BOS2c.004 A PROVINCIAL WHOLE-SYSTEMS APPROACH TO PROMOTING CONVERSATIONS THAT MATTER

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Background In 2016, the British Columbia Centre for Palliative Care, Canada, broke new ground in adopting a province-wide, multifaceted approach to ACP promotion and engagement, using complementary strategies across key stakeholder groups: the health system, healthcare providers, students, community, and the public.
Methods Informed by the four pillars within the Pan-Canadian ACP Framework, and provincial surveys with the public and healthcare providers, our programs focus on building capacity within the healthcare system and academic institutions using a train-the trainer strategy (e.g. Serious Illness Conversation (SIC) Training Program), empowering the community to support ACP awareness and education (e.g. Community-led ACP education sessions for the public), and developing culturally and linguistically appropriate ACP resources for the diverse population in BC. Research and evaluation activities informed the development of the programs and strategy overall.
Results Our role as a catalyst for a collective impact in ACP engagement allowed us to bring together the healthcare and community partners from across the province to co-design, test and spread solutions that are based on evidence and inputs from experts, end users and people with lived experience. We focused on the mobilization of assets and pockets of excellence already existing, while acknowledging that adaptation for specific populations would be required. Examples of the successes achieved to-date are: thousands of clinicians completed the SIC training, incorporation of SIC training in the education curriculum for medical, nursing and social work students, more than 70 community organisations trained to deliver ACP education sessions with around half of these organizations serve rural and remote communities.
Conclusion Based on our experience, an effective whole-systems approach to ACP engagement requires meaningful public engagement, ongoing collaboration with partners, culturally considerate messaging, user-friendly resources, and consistent education programs for everyone. Flexibility in programs and strategy was advantageous, with evaluation and research results informing new directions.

BOS3b: ACP Framework, Education and Policy

BOS3b.001 IMPROVING ADVANCE CARE PLANNING COMPLETION RATE FOR INPATIENT FRAIL ELDERLY

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Background and Aims The National Healthcare Group (NHG) River of Life framework is our blueprint of care continuum to live well through 5 care segments. One main challenge of Singapore's aging population is with lifelong care - living with frailty and leaving well with advance care planning (ACP). ACP has many positive outcomes, including reduced hospitalisation and healthcare utilisation cost. Frailty is a key driver of healthcare cost which makes it crucial to address ACP in the frail elderly patients.

This project aims to create awareness of ACP and frailty within Geriatrics Medicine (GRM) department; and to improve ACP completion rate of GRM patients in 2 GRM wards with Clinical Frailty Scale (CFS) $\geq$ 7.
Methods Reasons why ACP is not completed in the GRM wards were evaluated through root cause analysis. Plan-Do-Study-Act cycle was used to propose changes and improvement. We analysed the issues at levels of staff, process, equipment, patient/family and environment (Table 1).
Results Figure 1 illustrates the ACP completion rate in 2 GRM wards with time. Data was collected on a 2-weekly basis. The ACP completion rate showed a steady increase with time and intervention. It peaked at 77.8% and the mean rate was 60.9%, compared to pre-intervention rate of 27%.
Sustainability and Project Impact The main outcome is to improve ACP completion rate; the secondary outcome is to train and identify frail patients using CFS, which enhances NHG frailty framework in integrating ACP into care plans.

Staff are continually trained to facilitate ACP. CFS is incorporated into electronic clerking notes and ACP office is continually monitoring the completion rate. This work has expanded to other wards too.
Conclusion This project fulfills its objectives of creating ACP awareness and frailty within GRM department and improving ACP completion rate of our frail elderly.

BOS3b.002 USING A CO-PRODUCTION INCLUSIVE APPROACH TO DEVELOP A HOLISTIC ADVANCE CARE PLANNING POLICY FOR ADULTS

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Background In 2020, the Minister for Health approved the development of a health-related Advance Care Planning Policy for Adults.
Method Between December 2020 and September 2021, two phases of early engagements with stakeholders helped inform and shape the development of the policy. The draft Advance Care Planning policy document and a full Equality Impact Assessment (EQIA) were launched for a 12-week public consultation in December 2021, as phase 3 of the process.

The aim of the engagement was to support the active involvement of all stakeholders, primarily in shaping the policy development and to inform the policy implementation plans.

