

between 6.5% and 45%, and for the three medical treatments between 11.5% and 34.5%. Respondents whose partner discussed their EOL preferences with them, completed an advance directive and designated them as a healthcare proxy were more likely to report a better subjective knowledge. Respondents whose partner completed an advance directive and designated them as a healthcare proxy were more likely to have better objective knowledge of partner's preferences for medical treatments.

**Conclusion** Being a couple is not enough to assess one's partner's EOL preferences correctly. Communication about EOL wishes among the couple and individual ACP should be encouraged, as they improve the level of subjective and objective knowledge of partners' EOL preferences.

PP05.007

### SOCIAL, REGIONAL AND HEALTH DETERMINANTS OF ADVANCE DIRECTIVE ADOPTION: A FOUR-YEAR STUDY AMONG OLDER ADULTS IN SWITZERLAND

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**Background** While numerous cross-sectional studies reported that advance directive (AD) completion varies significantly by age, gender, and education level, little is known about the factors that prompt AD completion over time. This study aims to identify the social, regional, and health characteristics associated with AD adoption over four years in a population-based sample of adults aged 55+ in Switzerland.

**Methods** We used data from wave 6 (2015) and wave 8 (2019/2020) of the Survey of Health, Ageing and Retirement in Europe (SHARE) in Switzerland. AD adoption was defined as not having completed ADs in wave 6 while having completed ADs four years later. We used probit regression models to examine the associations between key social, regional, health characteristics and their change between wave 6 and wave 8 and AD adoption over the same period.

**Results** In wave 6, 842 respondents reported not having completed ADs. Among them, 269 (30.9%) reported the completion of ADs in wave 8. We found that older age (being 65–74 or 75+ vs 55–64 years) was the only social characteristic significantly and positively associated with AD adoption. Respondents living in French- and Italian-speaking Switzerland were significantly less likely to adopt ADs than those in German-speaking Switzerland. Self-rated health, having limitations with activities, and frailty status in wave 6 were not significantly associated with AD adoption between waves 6 and 8. Consistently, a change in partnership status, in self-rated health, in limitations with activities, in frailty status, and the occurrence of a major health event (stroke, cancer, heart attack) between wave 6 and wave 8 were not associated with AD adoption over the same period.

**Conclusion** Older age and living in a German-speaking region seem to be more critical determinants of AD adoption than

health status or change in health status in older adults in Switzerland.

PP27.001

### I THINK IT'S EVERYONE'S CONVERSATION REALLY

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**Background** Advance Care Planning (ACP) in the context of end-of-life care has been identified as 'everyone's responsibility'. However, the research literature tends to focus only on the roles and responsibilities of medical and nursing staff and students. The relative engagement and experiences of the diverse group of health professionals in providing ACP has been underexplored in the hospital setting.

**Methods** This research was conducted using Mixed Methods Phenomenological Research (MMPR). Three separate studies were undertaken: a retrospective chart audit evaluating the prevalence of ACP documents health records; a survey exploring perspectives of providing ACP; and an interview study investigating perceived roles and responsibilities in providing ACP. Participants were health professionals from medical, nursing, and allied health workforce groups across a regional health service in Queensland, Australia.

**Results** The Role Identity Equilibrium Process was used as a theoretical model for conceptualising ACP provision. The prevalence of ACP documents in the health records was low, with only 7% of records containing a formal document. Discussions about ACP with a patient or their decision maker were documented in 48.3% of health records. Health professionals did not share a common understanding of the end-of-life time frame, nor the full extent of activities considered part of ACP. Apart from doctors, other health professionals did not identify a legitimate role in ACP. Self-perceived confidence, knowledge, and skills were low, which contributed to lack of an individual or collective professional identity, and abdication of responsibility for conducting ACP.

**Conclusion** Implications for clinical practice include defining roles, responsibilities, and scope of practice for novice and experienced health professionals and including a broader range of health professionals in education programs. Changes to roles and responsibilities will need to be managed sensitively, slowly, and in a safe environment that respects and builds upon existing skills and knowledge.

## PP07: ACP in the Era of Pandemic

PP07.001

### AN EVALUATION OF TELE-ACP IMPLEMENTATION IN ACUTE CARE AND COMMUNITY SETTINGS IN SINGAPORE

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**Background** Since May 2020, MOH and AIC have worked with the ACP Steering Committee to issue a set of tele-ACP guidelines to institutions during COVID-19. The guidelines include guidance on enrolment criteria, consideration for