inpatient to the outpatient setting to follow up on patients who have been referred for ACP.

PP10.003 THE CAUSES OF DISCORDANT BETWEEN ADVANCED CARE PLAN PREFERENCE AND END-OF-LIFE CARE TREATMENT IN PATIENTS RECEIVED CONSERVATIVE KIDNEY MANAGEMENT

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Background Share decision-making and advance care planning (ACP) is essential for patients with end-stage renal disease (ESRD). Karunrak Palliative Care Center started a Renal Palliative Care Program in 2017, which is the first joint Chronic kidney disease-Palliative care program in Thailand. ESRD patients always received discordant end-of-life care (EOLC).
Methods The causes of the discordance of EOLC of conservative kidney management (CKM) patients who died during the period of October 1, 2020 to September 30, 2022 were retrospectively reviewed.
Results The demographic data of 38 deceased CKM patients were: 78.9% aged ≥75; 55.3% Charlson comorbidity index ≥8, 89.5%; Karnofsky Performance status > 40%. Median survival time after entered the program was 409.0 days, IQR= 184.5–602.5 days and 42.1% is greater than 12 months. All patients had ACP documentation, but only 15.8% had advance directive.
Conclusion The causes of discordance between ACP preferences and actual EOLC received majority are from severe symptoms especially dyspnea. Other serious illnesses which led to hospitalization in this report are COVID-19 infection and stroke.

PP10.004 SUCCESS FACTORS FOR IMPLEMENTING ADVANCED CARE PLANNING FOR SINGAPORE'S LARGEST HOME CARE PROVIDER

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Background Home Nursing Foundation (HNF) is a non-profit home care provider established since 1976, traditionally providing chronic disease management and procedural nursing care for home bound patients. In recent years, patients' needs have evolved to more complex, requiring a multidisciplinary approach. Including Advance Care Planning (ACP) in patient care became clear as many of our patients are approaching End-of-Life (EOL). However, the journey from training to successfully performing ACP has been challenging. Efforts have been made to train our clinical staff in ACP over the last four years, yet the execution and filing of ACP has remained dismal.
Methods A root cause analysis (RCA) was done to identify the different factors for failure to execute ACP conversations. Factors identified were lack of readiness from patients and their health proxy in discussing general ACP, lack of mentors for newly trained staff, logistical challenges in the home setting, mismatch in capabilities, staff turnover, lack of guidelines and suitable care models to identify and manage patients who would benefit from ACP and ultimately EOL care.

We addressed the factors identified by the RCA, re-examined staff training and recruitment, developed an EOL care path to identify, assess and manage patients who might benefit from palliative care and targeted these patients to start Preferred Plan of Care* (PPC).
Results The team subsequently performed three successful PPC conversations with signed documentation within a month of piloting the EOL care path.
Conclusion For home bound and frail elders, PPC might be the format of choice. Staff training and recruitment should be accompanied by redesigning the care process and models. With the care path, there was a clear trigger and assurance of follow up which ensured the PPC was formalised.

* PPC is a format of ACP designed for people in the last twelve months of life.

PP10.005 BARRIERS TO COMPLETION OF ADVANCE CARE PLANNING IN HEART FAILURE PATIENTS

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Background Advance care planning (ACP) is known to improve the end-of-life care of patients with heart failure (HF) and has been emphasized in international HF guidelines. Despite its known benefits, ACP completion rates remain dismal. We aimed to study the barriers to completion of ACP in HF patients.
Methods We systematically reviewed all the ACP referrals that were made at a tertiary cardiac centre from 2017 – 2021 in Singapore. There were 164 referrals and only 69 were completed. We studied the reasons for incompletion of the remaining 95 referrals. We also conducted a self-administered questionnaire survey to understand the Cardiologists' perceptions of ACP.
Results Common reasons for ACP incompletion include: 1) Patients/Family declining to complete the ACP discussion. (34%) This is especially so in Singapore as discussion about death is still considered taboo. 2) Patients not returning for ACP discussion (25%) as most of the discussions were conducted in the outpatient setting. 3) Patients/Family changing their minds about completing ACP at the last minute (11%). 4) Patients/Family not being able to make a decision on their preferences (9%). 5) Patients/Family not understanding ACP (5%).

Out of 22 Cardiologists surveyed, 22% felt that ACP was not important for their patients. 68% felt that they were not confident in conducting ACP and only half had ever attempted to do one. The common reasons identified for barriers to ACP include: not having enough time, not knowing how to do ACP and that patients are not ready to talk about ACP. 82% indicated that they would want to learn more about ACP and apply it in their clinical practice.
Conclusion Our study identifies the common reasons for incompletion of ACP and the perception of Cardiologists towards ACP. Future interventions could be developed based on these findings to improve ACP completion rates.