feel?

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Objective: To know the emotions of community nurses when they talk to end-of-life patients about health care decisions for their future

Design: Qualitative methodology.

Location: Basic health zone. Jaén. Spain

Participants: Community nurses who care for people at the end of life.

Main interventions: Fourteen recorded interviews after informed consent. Analysis: transcription of speeches, coding of texts and grouping in categories.

Results: Nurses' emotions include discouragement, worry, sadness, anxiety, insecurity, bewilderment, anger, compassion or frustration. These affective phenomena appear after negative experiences such as deception or difficulty in certain situations, lack of resources to face dialogical processes of health decisions planning or acknowledging the other's suffering. The presence of such emotions leads the professional to adopt avoidance attitudes to elude a reality that causes them emotional distress. There are also participants who feel tranquility, respect, security, satisfaction or affection. These emotions are related to positive experiences, which generate a proactive attitude in the professional and promote actions that improve the quality in care at the end of life.

Conclusion: Knowing the present emotions in the clinical relationship can help the professional. When the professional manages properly his/her emotions there is a better healthcare provision at the end of life. It is necessary to improve nurses' emotional competencies through affective education.

P18

Advance Care Planning (ACP) Discussions: What do they really cost?

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Background: Understanding both costs and consequences of ACP programs is important. Available economic analysis have typically reported the consequences but not the prevalence, frequency, duration and with whom ACP discussions take place.

Methods: We conducted an economic analysis of ACP discussions alongside a trial evaluating ACP videos, across three clinical settings (cancer, heart and kidney disease) and 18 sites in Alberta, Canada. We administered a Health Services Inventory monthly for three months. Participants were asked to recall ACP discussions with professionals from healthcare, legal, financial and spiritual sectors.

Results: 241 participants (36.1% female; average age, 66 ± 12.2 years) were interviewed at baseline with 95.0% follow-up over the three months. Participants across cancer (n=36), heart disease (n=24), and renal disease (n=40) settings had in total 100 ACP discussions with professionals from healthcare (n= 58), spiritual (n= 14), legal (n=19) and financial (n=9) sectors. The discussions averaged 20.4 minutes and resulted in completion of 16 Goals of Care Designation GCDs, 14 Personal Directives and 9 financial documents. Discussions mostly occurred outside home (n=82, 80.4%) and patients were almost always accompanied by a family member/friend (n=99, 97%).

Conclusion(s): Compensating professionals to engage in ACP discussions represents a substantial segment of ACP program cost. Patients and their family/friends also incur costs travelling to and taking time for appointments. Assessing cost-effectiveness of ACP requires program costs in addition to consequences. Patient engagement likewise benefits from understanding the nature and personal costs of these discussions. These data may help professionals advocate for commensurate compensation

P19

The use of advance care plans in patients admitted to a public hospital

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Background: This study followed the clinical history of a cohort of patients with a published Advance Care Plan (ACPlan) and examined the influence of the patient's clinical and demographic characteristics on the content of the ACPlan. The concordance between the instructions in the ACPlan and the care received during admissions and/or end of life care in a public hospital was also investigated.

Methods: 149 patients with a published ACPlans between 10/09/2014 and 31/09/2017, and an admission to Christchurch Hospital within that timeframe, were randomly selected from the ACP database (n=1939). The electronic and written clinical records of each hospital admission of the patients (n=411) were reviewed to record demographic characteristic and assess competence. For those who lacked capacity, further review was undertaken to determine treatment given and concordance with the ACPlan.

Results: Median age was 78 years. 57% were female, 43% male. The study showed a 98.3% concordance rate regarding the Goal of Care, and 85.7% concordance rate regarding the specific treatment preferences. A Do-not-attempt-CPR form was in place in 60.2% of the records of patients who did not want to receive CPR. Of the patients who died during the study period (n=55) 37.5% died in their preferred location, while 18.8% did not state a place of

death preference.

Conclusion(s): Although the study population was limited, the results add to the evidence that ACPlans encourage the wishes of hospitalised patients to be recognised and used to guide care.

P20

Quality review process for electronic Advance Care Plans in Canterbury, New Zealand

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Background: An Advance Care Plan (ACPlan) that is ambiguous, contradictory or difficult to interpret can undermine confidence in the ACP process, lead clinicians to question the value of ACP and reduce the likelihood a person's ACP wishes will be honoured.

In Canterbury, a quality process has been developed to ensure ACPlans published to the electronic medical record (EMR) are clinically interpretable and any advance directives (AD) contained within the document meets NZs criteria for validity.

Methods: a two-step process has been developed

Step 1 - Administration review to ensure the plan has been entered onto the EMR; the signed scanned copy matches the EMR version; there are two signatures – that of the person creating the ACPlan and the health care professional (HCP) supporting them.

Step 2 - Clinical review to ensure the content of the ACPlan is consistent with any ADs contained in the document and the plan is clinically interpretable.

If an ACPlan does not meet the quality parameters, it is returned for review and amendment. This process enables the ACP team to engage with the HCP leading the process, provide individual feedback and support them to improve the quality of plans submitted in the future.

Results:

Numbers of ACPlans published continue to grow (2014 n=118; 2015 n=354; 2016 n=519; 2017 n=772). While the percentage of plans requiring support from the ACP team to meet publishable criteria is falling (2014=31%; 2015=32%; 2016=27%; 2017=20%).

Conclusion(s):

The quality review process established in Canterbury supports the creation of clinically interpretable ACPlans.

P21

Advance Care Planning facilitator training for medical students: more than a drop in the ocean

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Background: Healthcare professionals (HCP) often feel insecure and therefore hesitate to start ACP conversations with patients. And patients often feel reluctant to initiate ACP-conversations. Trying to discontinue this vicious circle we developed an elective ACP course for medical students.

Methods: The course was developed on the base of the German facilitator-curriculum, which was revised in 2017 to include intensive role-play supported by the use of standardized-patients (SP). We adapted the facilitator curriculum to the students' experience and early stage of medical training. Course preparation comprised a letter of motivation and 10 CME questions referring to an ACP journal paper. The course is divided into 2 parts, each lasting 32 hours and including 10 hours of SP-training in groups of 2 or 3.

Results: In August 2018, 7 students joined part 1 of the new ACP-course. All 7 students were in their 2nd year of medical training, the age range was 20-42 yrs, 3 were female. 5 happened to have a Muslim background which added an unexpected cultural component to the course. 4 had worked in other disciplines in healthcare before. Their motivation to participate ranged from traumatizing personal experiences to practical reasons. Their attitudes towards patient-centeredness and ACP-facilitation strongly changed from a traditional-paternalistic towards an autonomy-oriented view. At the end, student performance varied from moderate to very good.

Conclusion(s): Discussing legal and ethical basics of ACP conversations, and practicing ACP with SP, were judged by the students as highly relevant, both personally and professionally.

P22

Integration of ACP into primary care. The Canterbury experience

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Background: In 2013 a project was developed for the provision of formal Advance Care Planning (ACP) processes in the Canterbury Health System.

A key component of the project was facilitating general practice to engage with and support patients to undertake ACP conversations and develop electronic advance care plans (eACPlans).

Methods: Integrating ACP into the primary care system in Canterbury required a multifaceted, cross system approach, with each component supporting and enhancing the other.

Practice engagement and education including practice visits, phone support, ACP processes on the clinical website, presentations, training, one-to-one support/mentoring

Consumer engagement and education including community presentations, radio interviews, articles in local

publications, a consumer website & community ACP champions. Increasing the community's knowledge and desire to create plans, has been the impetus for many practices to engage with ACP.

Systems and processes including electronic sharing of eACPlans, a subsidy to support practice teams adopt ACP and dedicated ACP facilitators & administrators to support the process.

Quality loop plans are reviewed to ensure patient's wishes are clinically interpretable and clinicians are confident to use plans to guide care. Plans that do not meet the quality parameters are returned for follow up providing further opportunities for the ACP team to engage with the practice.

Results:

87% of general practice teams in Canterbury have supported patients to create an eACPlans.

General practice teams create 80% of the Canterbury's eACPlans.

Increased multidisciplinary approach to plan creation.

Conclusion(s): A cross-system approach to implementation has facilitated the establishment of ACP in general practice.

P23

Development and implementation of a regional electronic ACP platform in the South Island of New Zealand

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Background: The South Island Alliance (SIA) strives for innovative and efficient health services by bringing together the five South Island District Health Boards (DHBs) to work collaboratively. ACP is a focus area for the SIA leadership team. The Health of Older People Service Alliance has been endorsed to provide oversight and leadership to support SI DHBs develop and embed electronic Advance Care Plans (eACPlans).

Methods: a four step approach

Step 1 – Systems development: The creation of a single ACP platform in the electronic medical record enabling eACPlans to be created, shared and viewed across services and systems throughout the region.

Step 2 - Quality processes: A South Island Regional quality Verification (SIRV) team has been established to implement the SIRV processes and ensure the content of SI eACPlans, are clinically interpretable and can be confidently used by clinicians to guide care and ensure patient wishes are honoured.

