making and an increase of meaningful and reliable documents can be strived for, as outlined in ACP programs.

PP18.003 NORMALIZING END-OF-LIFE (EOL) CONVERSATIONS IN NURSING HOME THROUGH GROUP WORK

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Background Although Advance care planning (ACP) and Preferred Plan of Care (PPC) are pertinent conversations for nursing home (NH) residents, its uptakes in NH are relatively low. Barriers to ACP and PPC conversations are due to manpower crunch, cultural diversity and language barrier between foreign care staff and residents. EOL decisions are often made too late to allow resident's participation in decision making. EOL conversations with residents/families at the end of life may happen late or not at all.

This study aims to determine (1) the take-up rate of ACP documentation upon completion of group work and (2) the improvement scores of residents' Satisfaction with Life Scale (SWLS).

Method A sample size of 5 NH residents with mental capacity were recruited for EOL conversation group work, 'KOPI Talk'. The group work washeld over 6-week period, facilitated by Medical Social Worker (MSW), Physiotherapist and Chaplains. Group activities such as memory box, narratives and visual audio etc were used. 6 thematic death conversation cards were used to discover residents' values, motivation and lifegoals.

Pre/post SWLS survey were conducted to measure outcome of residents' cognitive judgement of their satisfaction with their life.

Results Upon completion of group work program, residents were invited to consider documenting ACP conversation with their families. Out of 5 residents, 2 (40%) have agreed and completed ACP facilitated by MSW Associate.

3 (60%) out 5 residents' SWLS scores were improved.

Conclusion EOL conversation group work had never been undertaken in NH setting. Residents reported gaining valuable opportunity to engage in EOL conversations. Staff gained better understanding of residents' EOL care preferences. Several barriers were identified, family's procrastination and resident's dependence on family for decision making for their healthcare preferences. There is a need to raise awareness on the importance of ACP not just the residents but also their families.

PP18.004 ENGAGEMENT WITH ADVANCE CARE PLANNING AND LEVEL OF DECISIONAL CONFLICT AMONG NURSING HOME RESIDENTS AND THEIR NEXT-OF-KIN IN SINGAPORE

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Background Readiness for advance care planning (ACP) and uncertainty about end-of-life (EOL) decisions in nursing home (NH) residents and their next-of-kin (NOK) could affect the effort to implement ACP and concordant EOL care in NHs. We aimed to establish the level of decisional conflict and engagement with ACP among NH residents and their NOK.

Methods We surveyed NH residents with decision-making capacity (DMC), or their NOK if they lacked DMC. The survey comprised of a 9-item ACP Engagement Survey (AES) and a 10-item low-literacy Decisional Conflict Scale (DCS). The AES assessed participants' self-efficacy and readiness for ACP, and was modified for NOKs to reflect decision-making for both their family member and themselves. The proportion of participants reporting scores of 4 and above out of 5 for each question was reported. The DCS assessed participants' perceptions of feeling uninformed, unclear about what they valued, unsupported and uncertain towards EOL care decision-making. Scores ranged from 0 to 100 across 4 domains, with 100 indicating extremely high conflict. The median and interquartile range (IQR) of domain scores were reported.

Results 31 participants (10 NH residents, 21 NOK) completed the survey. of the residents who completed the AES, most were confident and ready to talk to their doctor/NHS and sign documents about their care preferences (50%-90%). Similarly, most NOK were confident and ready to engage doctors and document their family member's preferences, or do so for themselves (75%-90%). Participants reported strongest sentiments towards feeling unclear about the benefits, risks and side effects that mattered to them (median=50, IQR=25–50).

Conclusions Prior to the ACP discussion, most participants were confident and ready to discuss care preferences for themselves or their loved ones. However, they were most unclear about their values towards EOL care. Subsequent work will look at the effect of ACP discussions on these sentiments.

PP18.005 ACP IN NURSING HOMES FOR PROJECT RESPECT – INTERMEDIATE REVIEWS

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Background Advance care planning (ACP) is often discussed with next-of-kins (NOK) as nursing home (NH) residents have lost decision-making capacity (DMC). This may result in a care plan that may not be truly reflective of the values and care preferences of the residents. It is increasingly paramount to bring ACP conversations upstream and discuss it with residents while they can still communicate and make decision. Project RESPECT (RESpecting Preferences, Empowering Conversations Together) was initiated in March 2021 to enhance ACP culture and improve uptake in the NH over 3 years

Objectives Support NHs in building a sustainable culture of ACP and increasing ACP uptake.

Methods Retrospective evaluation of the project was conducted through an analysis of the five key elements in designing and sustaining an effective ACP program curated by Respecting Choices (USA), namely leadership support, ACP facilitator

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