

(RRR = 0.90 [0.87, 0.92]), while those with a recent health shock were more likely to report inaccurate (RRR=2.83 [1.56, 5.13]) or uncertain belief (RRR=2.42 [1.39, 4.22]), compared to accurate belief. Increase in symptom burden was associated with change towards accurate belief (RRR = 1.77 [1.34, 2.33]), as opposed to no change.

**Conclusions** Patients' prognostic beliefs are unstable, change from accurate to inaccurate/uncertain, and vice-versa, and are associated with their changing health status. Findings underscore the need to understand prognostic belief as a dynamically evolving construct and imply that conversations about goals of care must occur regularly to factor in these changes.

**PP13.002 CAREGIVERS' END-OF-LIFE CARE GOALS FOR PERSONS WITH SEVERE DEMENTIA CHANGE OVER TIME**

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10.1136/spcare-2023-ACP.86

**Background** End-of-life (EOL) care decisions for persons with severe dementia (PWSs) are guided by their family caregivers' goals and preferences. It is not known if the caregivers' EOL care goals for PWSs change over time. We assessed caregivers' EOL care goal for PWSs, extent to which these change over time and the factors influencing them.

**Methods** In a prospective cohort of 215 primary informal caregivers of community-dwelling PWSs in Singapore, we surveyed caregivers every four months over a period of 16 months. We assessed the proportion of caregivers whose EOL care goal for PWS changed between two consecutive time points. Multivariable regression models assessed factors associated with caregivers' EOL care goals for PWS (maximal, moderate, minimal life extension); and change in EOL care goal from previous time point.

**Results** 21% of the caregivers had a goal of maximal life extension for their PWS, and 59% changed their EOL care goal at least once over a period of 16 months. Caregivers of PWSs with lower quality of life (RR: 1.15, CI: 1.06, 1.24), who were less optimistic about PWSs' remaining life expectancy (RR: 10.34, CI:2.14, 49.9) and who had an advance

care planning discussion (RR:3.52, CI: 1.11, 11.18) were more likely to have a goal of minimal life extension for PWS. Caregivers with higher anticipatory grief (RR: 0.96, CI: 0.93,1) were more likely to have a goal of maximal life extension. Change in PWSs' quality of life and change in caregivers' anticipatory grief were associated with change in caregivers' EOL care goals.

**Conclusions** Results highlight that caregivers' EOL care goals for PWSs change over time, and that this change is associated with both PWS and caregiver related factors. Findings have implications regarding how health care providers can best engage caregivers to make informed decisions for PWS's EOL care.

**PP13.003 CONCORDANCE OF THE PATIENTS' PREFERENCES AND THE ACTUAL OUTCOMES IN ELDERLY WITH LATE-STAGE DEMENTIA IN KARUNRUK ADVANCE DEMENTIA CARE PROGRAM**

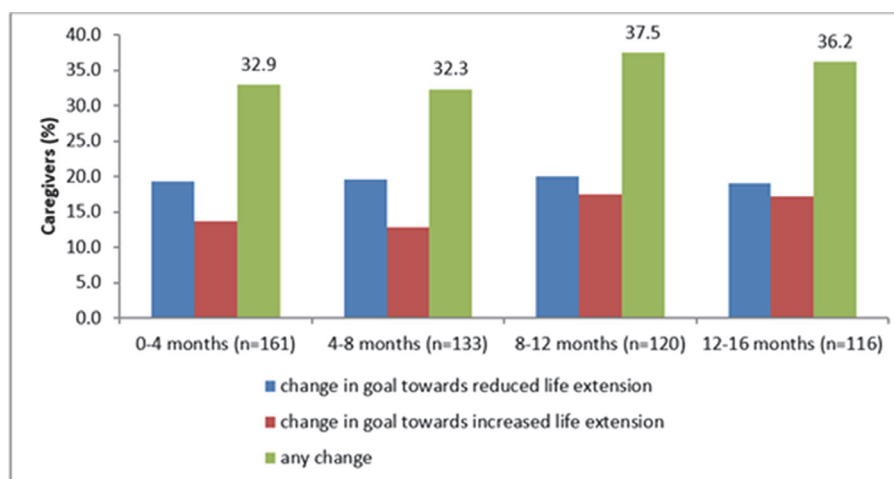
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**Background** Dementia is fatal disease and becomes burden due to increased elderly population. Karunruk Palliative Care Center (KPC) has established a care program for late-stage dementia. Family education on disease trajectory and established advance care plan (ACP), which inform about the preferences on place of care and death and medical treatment. The program provides routine home visit by multidisciplinary palliative care team, 24-hour emergency call and direct admission to palliative unit.

**Methods** Profiles of 65 patients recruited from October 1, 2020 to September 30, 2022 were: 84.6% were > 80 years, 76.93% were in FAST stage > 7c, and 43.07% retained NG feeding/PEG. Data were analyzed to obtain the concordance between the patients' preferences and the actual outcomes.