Step 3 – Implementation support: Development of a regional workbook, communication releases & clinical pathway. Regular teleconference meetings are held to provide a platform for DHB ACP leads and SIRV team members to share ideas and develop 'broadly similar' approaches to support the roll out of the eACP.

Step 4 – Regional measures and reports:

Results: Steps 1,2 & 3 have been implemented and the coordinated 'go live' date for the project has been agreed by the 5 DHBs for early December 2018.

Conclusion(s):

Regional implementation of eACP in the SI is helping to optimise efficiency and encourage a broadly similar approach.

P24

Predicting life expectancy to aid in Advance Care Planning

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Background: Accurate timing of ACP is considered challenging. Available tools are not widely implemented, can be unfeasible to screen large populations, and require prior awareness to be used proactively in individual patients. We are developing an automated signaling tool for early identification of patients who might benefit from ACP. In this talk, we will focus primarily on the model we created to predict life expectancy, which we consider to be a first step towards identifying these patients. Additionally, we will discuss further model development and deployment in a real-world setting.

Methods: We used machine learning (ML) and natural language processing (NLP) techniques to train a recurrent neural network on 1234 medical records of deceased patients. We trained several models, and compared the best-performing model to doctor's performance on a similar task as described in the literature.

Results: While doctors were correct in 20% of the cases (allowing an error margin of 33% around the actual moment of death), our best-performing model attained a prognostic accuracy of 29%. Being overly optimistic about life expectancy harms anticipation to end-of-life care. Our model was less likely to overestimate life expectancy (in 31% of the incorrect prognoses) than doctors (63%) were.

Conclusions: Our research shows that ML and NLP offer a feasible approach to predicting life expectancy. The results are promising, given that our model is trained on a relatively small data set. Current work focuses on further model development with an increased dataset, and implementation of the tool in primary care facilities.

P25

Frequency and contents of advance care planning discussions in primary care

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Background: General practitioners (GPs) are well placed for identifying patients in need of advance care planning (ACP) and initiating ACP before acute deterioration in their illness trajectory. However, little is known about the frequency and contents of ACP discussions in primary care. We aimed to explore the frequency and contents of ACP discussions among patients, family members, and GPs.

Methods: A multicenter, cross-sectional, observational study was conducted at 17 clinics with 22 GPs. In March 2017, each GP set an arbitrary day in advance and we enrolled all patients aged ≥ 65 years who visited the GPs on that day. We explored the frequency and topics of ACP discussions. We identified patients at risk of deterioration and dying based on the Japanese version of the Supportive and Palliative Care Indicators Tool (SPICT™).

Result: In total, 382 patients with a mean age of 77.4 ± 7.9 years were included. Twenty-three patients (6.0%) had ACP discussions with their GP. Of 66 patients at risk of deterioration and dying, 13 patients (19.7%) had ACP discussions with their GP. The most common topic among patients overall was anticipated declines in activities of daily living (ADLs), but the topic of surrogate decision-makers was the most common with neurological patients.

Conclusion: Primary care patients aged ≥ 65 years did not necessarily have frequent ACP discussions with their GP, but discussions were more common with patients at risk of deterioration and dying. The anticipated declines in ADLs was most frequently discussed topic among patients, family members, and GPs.

P26

Advance Care Planning in Swiss Nursing Homes: Results of a Focus Group Study

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Background: Until now, there has not been any official ACP program in Swiss nursing homes. We implemented an already developed and successfully tested Swiss ACP program for acute care hospitals in two Swiss nursing homes. The aim of this study was to better understand the process, chances and difficulties of the implementation steps.

Methods: After having informed staff and residents, interprofessional facilitators were trained via a previously developed ACP education programme based on Respecting Patient Choices (Australia) and Beizeiten Begleiten (Germany). Six months after first implementing steps, we conducted focus group interviews with the staff and the physicians and analysed data by MaxQDA and the Krueger and Casey thematic analysis.

Results: Even though the data collection was very early in implementation, our results confirm some already known facts of implementing ACP in nursing homes: The staff described an increasing sense of responsibility regarding ACP but underlined that the used forms have to be tailored to the need of the different age groups. They stressed that there must not be any pressure to undergo ACP. In addition to that, our study emphasised once more that professional palliative care is also vital for ACP programs.

Conclusion: The results showed that it is not enough to only train facilitators: To be successful and sustainable, the implementing process has to include the whole healthcare system. The forms used have to be homogeneous and accessible for all involved parties. Furthermore, there is a need of public relations work to increase awareness of the subject.

P28

Development of a smartphone-based communication application to support, record, and share the process of ACP along with frailty evaluation

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Introduction: In the super-aged society, implementation of ACP is essential for people's sense of security. The interdisciplinary care team for frail older people in National Center for Geriatrics and Gerontology (NCGG) needs a communication tool for sharing the process of ACP.

Methods: A smartphone-based communication application (SBCA) was developed to support, record, and share the process of ACP correctly and effectively among different care settings and various healthcare professionals.

Results: SBCA enables to record a range of patients' values, goals, and preferences regarding future medical care, and preferred substitute decision-maker according to the words of patients using voice input system. Records are discussed at the inter-disciplinary care conference to confirm at each time point, and share the process of ACP. SBCA simultaneously records the descriptions of patients' medical problems, including the frailty status, and their responses by patients and families, or helpers, which indicate that patients have received enough explanations before ACP. SBCA renews records continuously and enables to activate ACP information confirmed among various healthcare professionals at any time of future incapacity, not just at the end-of-life. SBCA is developed to be added to the existing local health care information system, "Obu-chan Network", operating near NCGG, adhering the personal information protecting guideline. Feasibility of SBCA is examined by healthcare professionals using Obu-chan Network. The prototype of SBCA got favorable feedback at SBCA promotion conference in NCGG.

Conclusion: We have developed SBCA to share the process of ACP along with frailty evaluation, which is supposed to provide genuine person-centered care.

P29

Study on advance care planning in care dependent community-dwelling older persons in Germany (STADPLAN): protocol of a cluster-randomised controlled trial

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Background: In Germany, advance care planning (ACP) was first introduced by law in 2015. Since then, implementation efforts of ACP have been limited to nursing homes and mental health institutional setting. This study aims to evaluate the evaluation of an ACP programme in care dependent community-dwelling older persons.

Methods: A cluster-randomised controlled trial of 12 months duration will be conducted in 3 German regions. Using external concealed randomisation, 16 home care services will be allocated to the intervention and 16 to a usual care group (each with 30 participants; n=960). ACP will be delivered by two trained nurse facilitators of the respective home care services. The communication process will include a proxy decision-maker.

Expected results: primary endpoint is patient activation, operationalised by the Patient Activation Measure (PAM-13). Secondary endpoints include ACP-engagement, proportion of advance directives, hospitalisation, quality of life as well as depression and anxiety. An economic evaluation as well as a comprehensive process evaluation will be conducted. After completion of the ongoing pilot study, recruitment will start in June 2019.

Conclusion: STADPLAN is the first study internationally that assesses the effects of ACP in community-dwelling older persons and the first study in Germany educating nurses of home care services as ACP facilitators. The results will support the improvement of understanding and communicating the patient's will regarding future medical treatment and care, and thereby contribute to patient's autonomy at the end of life.

P30

Sustainable Implementation of Advance Care Planning in a General Medical Unit

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Background:

Singapore has a growing ageing population with an increase in chronic progressive illnesses. The need for advance care planning (ACP) has become increasingly important. It has been found that ACP is better accepted by the patient when offered by their doctor. Unfortunately, many institutions have struggled to get the main stakeholders involved.

Our aim was to integrate ACP into daily clinical practice- a systematic and sustainable model for ACP implementation in a general medical unit in an acute hospital, targeting the population who would most benefit from it.

Methods: Implementation involved a three-pronged approach of promoting awareness, facilitator training and formal screening, using triggers- age >75 years, poor pre-morbid function and more than 3 recurrent admissions in a year. These triggers apply to our target group, and their simplicity makes it easy for clinicians to remember and implement. Reminders were relayed via email to the teams involved in the care of the patients, to initiate ACP discussions.

Results: The implementation of ACP in the medical unit, occurred in phases.

From 2013-2014, the number of ACP discussions doubled with promotion of ACP and facilitator training.

From 2015-2016, the numbers increased by 60% after introduction of formal screening for new admissions using our three key triggers.

In 2017, these numbers were maintained even after we stopped formal screening and email reminders.

Conclusion: ACP rates increased, using the three-pronged approach of implementation, with improved sustainability and consistency.

Future initiatives may focus on refining the triggers, and incorporating them into medical records systems.

P31

Current status, Needs and Barriers towards Advance Care Planning (ACP) in Nursing Homes

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Background and objectives: Fostered by a legislative initiative in 2015, German nursing homes face the challenge to implement ACP- structures. Project background is to conceptualize and evaluate a practicable ACP-concept for the region Würzburg (130.000 inhabitants, Bavaria) with 12 nursing homes. In advance of a concept development, the current status of advance care practices in nursing homes, requirements of nursing homes and possible barriers were assessed.

