While there is no consistent approach in identifying suitable patients for ACP, MSWs were inclined to approach patients with no next-of-kin and those at the end of their lives. Although MSWs' skills in communication facilitated the work of ACP, the need to juggle a heavy workload and to potentially manage misaligned healthcare preferences between patients and physicians remained as barriers. MSWs reported greater conviction in the cause of ACP after gaining experience in facilitating ACP.

Conclusion This study provided insights into the perceptions and experience of MSWs in facilitating ACP conversations, and identified areas that MSWs needed support in. Providing post-training support, such as mentoring, is recommended.

PP20: Programme Development in ACP

PP20.001 A NURSE-LED ADVANCE CARE PLANNING PILOT FOR FRAIL OLDER HOSPITALISED AUSTRALIANS TRANSITIONING TO RESIDENTIAL AGED CARE

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Background Our health service serves the largest proportion of older people in Western Australia, and numbers of adults aged over 65 years is projected to increase by over 40% by 2030. Older people now live longer with more complex health needs; and, especially once hospitalised, can receive care that is not aligned to their values and wishes. Advance care planning (ACP) can help ensure that older hospitalised people receive the type of care they would like to receive that aligns with their preferences, wishes and values.

Method A pilot senior clinical nurse service, the Transition Support Navigator, aims to improve advance care planning discussions, documentation and communication (between patients, carers, health and aged care providers) being discharged from hospital to a residential aged care facility (RACF). This includes screening for palliative care needs (Symptom Assessment Scale, Problem Severity Score, Performance Status, Clinical Frailty Scale), facilitating ACP discussions and documentation (including statutory documents), uploading ACP documents to electronic medical records, and facilitating communication between acute, subacute, primary care and aged care services.

Results The pilot commenced in October 2022 and will see patients aged over 65 years in our acute tertiary hospital and subacute secondary hospital diagnosed with frailty and multimorbidity, including moderate to severe dementia. In addition to demographic data, we will collect quantitative and qualitative data regarding number of ACP discussions, number and type of ACP documents completed and uploaded to digital medical records, referrals to specialist palliative care services, hospital readmissions, and place of death.

Conclusion A new nursing led service, based in the Department of Geriatric Acute and Rehabilitation Medicine, aims to improve ACP discussions, documentation and communication for frail, older hospitalised patients who required residential aged care, to reflect the values and preferences of these patients.

PP20.002 A SIMPLE INTERVENTION TO INCREASE OPPORTUNITIES FOR ACP DISCUSSION AMONGST PATIENTS IN THE SUBACUTE WARDS

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Background There has been increasing focus in improving care for the elderly as the population in Singapore ages. Advance care planning (ACP) is an effective way in improving the quality of life especially in the frail elderly. Review of published literature has shown a large discrepancy in the proportion of elderly patients who are keen to do ACP versus the number of ACP facilitation that is done. One barrier is the lack of opportunity to discuss ACP as there are other competing acute medical issues. Other literature has also shown that increasing frailty and a change in social circumstances such as transitioning to a long-term care facility are common catalysts for initiating ACP discussions.

Methods In this quality improvement project, we targeted patients under General Medicine who are admitted in the subacute wards. A prompt to ask if ACP is appropriate was added in the screening checklist before the patients are transferred to the subacute wards. All patients who are already admitted in the subacute wards are also screened for frailty and ACP discussion is offered to those who score 7 and above in the Clinical Frailty Score (CFS).

We reviewed the number of ACP facilitation in the subacute ward for the period of 2017–2019. We have excluded the numbers after 2019 as the subacute wards were closed during the COVID-19 pandemic.

Results The number of ACP facilitations increased from 20 in 2017 to 61 and 73 for 2018 and 2019, respectively. Our experience has shown that the number of ACP discussion has increased significantly and remained sustained after 2 years.

Conclusion The number of ACP facilitation can be improved amongst frail and elderly by increasing the opportunities for ACP discussions. This can be achieved by incorporating simple prompts in existing work processes.

PP20.003 INCREASING REFERRALS FOR ADVANCE CARE PLANNING DISCUSSIONS IN A COMMUNITY HOSPITAL SETTING

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Background Advance Care Planning (ACP) discussions allow patients to express their wishes with regards to end of life care. Initiating the ACP conversation is part of care for patients recovering from acute illness in our community hospital.

The number of referrals for ACP at baseline is low, averaging 16.7 patients per month over a period of 3 months from April to June 2022. This is in relation to a 259 inpatient bed