**Results** Only 7/65 (10.76%) had an ACP before referral. All patients in our program had an ACP. Place of death of 30 patients who died were 43.33% at home, 43.33% at Palliative unit, 10.0% at medical ward, and 3.34% at nursing home.



**Abstract PP13.002 Figure 1** Proportion of caregivers who changed end-of-life care goal for persons with severe dementia from previous time point

Concordance of patients' preferences and the actual outcomes

Place of death Preferences Actual outcomes Concordance (%)

Home 18 13 72.22  
Hospital 10 10 100.0  
Nursing home 2 1 50.0  
Medical treatment  
Comfort 30 30 100

\*Six patients changed place of death to hospital due to COVID-19 infection required admission (2), and care giver burden (4). Overall concordance of place of death was 80% and all patients received comfort care. The mean length of care was 404 days (max 1,794, min 13 days)

**Conclusion** The patient preferences in our program were well respected. A comprehensive palliative care program is essential to improve outcomes and avoid medical futility in these patients.

PP13.004

#### EMPOWERING THE AGED AND PRIMARY CARE WORKFORCE TO INITIATE ADVANCE CARE PLANNING CONVERSATIONS WITH PEOPLE LIVING WITH DEMENTIA

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**Background** Dementia is the second leading cause of death in Australia. However, people living with dementia often miss out on the opportunity to discuss advance care planning (ACP) and access palliative care.

Frontline aged and primary care staff are well placed to initiate ACP discussions with people living with dementia. However, many staff report a lack of confidence and skills in ACP and palliative care for people living with dementia.

The Advance Project Dementia is funded by the Australian government and aims to improve aged and primary care staff confidence, capacity and skills in ACP and assessing palliative care needs of people living with dementia.

**Methods** A literature review, environmental scan, input from an expert advisory group and extensive stakeholder engagement informed the development of a dementia-specific model and guide for initiating ACP and palliative care needs assessment at various levels of cognitive capacity, a suite of practical resources and online training to explain how to use the resources in everyday practice. Stakeholder interviews were held with 56 participants across Australia, including people living with dementia, family members, general practitioners, aged and primary care nurses, aged care providers and peak bodies. **Results** The toolkit and online training are freely accessible and being disseminated to aged and primary care organisations across Australia. A train-the-trainer program is available to support implementation of the toolkit by aged and primary care organisations as part of routine practice. An evaluation is being conducted with train-the-trainer participants and a subset of implementation sites to inform ongoing quality improvement of the program.

**Conclusion** The Advance Project Dementia [www.theadvance-project.com.au/dementia](http://www.theadvance-project.com.au/dementia) provides a suite of dementia-specific

training and resources that aim to make it easier for aged and primary care professionals to initiate courageous end-of-life conversations and assess palliative care needs of people living with dementia, to enable better care.

## PP14: ACP in Palliative Care

PP14.001

#### ATTITUDES AND BEHAVIOURS TOWARDS COMPLETING ADVANCE CARE PLANS IN THE PALLIATIVE DEPARTMENT OF AN ACUTE CARE HOSPITAL

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**Background** A background review of the baseline rate of Advance Care Plan (ACP) completion in patients admitted to the palliative department of Tan Tock Seng Hospital (TTSH) was 4.9%. As part of an ongoing effort to increase the rate of ACP completion, an improvement project was embarked on in March 2022. Initial efforts were encouraging, but the rate dropped 5 months after the project had started. An online survey was conducted to ascertain the attitudes towards completing the ACP.

**Methods** The survey was conducted in November 2022. The survey targeted clinical staff of the TTSH Palliative department. Responses were collated by a medical student who was part of the team.

The questions posed pertained to confidence in conducting ACP discussions, reasons for not completing an ACP, barriers that significantly deter one from completing an ACP and what would help staff conduct ACPs.

**Results** There were a total of 22 medical staff who completed the survey. 91% of respondents were confident in conducting an ACP. Responses were divided on whether patient-related factors had a part to play with non-completion. At times, family or patients are not ready for ACP discussions. >50% of staff found entering data into the national ACP platform portal very cumbersome. 22% felt that there is a lack of reminders to complete ACP.

**Conclusions** In conclusion, the main barrier in completing ACPs was that the national ACP platform portal is too cumbersome. Majority felt that post ward round reminders to screen for suitable patients would be useful. This survey has helped the project team understand and implement more relevant measures in trying to prioritize ACP appropriately at the end of life.

PP14.002

#### FINAL DESTINATION: A FOCUS ON THE PREFERRED PLACE OF DEATH IN A PALLIATIVE HOMECARE SERVICE

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**Background** In developed countries, patients receiving Palliative Homecare (PHC) service are more likely to discuss care preferences and fulfilment of preferred place of death (PPOD). Amid Singapore's aging society, the Ministry of