Methods: Written survey addressed to directors of 12 nursing homes in Würzburg. The questionnaire focusses – amongst others – on structural data (number of nursing places, nursing level of residents, qualifications of staff members ...), regional networking (cooperation with general practitioners, hospitals, hospices ...), reasons for and extend of hospital admissions and reanimations, dealing with cardiac arrest, kind and amount of documentation of residents will related to end of life care, professions with function in ACP, possible barriers towards ACP and need for further support in implementing ACP.

Results: NH are still not prepared for implementing an ACP-Concept. Development of structures and support are as necessary as development of human resources and establishment of cross-provider networks. Misperceptions about legal requirements, uncertainties in communication and little time are some further barriers that have to be addressed in an ACP-concept.

Conclusion: The sustainable implementation of a viable ACP-concept assumes the development of structural and personal resources and has to address popular misperceptions and communicative barriers.

P32

An Examination of ACP Implementation in an Acute Hospital - Too Little, Too Late?

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ACP has been part of holistic care in Singapore since 2011. When patients do not have an ACP, healthcare teams often rely on surrogate decision-makers to determine patient's values and preferences. Several studies have been done and demonstrated a discordance of 26-35% between patients and their surrogates in decisions on CPR and extension of life. There are no national statistics on the number of ACPs that are done by surrogates. There are few studies to demonstrate the concordance of ACP at the end-of-life.

A retrospective analysis was done for patients admitted to General Medicine Department in Tan Tock Seng Hospital in 2015, who had an ACP on admission. The aim was to determine how many ACPs involved patients, secondary aims were assessment of ACP concordance at the end-of-life care.

Our study involved 56 patients, 16.07% of the ACPs involved the patient. ACP discordance was highest in those who had chosen home as the preferred place of death (PPOD), with 69.23% passing away in the acute hospital instead of at home. 82.6% died within 1 year of the ACP and 39.47% died during the hospitalization when the ACP was first done.

ACP requires involvement of the patient to ensure an accurate reflection of their values and preferences. The biggest discordance in the ACP is in the PPOD. There are many factors that cause PPOD discordance. More training and support is needed in nursing homes and home medical services to allow patients to pass away peacefully in a place of their choice.

P33

'To talk about it, that's a problem ...'. Analysis of needs concerning advance planning with regard to End-of-Life Decision Making

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Background: In Germany ACP has only gained importance in recent years. It is still a long way to a nationwide implementation. A legislative initiative from 2015 focusses the development of supportive ACP-structures in the field of nursing homes (NH). In the region Würzburg (130.000 inhabitants, Bavaria) there is no ACP-program provided. Major purpose of the project is the conceptualization, implementation and evaluation of an effective, target group-specific concept. Within the project needs of nursing home residents (NHR) concerning the process of ACP are reconstructed, barriers of sustainable implementation of ACP are identified.

Methods: The study includes problem-centered interviews with NHR (n=24). Main topics of the interviews: requirements regarding to EoL, communication about needs at EoL, documentation of advance planning, decision-making/-behavior concerning EoL. Data are analyzed by content analysis.

Results: NHR have a lack of knowledge relating to scope, reach and potential objects of advance planning for EoL(C) even they have already prepared an advance directive or a power of attorney. Often there is no differentiated reflection of own needs even they remark the wish of self-reflection concerning preferences for their EoL. NHR express the wish to compare notes with non-professionals and at eye level, trustful dialogue partners on EoL-topics and decision-making (informal dialogue). Otherwise, the recording of decisions and responsibilities regarding to the EoL takes place within the family-network and in the dialogue with health professionals (formal dialogue).

Conclusion: A viable ACP-concept has to close the gap between informal and formal dialogues by creating trustful dialogue spaces and identifying trustful dialogue-partners.

P35

Experiences with approaches to advance care planning with older people: a qualitative study among Dutch general practitioners

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Background: Advance care planning (ACP) is still used with only a minority of older patients due to a lack of knowledge regarding appropriate approaches to ACP with older people. General practitioners (GPs) may play a key role in ACP with older people. We explored their experiences with different approaches to ACP with older patients in daily practice.

Methods: A qualitative study among a purposive sample of 19 Dutch GPs based on semi-structured interviews.

Results: Approaches to ACP with older patients can be divided into two categories: systematic and ad-hoc. Systematic approaches consisted of discussing a fixed combination of topics during group information meetings, intakes, comprehensive geriatric assessments, and periodic assessments with community-dwelling older patients who are frail, cognitively impaired, or aged >75, and with older patients living in residential care homes. Meetings were aimed at making agreements in anticipation of future care, at providing information and at encouraging older people to take further steps in ACP. With ad-hoc approaches, respondents discussed only one or two topics related to the near future with deteriorating patients or when patients or family-initiated ACP. Systematic and ad-hoc approaches were used simultaneously or sequentially. Due to a lack of time and knowledge respondents seemed to

underuse many occasions and topics.

Conclusions:

Awareness of appropriate systematic and ad-hoc approaches to ACP, and the focus on providing information and encouraging older people to take further steps in ACP can support GPs and improve older patients' access to ACP.

P36

Development of the STADPLAN intervention on advance care planning in care dependent community-dwelling older persons in Germany

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Background: The STADPLAN project is a multicentre, cluster-randomised controlled trial on advance care planning (ACP) in older people receiving professional home care. The aim of the intervention is to encourage patients to deal with the topic of ACP in a structured way, to nominate a surrogate decision maker and to regularly discuss own preferences and wishes with this person.

Methods: Following the MRC framework for complex interventions, we systematically adapted the intervention components of existing ACP programmes to the needs of community nursing care in Germany. The design of the modelled multicomponent intervention was guided by the Behaviour Change Wheel method. Experts reviewed and discussed the proposed intervention programme.

Results: The complex intervention addresses patients aged ≥ 65 years, nursing professionals and general practitioners comprising:

- 1) A minimum of two guideline-based conversations led by qualified nurses to be offered to dyads of patients and relatives.
- 2) A two-day training course including practical exercises to prepare nurses for the conversations.
- 3) Written information about ACP provided to patients, aiming to encourage patients to reflect on and write down own wishes and health care preferences in various situations. The information offers further local counselling options for the preparation of ACP documents.
- 4) Participants' general practitioners will receive concise written information about the study.

Conclusion: The acceptance, feasibility, and comprehensibility of the complex intervention are currently piloted in four home care services including 120 patients. Results are expected in early 2019 and will be used to optimise the intervention before the efficacy trial.

P37

Differences in the perceptions of end-of-life care preferences between non-dyad patients and proxies in an Asian context

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Background: In Singapore, Advanced Care Planning (ACP) for patients who lack mental capacity is often conducted with the patient's family or proxy. The mismatch of perspectives between patients and proxies has been known in the West and this study investigated how perspectives differ in an Asian context.

Methods: Twenty ACP discussion sheets completed with the patients, with or without a proxy decision maker and 20 ACP discussion sheets completed only with proxy, without the patient, were chosen at random for analysis. Thematic analysis was used to identify salient themes from both sets of discussion sheets and compared to understand the differences between decisions made by patients and proxies.

Results: While overarching ideas on suffering and living well remain largely similar between the groups, there were marked differences in the area of medical interventions, place of care and religion. More proxies wanted comfort measures only for their loved ones, while patients tended to opt for additional interventions, such as intravenous medications or antibiotics. Similarly, while proxies preferred a trial of treatment at home or in a hospice before transferring to hospital, more patients wanted to be transferred to hospital immediately upon illness onset. Many patients mentioned religious beliefs as of importance whereas this was less mentioned by proxies.

Conclusions: There are differences between the perspectives of patients and proxy decision makers in making ACPs. Future investigation should look at ways to align the proxy's perspectives with that of the patient especially in dyad pairs including means to reduce differences during ACP facilitation.

P38

Integrative Literature-Review on Shared Decision-Making, Advance Care Planning, including values and preferences of elderly patients with symptomatic aortic valve stenosis

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Background: Only very few studies have been published on Shared Decision-Making (SDM) and Advance Care Planning (ACP) including high risk patients with aortic valve stenosis addressing transcatheter aortic valve replacement (TAVR), surgical valve replacement (SAVR) and palliative care as treatment options. Therefore, the

aim of this study is to strengthen the basis for further investigations on this increasingly important theme.

Methods: We currently perform a computerized integrated literature review of MedLine (PubMed), EMBASE and Cochrane databases, including among others the MeSH terms *aged, frail, aortic valve stenosis, advance care planning*, and sensitive search filters on health outcomes such as patient values and health care related quality of life. Qualitative and quantitative studies are both included. For quality evaluation we will use the method of systematic review developed by Hawker et al. (2002) and based on the Critical Appraisal Program (CASP) tool for qualitative research. Since a great variability of the study types can be expected, they will be systemized using thematic analysis approach.

Results: We will present the ethical and practical relevance of this specific topic with regard to Advance Care Planning and Shared Decision-Making and present first results of our integrated literature review.

P39

Collusion, advance care planning and therapeutic privilege - paternalism via the back door?

