

children, who are either too young or lack mental capacity, participated in the ACP conversation. For the others, parents do not want their children be involved as they may not be aware of their condition or the severity.

**Discussion/Conclusions** To increase outreach and awareness on ACP, strategies like holding roadshows for hospital staff; developing collaterals such as brochures to facilitate the communication with parents; incorporating initial ACP exploration as part of MSW's standard of care and embedding facilitators in high-risk clinics to identify patients suitable for ACP introduction.

With an ACP discussion, parents are engaged early and have the opportunity to act as their child's proxy by articulating preferences, thus allowing the medical team to clarify their wishes before any medical crises. Nevertheless, ACP is a complex and sensitive conversation, particularly in the child-parent-HCP triad.

**PP16.002 EFFECT OF FACE<sup>®</sup>-TC ON ADOLESCENTS' DECISIONAL SUPPORT, PREPAREDNESS, AND SYMPTOMS AT 3 AND 12-MONTHS POST-INTERVENTION**

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**Background and Aims** Pediatric advance care planning (pACP) is a process of preparation and skill development to facilitate discussions about future medical care choices. We evaluated the efficacy of FACE<sup>®</sup>-TC on adolescents' decisional support, preparedness, and quality of life (QoL).

**Methods** Single blinded, intent-to-treat randomized clinical trial. Adolescents with cancer/family dyads were randomized at a 2:1 ratio to either FACE<sup>®</sup>-TC or Treatment as Usual (TAU) at four pediatric hospitals. Dyads received 3 weekly 60-minute FACE<sup>®</sup>-TC sessions: pACP Survey; Respecting Choices<sup>®</sup> Next Steps<sup>™</sup> ACP; and Five Wishes. Control dyads received Treatment As Usual (TAU). All received pACP information. Outcome measures were: Decisional Support and Preparedness; FACIT-Spirituality; and PROMIS measures.

**Results** 126 dyads underwent randomization (83 FACE-TC and 43 TAU). Compared to TAU, FACE-TC adolescents were significantly more likely to agree or strongly agree to 'I feel prepared for the future' (76%vs.94%,  $p=0.025$ ) and to 'I feel we are now on the same page' (76%vs.94%,  $p=0.044$ ) at 3 months post-intervention ( $N=107$ ). There was no intervention effect at 12-months ( $N=104$ ). Compared to TAU, FACE-TC had no significant effect on meaning/purpose or peace at 3-months, but significantly decreased meaning/peace at 12-months [Mean,  $SD=28(4)$  vs.  $26(5)$ ,  $p=0.029$ ]. Compared to TAU, FACE-TC had no effect on the PROMIS measures at 3 months, but significantly increased Pain Interference [Mean,  $SD=40(80)$  vs.  $4(10)$ ,  $p=0.030$ ]; Anxiety [42(12) vs. 52(10),  $p=0.001$ ]; Depressive symptoms [43(8) vs. 49(11),  $p=0.007$ ] at 12-months.

**Conclusions** Although FACE-TC increased adolescents' feelings of being prepared and supported. By 12-months FACE-TC adolescents had poorer quality of life. The outbreak of COVID during the 12-month follow-up visits may have made pACP more salient, given this effect was not observed at 3-months post-intervention.

**PP16.003 FACILITATORS' EXPERIENCE AND CHALLENGES IN PAEDIATRIC SETTING**

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**Background** Paediatric advance care planning typically involves parents for surrogate decision-making as many children do not have the capacity to consent due to developmental immaturity or communication impairment in view of clinical condition. It requires effective communication to clarify goals of care while focusing on the future wishes, and establish agreement on preferred treatments with the development of an advance care plan document.

**Methods** Paediatric Palliative Care Service (PPCS) has health care professionals (HCP) who provide palliative care for children aged 0–18 years. All members are qualified facilitators and the number of completed advance care planning (ACP) document for all new referrals to the service is measured annually. Conversation with them where appropriate is set as a measure to effectiveness of the care rendered. The present study will be the analysis of discussions with parents of children (non- oncology group and oncology) referred to palliative team from 2020–2022.

**Results** The previous analysis in 2018, 5 (21%) new patients referred to PPCS completed advance care planning documents of which 8% (2) of patients were from oncology and 13% of patients were from non-oncology group. Two children (40%) had their wishes respected. Most parents were reluctant to engage the discussion initially however stated a relief once the document was completed. Majority of them would like medical team updates and assistance in their decision making. Some did not feel comfortable, not ready and refused participation while some did not complete the session. Few were not averse to escalation of care as afraid physicians are giving up. The detailed analysis for 2020–2022 on parents' preferences and challenges will be presented.

**Conclusion** Though ACP provides an action plan for everyone, future care plan around end-of-life (EOL) for children is most challenged by high emotional impact related to end-of-life care decisions.

**PP17: ACP in Special Populations**

**PP17.001 ARE STROKE SURVIVORS READY TO TALK ABOUT ACP? A CROSS-SECTIONAL STUDY OF STROKE PATIENTS IN A REHABILITATION CENTRE IN SINGAPORE**

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**Background** Stroke is often associated with long term morbidity and increased mortality risks of up to 30% within the first year. Advance Care Planning (ACP) has a role in ensuring good delivery of care by considering one's values and preferences. In Asian cultures, it may be considered taboo to talk about end-of-life (EoL) issues, especially among the