These engagements were conducted based on principles of inclusiveness and accessibility, with a wide range of organisations and individuals including those representing equality categories of persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; men and women generally; persons with a disability and persons without; and persons with dependants and persons without. There was thematic analysis of all commentary.
Results Following Phase I engagement there were 2 significant recommendations. That the scope of the policy should be

broadened to include other aspects such as making a will, financial aspects, spirituality and online accounts. That a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) be considered as a potential alternative to a standalone do not attempt cardiopulmonary resuscitation (DNACPR) process and form.

The holistic Advance Care Planning policy for adults was launched in October 2022, with implementation via public information, operational frameworks, training and education, and evaluation and outcome.

Conclusion A co -production inclusive approach has led to the development of a more robust policy and implementation that moves beyond traditional focus on palliative care and is instead based on a 4- component model of personal, legal, clinical and financial planning for all adults.

BOS3b.003 UTILIZING SIMULATED LEARNING TO DEVELOP NON-CLINICAL SKILLS: A UNIQUE APPROACH TO IMPROVING ADVANCE CARE PLANNING PROCESSES

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Background Simulation learning is often associated with clinical skills development, particularly for patients facing high risk urgent situations. In these learning environments, clinicians typically practice urgent acute skills such as Cardio Pulmonary Resuscitation, intubation, and chest tube insertion. Recognizing how successful this learning method is for tangible skills, Fraser Health's Regional Advance Care Planning (ACP) Team proposed this unique and innovative learning approach for use with other essential skills, namely communication.

The teams' objectives were:

1. Increase familiarity with advance care planning processes,
2. Facilitate knowledge translation of topics such as medical order designation, symptom management, and end of life care.
3. Improve communication skills between interdisciplinary health care providers, patients and the people who matter most to them.
4. Establish a debrief culture for reflection and learning.
5. Demonstrate a shared decision making model.

Methods Quality Improvement

Results In 2022, pilot funding for the project was secured from the Physician Facilitated Engagement Program. An interdisciplinary panel of health care providers created two case studies. Following this, four interdisciplinary acute care simulation sessions were held at a community hospital. The sessions concluded with an extensive debriefing session and post-participation survey to assess confidence and provide suggestions for improvement.

Conclusion In this oral presentation, details of the cases, debriefings and surveys will be shared and be the primary teaching tool. Participants will be encouraged to explore implementing this unique non clinical simulation learning in their own settings of care. Learners will be able to apply simulation learning approach to improve confidence of HCPs to engage in Advance Care Planning, Serious Illness, and End of Life conversations and processes.

BOS3b.004 IMPLEMENTING A SHARED GOALS OF CARE FRAMEWORK IN A LARGE METROPOLITAN HOSPITAL IN NEW ZEALAND

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Shared Goals of Care (SGOC) is a process of shared decision making that involves the patient, their whaanau (family) and clinicians. It ensures treatment options are aligned to patients' values and achieves clarity and agreement on the goal of care should the patient deteriorate during that episodes of care.

Te Whatu Ora Counties Manukau, a large metropolitan based in Auckland, formed a project team in 2020 aimed at implementing the SGOC process organisation wide. The aim was to provide a single source of truth via an electronic health record that records both a discussion and decision for an episode of care. This replaced a number of different documents including the existing resuscitation form with an e-SGOC form and was supported by a comprehensive training programme to all clinicians.

The presentation will outline the experiences of the project team during implementation and the real life difficulties in achieving behavioural change amongst clinicians. Acknowledging the different needs of patients versus clinicians, we will provide a detailed discussion of the insights gained and learnings achieved on the barriers and facilitators relevant to producing a change in the practice culture within complex health environments. The importance of cultural responsiveness to the local population will also be highlighted as well as adapting to recent stressors including COVID and other macro-level challenges.

BOS3c: ACP in Nursing Homes

BOS3c.001 EVALUATING THE IMPACT OF A VIRTUAL TRAINING PROGRAMME FOR ADVANCE CARE PLANNING FACILITATION IN NURSING HOMES IN SINGAPORE

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Background Advance Care Planning (ACP) is vital for efforts to promote good end-of-life care, and this is especially important among nursing home (NH) residents. However, NH staff may not be trained to facilitate these discussions. A virtual one-day facilitation course that also encompassed discussion about the goals, ethics, and legislation related to ACP, was implemented, with separate sessions for General ACP (GACP) and Preferred Plan of Care (PPC) facilitation. We aimed to evaluate the impact of this training curriculum on participants' knowledge, attitudes and confidence (KAC) in ACP facilitation.

Methods Study participants who had no prior experience with either GACP or PPC completed a KAC survey before training, and at three-months. Questions were modified from published