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Collusion in the healthcare setting occurs when a patient's loved ones seek healthcare professionals' cooperation in hiding or moderating the disclosure of a serious illness from the patient with capacity to make their own healthcare decisions. Collusion more commonly occurs in patients who are older, perceived as vulnerable and in need of protection from the harsh truth. When collusion occurs, the patient is excluded from the decision-making process, their autonomy is suspended, and advance care planning is not even an option. Collusion may be justifiable if the doctor exercises therapeutic privilege and withholds diagnostic and/or prognostic information from the patient because of concerns that the patient may be seriously harmed physically or psychologically, if informed. The highest court in Singapore in the recent case of *Hii Chi Kok v Lucien London Ooi* expanded the concept of therapeutic privilege. The court endorsed the view that therapeutic privilege should not be abused by doctors to prevent patients with mental capacity from deciding for themselves just because the doctors think their choice is not in their best interests. However, it seemed to leave the door open for the possibility of triggering the therapeutic privilege if the patient is impaired in their decision-making capabilities, although still possessing mental capacity, and refuses low-risk beneficial treatment because they misunderstand the rationale treatment for it, even with appropriate assistance. Are there limits to an individual refusing beneficial treatment? Is this compatible with respecting an individual's right to make an unwise decision? Where should the line be drawn?

P41

Effectiveness of ACP to improve patient-centred care: study protocol of a cluster-randomised intervention trial focussing on nursing home residents (BEVOR-Study)

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Background: Advance Care Planning (ACP) has been shown to increase prevalence of advance directives in German nursing homes (n/h) and therefore been introduced by recent legislation for n/h residents covered by sickness funds. However, clinical benefits and costs of ACP for n/h residents have not been studied in German speaking countries yet.

Methods:

cRCT in 4 study centres, each comprising 11 n/h (3.520 n/h residents altogether). 22 n/h will be randomised to the ACP intervention, the other half continue with usual care. The complex ACP intervention consists of comprehensive qualification of ACP facilitators and family physicians, education of all regional health care actors relevant for the care of n/h residents, and coordination within and between participating institutions.

Primary hypothesis is a reduced rate of unwanted hospital admissions. Secondary hypotheses include increased rates of

residents whose preferences are known and followed in pre-defined critical treatment decisions, residents dying in the n/h (versus in hospital) according to their preference, and residents, their families, and their caregivers who appreciate congruence between treatment wanted and delivered. Additionally, we plan a comprehensive process evaluation and a health economic analysis.

Conclusion: While ACP has been repeatedly shown to be clinically effective in n/h, recent data from the Netherlands indicate it may not. Our trial, funded by the Innovation Fund of the Federal Joint Commission, will provide elaborate, 8 days facilitator qualification involving 24 hours of role plays with simulated patients, and it will be the first to study hospitalisation rate in all residents of participating n/h.

P42

ACP implementation in Germany: a progress report of the political framework and its translation into

practice

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Background: In December 2015, §132g was introduced into Social Code Book V. It provides financial coverage of advance care planning (ACP) for residents in long-term care institutions and institutions for persons with disabilities. At the end of 2017, the sickness funds and care home providers defined the details of the implementation in a mutual agreement.

Methods: Policy analysis with description and critical reflection of the relevant regulations and the current status of ACP implementation in Germany.

Results: Since early 2018, German care homes can get reimbursement for ACP-facilitators (1/4 full time equivalent for 100 residents), who can be either employed by the care home, by its carrier or by a regional cooperating partner. The mutual agreement specifies the structure and content of the planning process and defines the qualification requirements for ACP-facilitators, but not for facilitator trainers. Furthermore, the agreement calls for intra- and inter-institutional coordination, but does not provide for adequate workforce. Since 2016, there have been courses qualifying some 270 ACP-facilitators and 35 trainers, and several institutional ACP implementations. To promote the quality of the ACP-implementations, a German ACP-association (the DiV-BVP e.V.) was founded in 2017 to further develop facilitator and trainer curricula using simulated patient supported role plays, the contents of ACP-conversations, and of their adequate documentation.

Conclusions: While §132g Social Code Book V provides a historic opportunity to implement ACP in German care homes, there are still major challenges to overcome, especially regarding facilitator qualification and institutional and regional implementation of the ACP system.

P43

Putting Pieces Together - A Multidisciplinary Team Implementing Respecting Choices in a Quaternary Health System Demonstrating Real Change and Sustainability

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The zenith of implementing the Respecting Choices systems approach to person centered and family oriented care is to provide person-centered decision making for each individual that honors current and future healthcare preferences. It is essential to understand that challenges exist for a quaternary health system to honor each individual's preferences. Challenges include but are not limited to; (1) assuring conversations are initiated and completed (2) broken or insufficient communication regarding healthcare preferences as result of conversations, and (3) difficulty in healthcare providers accessing information on preferences in real-time. This presentation will describe how a multidisciplinary ambulatory care team implemented this person centered decision making as foundational to achieving the quadruple aim. Outcomes include: For calendar year 2017: 334 enrolled. After enrollment: 90% had a person centered decision making conversation started, 80% had an Advance Directive uploaded into the EHR and 97% had a documented code status. Median survival after enrollment is 36 months with a overall cost of care reduction of \$455 per member per month during the time enrolled in the program. Further, 70 (43%) transferred to hospice with an average LOS in hospice of 50 days, and a median LOS in hospice of 29 days. This is compared to an overall hospice average LOS: 61.6 days and median LOS of 16 days. Likelihood to refer this program to others is 95%. Provider satisfaction is one of the highest of the 3600 providers in the delivery system.

P44

Improving Advance Care Planning (ACP) documentation in frequent Department of Geriatric Medicine (GRM) admits with dementia in an Asian Hospital

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Aim: To improve the percentage of completed ACP documentation of eligible recurrent admits (3 or more admissions within the last 1 year with no prior ACP documentation on admission) with background dementia to ward 7D under department of GRM from 7% to 60% within 6 months

Implementation: Micro and macro flow charts were created to evaluate the processes in conduct of ACP. Root causes for reduced ACP documentation were identified via Ishikawa diagram and Pareto Chart. Through multiple PDSA (Plan, Design, Study, Act) cycles, the following interventions were conducted: creation of mandated workflow for ACP, reminders to offer ACP and incorporation of ACP in clinical delivery through documentation of ACP status in interim discharge summary and daily clinical problem list.

Results: Root causes for low ACP documentation were ACP was not mandatory as part of clinical service delivery, lack of educational materials on ACP and exclusion of ACP in clinical notes. After multiple interventions over 6 months, mean monthly completed ACP documentation rose from baseline of 5.5% to 28.8%, with highest achievable completion of ACP documentation at 50%. Though the target of completed ACP documentation was not met, there was an increase in the number of ACP discussions and documentation conducted by the department with increase awareness. This promotes a community of practice where ACP is offered readily.

Conclusion: Changes in work processes and incorporation of ACP as part of clinical service delivery can improve ACP engagement in patients with dementia and their caregivers.

P45

Physicians' perceived acceptability of a question prompt list for dementia at the end of life

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Background: Question prompt lists can support communication between patients, relatives and professional caregivers. Examples of questions encourage to ask about topics that are relevant to patients and relatives, which may, for example, enhance participation in decision making and improve outcome. We developed a question prompt list about end of life for people with dementia and their relatives. Physicians' endorsement of its use and perceived acceptability is essential for effective implementation.

Methods: In 2018, we surveyed 65 physicians (elderly care physicians and general practitioners) to evaluate the list. The survey was based on decision aid evaluation methodology including a validated acceptability scale ranging 15-75 with scores of 45 and meaning the aid is acceptable. Subsequently, we interviewed those physicians with either very high or very low acceptability scores.

Results: The mean acceptability score was 51, but the physicians differed substantially in their evaluations of acceptability (SD 11). One third (32%) felt unable to answer the questions in the question prompt list. The interviews indicated this was bothering for some, and we explored this using the quantitative data. With inability to answer all questions, acceptability was lower and more variable (46 SD 13 vs. 54 SD 8).

Conclusions: When accompanied by physician guidance and training, the question prompt list may fill a gap in seeking ways to develop advance care planning specific to dementia. An improved version of the question prompt list will be tested as part of two innovative advance care planning interventions.

P46

Improving the quality of Preferred Plan of Care discussion using a companion guide for patients with advanced dementia.

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Background: For patients with advanced dementia, preferred plan of care conversations helps to improve end of life outcomes by creating an opportunity for their carers to discuss about the circumstances in which they would prefer to limit life prolonging treatments and instead opt for an approach that prioritizes quality of life. A discussion aid provides patients and families with structured information about clinical choices and help enhance the clinical decision making.

This will improve time efficiency and quality of informed decision making by increasing disease specific knowledge, reducing decisional conflict and promote evidence-based treatments.

Objectives: Use of a discussion guide to improve the quality of discussion for patients with advanced dementia.

Methodology: This study was a cross sectional study conducted in August 2018. The target population are physicians in the department of Geriatric Medicine, Tan Tock Seng Hospital. A discussion aid was designed to present balances, evidence-based information about risk, benefits and alternatives of clinical decisions to aid in discussion of end of life care in patients with advanced dementia.

Results: Of the 43 physicians surveyed, 30% of them strongly agreed; 62% agreed; 4% Neither agree nor disagree and 2% disagree that the discussion aid will improve quality of ACP discussions.

Conclusion: Most of the physicians surveyed felt that the discussion guide will improve the quality of communication and ACP discussion in patients with advanced dementia. They are also likely to use this guide for future ACP discussions.

P47

Impact of the Mental Capacity Act on place of death in heart failure patients with or without comorbid dementia

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Background: The Mental Capacity Act (MCA) came into force in England in 2007 to foster surrogate decision making, considered particularly relevant to advance care planning for those at the end of life. This study examined the impact of the MCA on the place of death (PoD) for heart failure (HF) patients sometimes affected by the loss of capacity.

Methods: A national population-based retrospective cohort study of death registry data (DRD) in England, 2001-2016. All patients dying from HF (ICD-10: I50) were included. Capacity status designation was based on documentation of dementia (ICD-10: G30, F01, F03) as a comorbidity on DRD. Using binomial regression analysis, we compared PoD of HF decedents with and without comorbid dementia before and after MCA enactment.

Results: 113,773 HF patients were included of whom 7,473 (6.5%) had dementia, these tending to be older, female, and with more comorbidities. 66% and 19% of HF patients with capacity died in the hospital or care home, respectively, the two commonest PoDs; in contrast, corresponding figures for those without capacity were 49% and 43%. Hospice as a PoD was rare ($\leq 0.5\%$) in both groups. Over the above period encompassing MCA implementation, PoD for HF patients with capacity shifted from hospital to home or care home (adjusted prevalence ratio (APR): 1.024 [95% CI: 1.021-1.026]; $p < 0.001$); this trend less evident in those lacking capacity (APR: 0.995 [0.981- 1.010]; $p = 0.51$).

Conclusions: Our analysis suggests a limited impact of the MCA on PoD for HF patients lacking capacity, perhaps reflecting greater complexity of care required of that clinical cohort.

P48

Advance care planning lead to better decision making for end-of-life care in patients with progressive idiopathic pulmonary fibrosis

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Idiopathic pulmonary fibrosis (IPF) is a progressive and ultimately fatal lung disease. The majority of IPF patients die in hospital settings in Japan not only due to severe symptoms but also late end-of life (EOL) decision. This report presents four cases where advance care planning (ACP) allowed patients to choose their own EOL setting. *Case 1* 70s male with IPF for 3 years with a stable condition but eventually worsen due to pneumothorax. Through ACP, he chose his home as the place of death. *Case 2* 60s male with IPF for 8 years but conditions eventually worsen due to severe pulmonary hypertension caused by pulmonary embolisms (PE). After ACP, he decided to remodel the house, allowing him to stay at home for 20 days before dying. *Case 3* 70s female diagnosed with familial IPF 3 years ago but conditions worsen due to acute heart failure due to PE. After recovering 7 months later, she decided to move to a nursing home through ACP. *Case 4* 70s male with IPF for 12 years, with existing malignant lymphoma, the condition gradually deteriorated leading to the decision to stay at a hospice through ACP

In conclusion, ACP was helpful in the cases mentioned above as it gave the patients the power to make their own decision. Although, medical professionals tend to lean towards disease-centered management they understand the difficulties in deciding the best timing to discuss EOL issues so that patients will not lose hope too early on

P49

How to translate an Advance Care Planning (ACP) Conversation in a future care Treatment plan? The ACP-NOPA web application

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Background: The application was developed 2016 in Switzerland. The tool combines the different concepts of ACP, shared decision making (SDM) and medical emergency planning. In step one all documents and decision aids to create a living will are provided. Depending on the specifications the patient made in the living will (especially concerning treatment intensity and last-place-of-care) during step 2 the tool supports the care team in discharge management and/or creating emergency plans. The underlying illness of the patient is considered by providing the likely symptoms and giving treatment suggestions for the case of an emergency situation.

Methods: The tool and the underlying educational program were developed based on our experiences with the MAPS –trial (a randomized controlled trial) and palliative emergency planning to support professional care givers in conducting an ACP conversation and creating a living will based on SDM and to translate both in concrete treatment planning and future treatment planning in case of decisional incapacity. The tool was implemented in the Kanton of Zurich and tested in a feasibility study with piloting teams.

Results: We will present our concept and the results of the feasibility study.

Discussion: Core competences of ACP, SDM, intensive and palliative care are combined in this web application to support professional care givers in creating highly individualized emergency treatment plans for severely ill, multimorbid or elderly nursing home patients. Providing caregivers with these combined competences is a good way to help patients to get their treatment of choice in their favorite place-of care.

P50

Advance Directives Inclination of Patients in Singapore - A Qualitative Study

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This study aims to understand which of the advance directives (ADs) i.e. Advance Care Planning (ACP), Advance Medical Directive (AMD) and Lasting Power of Attorney (LPA) patients are more inclined to.

The study was conducted from March to September 2018 in our institution. Patients aged 21 to 99 were asked to complete a survey to evaluate their awareness, perceptions and receptions on the ADs.

Out of 150 patients, the awareness was 101 for LPA, 77 for AMD and 74 for ACP with 41.3%, 28.6% and 20.7% of them learnt about them through media respectively. 55 out of 101 patients considered doing LPA. 51 out of 77 patients considered doing AMD. 40 out of 74 patients considered doing ACP. 70% of those considering doing ADs are influenced by their family. 38.6% of them favoured LPA over ACP and AMD as financial arrangement is made. 30% of them prefer AMD to ACP as AMD is legal-binding. 36% of them prefer ACP to AMD as they get to discuss their healthcare preferences with their caregivers. 48% of them think it is too early to talk about end-of-life treatments. 51.3% of them do not know the process of doing ACP and AMD.

There is no significant trend showing which ADs are patients more inclined to. Healthcare providers could initiate ACP conversations when patients are at their early disease trajectory. Also, more can be done to increase ADs awareness especially ACP through media to educate public on their importance and processes.

P51

Evaluation of the Advance Care Planning Programme in A Cardiac Centre in Singapore

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Our institution has initiated inpatient Advance Care Planning (ACP) programme since 2013. However, enrolment rate has been low. We plan to report our experience after extending ACP programme to outpatient setting in 2017. Patients were seen from both inpatient and outpatient setting in 2017 and mainly from outpatient setting from January to June 2018.

115 patients were enrolled out of 1410 patients in 2017 and 84 patients out of 1434 in 2016. This represented 2.3% increase in enrolment rate. From January to June 2018, 376 patients were seen and 69 patients enrolled. Average yield from June 2013 to December 2016 was 5.4%, which was considered low. Patients yield increase from 8.2% in 2017 to 18.4% within the first 6 months of 2018. In 2013 to 2016, we only managed to enrol 6 patients per month. The enrolment rate increase to 10 patients per month in 2017 and 12 patients per month in 2018.

There is a significant increase in ACP enrolment rate after shifting our focus from inpatient to outpatient setting. Patients and their caregivers are not ready for ACP conversations during hospitalisation as patients could be too sick to engage in the conversations. They are more willing and receptive to have ACP conversations when they are in outpatient setting. Moving forward, the ACP team will continue to work with primary care providers to offer ACP to patients who need them earlier in their disease trajectory.

P52

Opportunity to practice advance care planning as regarded by nurses caring for people with chronic illnesses in Japan

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Purpose: As the Japanese population ages and advanced medical care progresses, there is an increasing need to consider ACP for people living with chronic illnesses. Nurses assume an important role in the advancement of ACP. The purpose of this study is to clarify the opportunity to put it into practice as perceived by nurses who are providing nursing care for patients with chronic illnesses.

Methods: A quantitative study design was employed using a self-administered questionnaire survey. The questionnaire consisted of one to five Likert scales, and was sent via post to 1,855 addressees including all the Certified Nurse Specialists in Japan engaged in nursing care of people with chronic illnesses. 693 nurses responded.

Results: The scores were high for "Setting up a meeting as required (during hospitalization)" (4.50 ± 0.62), "Setting up a meeting as required (as an outpatient)" (4.43 ± 0.69), "At the time of discharge (including the meeting to discuss treatment details with the patient and personnel involved in their treatment)" (4.17 ± 0.83), and "When providing regular treatment or nursing care (during hospitalization)" (4.11 ± 0.82).

Discussion: The items raised as an opportunity to practice ACP, namely, "As required" and "When providing regular treatment or nursing care" are due to the characteristics of chronic illnesses, which require a long period of recuperation and carry uncertainty in the illness trajectory.

P53

Study protocol for a randomized controlled trial on the effectiveness of Advance Care Planning (ACP) in general practice

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Background: General practice is an optimal setting for ensuring timely initiation of ACP discussions. A multi-component ACP intervention developed for the general practice setting, aimed at patients with chronic life-limiting illnesses and their general practitioner, has been pilot tested. The aim of this study is to evaluate the effectiveness of this intervention and to evaluate its implementation by means of a process evaluation.

Methods/Design: Using a cluster-randomized controlled trial (RCT) (randomization at the practitioner level, n=53 practitioners per condition, n=133 patients per condition), we will compare the structured ACP communication intervention to usual care, employing baseline measures (T0), and follow-up at 6 months (T1) and 12 months post-baseline (T2). Primary endpoints are quality of communication about end-of-life care and concordance between patients' preferences and received care at the end of life (as reported by the family caregiver if the patient died). Other patient or caregiver-reported outcomes include health-related quality of life, anxiety and depression, quality of end-of-life care, and quality of death and dying. Following the RE-AIM framework, structured diaries for trainers and general practitioners, as well as qualitative interviews with general practitioners, patients and family caregivers are among the measures used for the process evaluation.

Discussion: After this Phase III RCT, we will be able to present a well-tested and evaluated ACP intervention that can be implemented in general practice. The results of the process evaluation will provide insight needed to allow adaptation of the intervention for a greater variety of national and international contexts.

P54

How Patients and Relatives Perceive the Concept of Advance Care Planning: an Interview Study

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Background: The EAPC consensus concept defines Advance Care Planning (ACP) as enabling persons to identify goals and preferences for future treatments and care, and to discuss, record and review these. However, this concept is defined by professionals. It is unknown how patients and relatives conceptualize ACP, however, this would be useful for (online) information provision on ACP.

Aims: To explore what patients and relatives consider important in ACP and how they would search for ACP information on the internet.

Methods: To address our aims, we interviewed 9 patients with chronic diseases and 7 relatives. We used constant comparative analyses to categorize their key elements of ACP.

Results: Patients and relatives would use search terms such as 'ACP', 'care/treatment plan', 'disease trajectory', 'advance directive' and patient associations. They would appreciate information on ACP and its importance; how to adapt ACP to individual needs; values and quality of life; diseases; treatment and care options; and communication of preferences. Furthermore, interviewees mentioned additional needs, such as how to get support, explanation of persons involved in ACP, encouragement to think about ACP, information for relatives, and peer support.

Conclusion(s): Key elements of ACP according to patients and relatives are in line with the EAPC consensus concept according to professionals. However, patients and relatives also mentioned additional elements, indicating their concept of ACP may be broader. Including the elements and search terms in ACP information may enhance online findability and may help meeting information needs.

Funding: The Netherlands Organisation for Health Research and Development (ZonMw).

P55

Nurses' understanding and perspectives of Advance Care Planning in COPD

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Background: Advance care planning (ACP) presents as a current issue within an Irish context. Recent publications by The Irish Hospice Foundation include documents 'Think Ahead' and 'Planning for the Future with COPD'. In 2015 The Assisted Decision-Making Capacity Act was published. Currently, the HSE are in the process of publishing professional guidelines for practice in relation to ACP (HSE 2018.) Much of the existing literature relates to physician's views on ACP in COPD. Articles relating to nurse's understanding of ACP entail more towards other patient subgroups such as oncology patients and the older adult.

Method: A descriptive qualitative design was used. Eight staff nurses from a respiratory unit were recruited. Semi-structured interviews were audio-recorded. A topic guide from a previous study was adapted.

Results: Four categories were identified; the importance of ACP in COPD, facilitators to ACP in COPD, barriers to ACP in COPD and the role of the nurse. Each category was further subcategorised.

Conclusion: Nurses identified the importance of ACP in COPD. Benefits included symptom specific factors but also an improvement in the overall quality of care patients could receive. A number of facilitating factors and challenges were identified by the sample in the provision of ACP. Nurses identified themselves as playing an important and broad role in ACP. Future implications were identified for education, research and practice. Recommendations include an increase in education across both undergraduate and postgraduate forums, further research and the appointment of lead nurses in relation to ACP in COPD patients.

P56

Enhancing the End of Life (EOL) communication: Evaluation of the 'EOL care education' for nurses in acute care setting

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Background: It is critical to discuss with advance cancer patients on their EOL issues to improve the quality for their future care. Japanese nurses, however, are apt to feel uncomfortable to deal with such discussions with these patients because most of them have limited opportunities for the training for EOL communication.

We investigated whether 'EOL care education course' for nurses may help improving their knowledge and skills on EOL care, including communication ability.

Methods: We provided 15 nurse participants with the educational course based on the ELNEC Core Curriculum including communication and ethical consideration. They all had more than 2 to 25 years of nursing experience. Efficacy of the course was evaluated by using the End of Life Nursing Education-Japan Core Quiz.

Results: The overall correct answer rate before the course was 66% which was significantly improved to 86% after the training ($p < 0.05$). The learning effect was obtained about the knowledge and attitude towards the EOL care by taking the course. The participants felt it challenging to deal with ethical facets and patients' spiritual pains. The results, however, showed an increase in the correct answer rates on 'communication skills' from 70% to 93%, before and after the course, respectively. We believe that the practical role play during the course contributed this improvement.

Conclusions: The education course we provided improved knowledge and skills for EOL communication in the nurse participants. We learned that in the future the course needs more attention on the 'ethical consideration' and 'spiritual care'.

P57

Collaborative Advance Care Planning: Improving palliative care by structured communications about matters of Life and Death - the study protocol

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Background: Implementation of advance care planning (ACP) is proceeding in the western world and often recognised as a sufficient approach to ensure patients' wishes for end of life (EoL) care. There is evidence that patient related outcomes are improved. However, information about the impact of ACP on quality of life (QoL) in palliative cancer patients is missing.

Methods: This randomised controlled trial investigates the efficacy and effectiveness of a collaborative ACP (cACP) intervention in palliative cancer patients and their care givers by comparing three groups: 1. cACP-Intervention; 2. Supportive intervention 3. Treatment as usual. The cACP-intervention consists of four sessions (two with the patient alone, one with the care giver alone, one together) that address potential barriers to discuss end of life issues (e.g. negative expectations concerning EoL issues and ACP) and two regular ACP sessions. Primary endpoint is the patient health-related QoL (FACIT-PAL). Secondary endpoints are general QoL; distress; acceptance; depressiveness; evaluation of the intervention; care-givers: health-related and general QoL. Patients' QoL is evaluated every second month for one year. In the event of the patients death, care-givers are asked to answer questions about concordance of advance care planning with actual care and the patients quality of dying.

Results: Until 11/18, 75 patients have been randomized, 13 patients finished the intervention, 21 patients died, denial rate is at approx. 55 %.

Conclusion: This study tries to implement ACP in a palliative cancer setting in Germany. The efficacy and effectiveness of a novel collaborative ACP intervention are evaluated.

P58

Advance care planning in glioblastoma patients: development of a disease-specific ACP program

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Background: It is unknown if implementation of an Advance Care Planning (ACP) program is feasible in daily clinical practice for glioblastoma patients. We aimed to develop an ACP program, and assessed the preferred content, the best time to introduce such a program in the disease trajectory, and possible barriers and facilitators for participation and implementation.

Methods: A focus group with health care professionals (HCPs) as well as individual semi-structured interviews with patients and proxies (of both living and deceased patients) were conducted.

Results: All predefined topics were considered relevant by participants, including the current situation, worries and fears, (supportive) treatment options, and preferred place of care/death. Although HCPs and proxies of deceased patients indicated that the program should be implemented relatively early in the disease trajectory, patient-proxy dyads were more ambiguous. Several patient-proxy dyads indicated that the program should be initiated later in the disease trajectory. If introduced early, topics about the end-of-life should be postponed. A frequently mentioned barrier for participation was that the program would be confronting, while a facilitator included access to information.

Conclusion: This study resulted in an ACP program specifically for glioblastoma patients. Although participants agreed on the content of the program, the optimal timing of introducing such a program was a matter of debate. Our solution is to offer the program shortly after diagnosis, but let patients and proxies decide which topics they want to discuss. The impact of the program on several patient- and care-related outcomes will be evaluated in a next step.

P59

Changes in End-of-life Decisions between Patients with Advanced Cancer and their Family Members after Implementation of the Nursing Program

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Background: Patients with advanced cancer and their family members tend not to adequately communicate with each other about the end of life in Japan. Previous studies have clarified that the obstacles for conversation are mostly posed by family members. Thus, the authors developed a nursing program for family members of patients with advanced cancer to promote End of Life Discussion (EOLD). This study aimed to clarify changes in EOLD between patients and their family members after implementation of the nursing program.

Methods: The researchers performed three interview sessions, based on the manual for nursing practices and the guidebook for family members, which were established by the researchers. The interviews were recorded, and the data was analyzed qualitatively and inductively. This study was conducted with approval by the Ethical Review Board of the affiliated institution of the researcher.

Results: The research participants were ten family members of patients with advanced cancer (seven females, forty

to eighty-nine years of age). The twelve categories were extracted regarding changes in EOLD between patients and their family members, including the following: They realized the necessity to discuss the end of life. They were able to discuss subjects that they had been concerned about. They wrote down what they discussed. They were highly motivated to continue talking about the end of life.

Conclusion: This research clarified that varied effects on the promotion of EOLD can be expected from this nursing program according to the situation and conversation of each patient and their family members.

P61

The effect of prioritising treatment goals on decision self-efficacy among older patients with cancer in a palliative setting (OPTion-study)

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Background: In the Netherlands, the General Practitioner (GP) is generally not involved in treatment decisions in cancer. However, the GP often has a long history with patients and can help to explore patients' values, especially in older patients. This can help the patient prepare for shared decision making with the oncologist. The aim of this randomised controlled trial is to study the effect of a conversation about treatment goals between GPs and patients on self-efficacy just after the diagnosis of non-curable cancer.

Methods: We included patients aged ≥ 60 years with a diagnosis of non-curable cancer, who have heard the treatment options from their oncologists. In the intervention group, patients consulted their GP using an Outcome Prioritisation Tool (OPT) to discuss the prioritisation of treatment goals (staying alive, maintaining independence, reduce pain, reduce other symptoms). The control group received care as usual. Primary outcome was the score on a decision self-efficacy scale after the decision-making consultation with the oncologist.

Results: Inclusion ends on 1 January 2019. Results are not yet available but we will present the first results during the conference.

Conclusion: The OPTion-study provides information about the effect of a consultation, about preferred treatment goals, between GPs and older patients with non-curable cancer on self-efficacy.

P62

The Distress Thermometer as a Prognostic Tool for One-Year Survival among Patients with Lung Cancer

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Introduction: Use of patient-reported outcome measures is advocated to support high-quality cancer care. We investigated the added value of the Distress Thermometer (DT) when combined with known predictors to assess one-year survival in patients with lung cancer.

Methods: Patients had newly diagnosed or recurrent lung cancer, started systemic treatment, and participated in the intervention arm of a previously published randomised trial. A Cox proportional hazards model was fitted based on five selected known predictors for survival. The DT-score was added to this model and contrasted to models including the EORTC-QLQ-C30 global QoL score or the HADS total score. Model performance was evaluated through improvement in the -2 log likelihood, Harrell's C-statistic, and a risk classification.

Results: In total, 110 patients were included in the analysis of whom 97 patients accurately completed the DT. Patients with a DT score ≥ 5 (N=51) had a lower QoL, more symptoms of anxiety and depression, and a shorter median survival time (7.6 months vs 10.0 months; P=0.02) than patients with a DT score < 5 (N=46). Addition of the DT resulted in a significant improvement in the accuracy of the model to predict one-year survival (P<0.001) and the discriminatory value (C-statistic) marginally improved from 0.69 to 0.71. The proportion of patients correctly classified as high risk ($\geq 85\%$ risk of dying within one year) increased from 8% to 28%.

Conclusions: Use of the DT allows clinicians to better identify patients with lung cancer at risk for poor survival, further explore sources of distress, and personalize care accordingly.

P63

Recruiting patients in difficult environments - Practical experiences from a German cACP trial

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Background: Researchers recruiting patients for clinical - non-pharmacological - studies in palliative cancer settings face multiple problems. Patients life expectancy is limited, physical and psychological wellbeing can be volatile and medical treatment tends to be challenging and tiring for patients. Rejection and dropout rates for scientific trials in general are therefore high, especially if concerning advance care planning (ACP).

Aim: Recruitment is often assigned to few members of staff who then gain a lot of experience in the matter, formal transition of knowledge can be difficult if

a.) theoretical framework about recruitment;

and

b.) practical examples how to handle difficult recruitment conversations;

are missing.

To address and overcome b.), we have developed "mini-interventions". These aim to change perspective of patients on participation in our randomized controlled ACP trial, and can be applied generally.

Results: We developed several interventions covering the following topics:

- Misconceptions towards “psychological” support and academic research
- Physical and emotional wellbeing and therefore no need to partake in the trial
- Time constraints, unwillingness to invest more time in “treatment” than necessary
- Fear of burdening care givers with psychological involvement

With these “mini interventions” delegation of recruitment and training of recruitment staff is eased and the recruitment process and success does not rely solely on single experienced staff members.

Conclusion: Interventions in recruitment conversations may have several effects, including improvement of patient decision making, increase of recruitment numbers and better transition of knowledge in research teams.

We seek to cross-link with other international groups facing similar challenges concerning recruiting.

P65

Development of a pediatric Advance Care Planning intervention

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Background: ACP-conversations in pediatrics seem to occur too late and infrequent. Standards to conduct ACP-conversations are lacking. This study describes the development of an evidence-based pediatric ACP-intervention.

Methods: The Medical Research Council framework for development and evaluation of complex interventions was used to structure the developmental process. The process included a systematic review, expert review, a survey among pediatricians and qualitative research among parents, adolescents and health care professionals (HCPs). Behavioral theories and theories of coping with bereavement and loss underpinned the intervention.

Results: ACP was seen as an ongoing communicative process, where children and their families work together with HCPs to discover, discuss and document values, preferences and goals of care. The intervention supports ACP by 1) educational materials, 2) an ACP conversation guide and 3) a training for HCPs. Educational materials prepare children and parents by clarifying the concept of ACP and providing preparation prompts to discover their values. The guide provides HCPs structures and wording to address the following identified ACP topics: the identity of the child, living with illness, the future, hope, fears and worries, preferences for daily life and goals of care. The training educates HCPs about the concept of ACP and coping with illness and loss and trains specific communication skills. The intervention includes a documentation format.

Conclusion: A pediatric ACP-intervention was designed targeted to the following needs: education about the concept of ACP, strategies to conduct ACP conversations and a documentation format. Our ongoing research will evaluate the feasibility of the intervention.

P66

Pediatrician's experiences with Advance Care Planning: a qualitative study

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Background: Pediatricians in academic care centers are involved in high-complex care for children with life-limiting conditions. They guide families in defining goals of care and medical decision-making. Advance Care Planning (ACP) supports family-centered care and shared decision-making. This study evaluates how pediatricians integrate ACP in their daily care for children with life-limiting conditions.

Methods: An interpretative qualitative study using thematic analysis was performed. Single interviews were undertaken with 17 pediatricians working in five pediatric tertiary hospitals.

Results: Initiation of ACP discussions is determined by expected disease progression, technical treatment options or increasing symptoms. Pediatricians prefer to discuss ACP within a long-term relationship with a child's family. This ensures and enables them to address issues concerning challenging medical decisions and end-of-life in the right way at the right time for a specific family. Pediatricians focus in ACP discussions on future scenario's and related care options. They try to balance between 'hope' (normalizing living with illness, focus on problem solving) and 'the worst' (decline of the child's condition and an inevitable death). They aim to prepare the child and family for 'a life as normal as possible and when inevitable, a good end of life'. Few pediatricians explore the child's and family's values and perspectives.

Conclusion: Pediatricians focus on prognosis and treatment options in ACP conversations. They take families by the hand throughout the disease trajectories and try to guide medical decision making in the best interest of the child. Exploration and integration of family values seems less integrated in their practice.

P67

Testing the effectiveness of a family-centered pediatric advance care planning intervention: study protocol for a randomized controlled trial.

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Background: A family-centered pediatric ACP intervention (FACE) was developed in the US, which demonstrated feasibility, acceptability and safety. The aim of this study is to evaluate the effectiveness of an ACP intervention, adapted from the FACE intervention, for pediatric oncology in Flanders, Belgium.

Methods: A total of 93 dyads of parents and adolescents (age 10 – 18) receiving care in pediatric oncology wards

will be recruited. Intervention dyads (N=46) will receive three weekly 60-minute sessions. Control dyads (N=46) will receive care as usual. Primary outcome is congruence in treatment preferences between adolescent and parent, measured by the Statement of Treatment Preference. Secondary outcomes are: quality of communication, decisional conflict for adolescents, and quality of life of adolescents and parents. Outcomes will be measured at baseline (T0) and 3 months after the intervention (T1). A process evaluation will be done by documentation of recruitment, analyzing audio recordings of the intervention, and post-trial qualitative interviews with adolescents (n=10) and parents (n=10) and focus groups with the involved healthcare professionals.

Discussion: This will be the first pACP intervention in Europe and will provide evidence on the effectiveness of an ACP intervention in adolescents with cancer. A process evaluation will provide in-depth insight into how the pACP intervention was delivered in practice and contribute to understanding the underlying mechanisms of the intervention.

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Developing a pediatric ACP intervention for adolescents with cancer in Belgium

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Background: Parents of adolescents with a life-limiting illness have expressed the desire to talk to their children about goals and preferences of care. Recently, a family-centered pediatric advance care planning (ACP) intervention (FACE) was developed in the US, which demonstrated feasibility, acceptability and safety. The aim of this project is to develop a pediatric ACP (pACP) intervention by translating the existing FACE intervention and adapting it to the Belgian situation for paediatric patients with cancer and their parents.

Methods: First, feedback about the proposed content and process of the FACE intervention will be obtained from pediatricians (n=4), psychologists (n=4), parents and adolescents with cancer (n=8) from four different pediatric oncology wards through semi-structured interviews. Second, four separate focus groups with the abovementioned groups will be organized. Third, experts with extensive experience in ACP with children will review the materials individually and findings will be discussed in an expert panel. Before pilot testing the intervention, cognitive testing of all questionnaires used for the outcome measurements with adolescents, their parent (n=4) and physicians (n=4) will be done. All retrieved information will be processed in a first version of a manual of how the intervention is delivered.

Discussion: After development of the pACP intervention, effectiveness will be tested in a randomized controlled trial design. Primary objective of the trial is to assess whether the pACP intervention improves congruence in treatment preferences between paediatric patients and their parent. A process evaluation will provide more information about the underlying mechanisms of the intervention.

P69

Development and evaluation of an ACP-program for professionals in palliative care for people with intellectual disabilities

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Background: People with intellectual disabilities (ID) have restricted cognitive and communicative abilities, and therefore encounter difficulties in clarifying their wishes and needs. Professionals in ID-care do not always recognize palliative care needs and lack communication skills to talk about future care in advance. Aim of this study was to develop and evaluate an advance care planning (ACP)-program to train professionals in knowledge and skills about ACP in palliative care for people with ID.

Methods: This study contained five phases. Phase 1 consisted of a systematic review, (medical)file analysis and supplementary interviews, and depth-interviews to discover important aspects of ACP. These were translated into an ACP-program in co-creation with professionals, relatives and people with ID (phase 2). A communication training framework was developed (phase 3). Implementation of the ACP-program took place in six organizations providing ID-care (phase 4). In phase 5 the program was evaluated by pre-structured questionnaires send to participants of the program.

Results: The ACP-program consists of 1.Methodology about important aspects of ACP, 2.ACP communication training, and 3.Consultation about implementation strategies for ACP. It is based on 10 competencies needed for ACP; palliative phase identification, signaling symptoms, communicating, documenting, structurally deploying ACP, taking wishes of people with ID into account, collaborating, paying attention to possible dilemmas, reflecting, and regarding ACP as a standard aspect of palliative care.

Conclusion: An ACP program is helpful to make professionals aware of the importance of ACP and improve communication skills. Research is needed to further investigate the effective elements of the ACP program.

P70

Effects of an Advance Care Planning Educational Program intervention in an Acute Hospital; A Qualitative data analysis

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Background: Advance care planning (ACP) is a crucial end-of-life care practice. However, an ACP educational program for practitioners in an acute care setting has not yet been established. This study aimed to examine the effects of an ACP educational program in acute hospital. Aim: This work is evaluating the effect of ACP education programme on acute hospital practitioners. Design: A mixed-methods, Pre-and post test study to evaluate changing practitioner attitudes post program. The intervention program was three times during the 3 month in 90 minutes per session. As a program evaluation, comments on participant's questionnaires two questions about an attitude and practice were categorized and evaluated. We used conventional content analysis. Setting/ Participants: The final sample of 63 practitioners whose they were working at B acute hospital. Results: As a result of analysis of qualitative data, Question1 was categorized into five categories, and Question2 was categorized into seven categories. The results that participants thought important of ACP implementation and talk with patient and family. It was suggested that participants were able to look back on their own way of thinking about death and found the tips of ACP implementation. Conclusion: The key message of this study was change sustained of awareness about positive attitude of ACP and EOL after 6 month intervention. These results suggest that the present ACP educational program was effective at improving staff attitudes towards the end of life care of patients.

P72

Translation into Spanish, cross-cultural adaptation and validation of an Advance Care Planning Self-efficacy scale: preliminary results

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Background: Advance Care Planning (ACP) explores patients' values and preferences to plan their care. Barriers for healthcare professionals to start it include fear to talk about end of life or lack of communication skills. Self-efficacy (SE) is a key factor that impacts learning about ACP. Measuring SE would show the impact of training to acquire ACP competencies. The ACP SE scale (ACP_SEs) of 17 items was validated in 2017; there aren't similar validated tools in Spanish.

Methods: The ACP_SEs was forward-backward translated. 10 ACP local experts tested it for clarity and comprehensibility. Validation: we designed a survey with 4 dimensions: sociodemographic variables; knowledge and self-perception on ACP; type of patients attended; 4 scales to predictive validity: ACP_SEs (Baughman, 2017); Trait Meta-Mood_s 24 (Salovey and Mayer, 1995); Personal Competence_s (Wallston, 1992); Coping with Death_s (Bugen, 1980). Participants: 5,500 professionals from 4 scientific societies: Palliative and Primary Care (3 societies); Geriatrics/Gerontologic (1society). Reliability will be determined by intraclass correlation coefficients, the measurement will be compared by T'Student and internal consistency by Cronbach's α . Test-retest reliability will be quantified with a 4-week interval.

Results: After the translation/adaptation process, the ACP_SEs has 19 items. New variables include to involve patients in ACP and to register ACP adequately. In a pilot with 47 professionals, consistency was $\alpha=0.909$. The results will confirm the scale's validity and show how professionals rate the ACP process.

Conclusion: A validated ACP_SEs in Spanish will allow measuring the impact of training programs designed to implement ACP in the Spanish-speaking context.

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Advance care planning and end of life care for patients with Huntington's disease: A qualitative study design

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Background: Huntington's disease (HD) is an inherited neurodegenerative disease, characterized by movement disorders, psychiatric symptoms, and cognitive decline. In the later stages of the disease patients often are no longer able to express their wishes for care, because of problems with communication and cognitive decline. Little is known about advance care planning, advance directives, and end of life care for HD patients.

Aims: In this study we aim to explore HD patients' perceptions of their future, end of life, and end of life care, and whether these perceptions change over time. Furthermore, we aim to study the views of elderly care physicians on advance care planning and end of life care for HD patients.

Methods: A qualitative approach is adopted using semi-structured interviews. Approximately 10-15 HD patients will be interviewed every 6 months for a period of 2 to 2.5 years. Topics are: quality of life, the future, end of life, death, advance directives and talking to others about these subjects. In addition, approximately 10 elderly care physicians will be interviewed once. The physicians will be encouraged to describe their experiences with advance care planning, end of life care, patients' decision making capacity, advance directives, and euthanasia in HD. All interviews will be audio recorded and transcribed verbatim. Atlas.ti will be used for analysis.

Results and conclusions: Data collection started in 2017 and results are expected in 2020. The results of this study will provide valuable information on advance care planning and end of life care for HD patients.

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Shared care planning, the twist that could save the unfulfilled potential of advance care planning in Spain

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Background: The “right to grant and register an advance directive” has spread in Spain’s health care legislation. Reality check: documents are completed by less than 1% of the population. Having ACP philosophy widespread elsewhere, this seems a rather meager approach that, additionally, does not sympathize with the way, we, human beings suffer, endure and face illness.

Method: Intellectual journey, rationale and roadmap for a new twist in Spain’s theoretical, ethical and policy development.

Results: Few healthcare administrations and some individual experiences in Spain are promoting ACP implementation into public health care systems. In 2017, the “Spanish Working Group on Shared Care Planning” (GET-PCA in Spanish) was built up with the conviction that what could be done to take advantage of our strengths as a National Health System and a caring Mediterranean culture was midwifing shared-decision making (SDM) for current care together with the pursue of ACP for future care in what we named as “shared care planning” (SCP). GET-PCA defines SCP as “a deliberative, relational and structured process that facilitates reflection and understanding of illness’ and care’s experiences, among all involved, focusing on each person facing a disease trajectory, to identify and express their preferences and expectations within their context of care. Its goal is to promote SDM in relation to current context and ACP to future care challenges, such as when the person might not be competent to decide for herself.”

Conclusion: SMD matching ACP may save the day for Spain. Best of both worlds: welcome shared care planning!

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PrepareDem: helping people with dementia and their carers prepare for care in advanced illness and end of life

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Background: The number of people living with dementia is expected to double by 2050. Experiences in advanced illness and at end of life for people with dementia and their carers can be poor. Advance care planning (ACP) is especially challenging in dementia. In this study we will explore how people with dementia and their carers prepare for advanced illness and end of life. Using quantitative and qualitative data, we will look at what factors influence them. We will ask about their experiences, including of advance care planning or other support. We will especially consider how people with dementia and their carers interact and influence each other, and what expectations they have of each other. We will also examine whether preparing, through ACP or other means, makes a difference to end of life outcomes and experiences.

Methods: Secondary analysis of data from the Improving the Experience of Dementia and Enhancing Active Life (IDEAL) study (gathered from a cohort of 1500 people with dementia and their carers).

- Qualitative interviews with 40-50 carers (and people with dementia where capacity allows) taking part in the DETERMinants of quality of life, care and costs, and consequences of INequalities in people with Dementia and their family carers (DETERMIND) study (a cohort of 900 people with dementia and their carers)
- Bereavement survey with carers from the DETERMIND study who are bereaved during the course of our study (2018-2023)

Results: Findings will be reported over the course of the study in academic papers, blog-posts and at a range of conferences and meetings. We will also produce guidance for policy-makers and practitioners and a short film.