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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10.1136/spcare-2023-ACP.19

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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10.1136/spcare-2023-ACP.20

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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10.1136/spcare-2023-ACP.21

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

ACP-related KAC surveys and contextualised to Singapore. Knowledge about ACP was assessed based on 17 True/False questions. Attitudes towards ACP was measured based on agreement with 14 statements on a 5-point Likert scale. Confidence in ACP facilitation was measured for 12 skills on a 5-point Likert scale.

Results Over 15 months, 16 training sessions were conducted for attendees from 8 nursing homes. of the 63 attendees eligible for the surveys, 41 and 26 participants completed the baseline and follow-up survey respectively. At three-months, participants responded incorrectly to 12 out of 17 questions, with >40% doing so in relation to ACP activation, completion and on discussions with residents with dementia. Comparing results at baseline and follow-up, participants maintained or increased both their agreement with the importance and impact of ACP, and their confidence in facilitating ACP (81%-92%).

Discussion and Conclusions Participants' KAC appeared to have improved after the training. The training curriculum will be adapted to provide more case studies on when an ACP can be activated and when the discussion is deemed completed, and how to approach discussions with patients with dementia.

BOS3c.002 THE POTENTIAL CONTEXTUAL FACTORS AND RECOMMENDATIONS FOR ADVANCE CARE PLANNING IN LONG-TERM CARE FACILITIES IN CHINA: A QUALITATIVE STUDY

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10.1136/spcare-2023-ACP.22

Background Advance care planning (ACP) provides an opportunity for older people to discuss and identify care at the end of life that is aligned with their preferences. ACP is a complex intervention, therefore its development and implementation requires evidence on the contextual factors in which implementation is planned. This study aims to identify potential contextual factors to ACP in long term care facilities (LTCFs) in China, and to develop recommendations to underpin future implementation.

Methods We conducted semi-structured interviews with residents, family members, and healthcare professionals in nursing homes. Reflexive thematic analysis was used to analyse data.

Results Four themes were generated from data collected with 12 residents, 10 family members, and 14 healthcare professionals. (1) 'Death-denying communication': cure-oriented understanding of medicine, bi-directional protection and lack of honest information sharing may hinder ACP initiation; (2) 'Decision-making process aligning with family interests': the guardian-centred decision-making model and potential ACP benefits and risks to family may influence engagement; (3) 'Initiating ACP in a dynamic and individualised way' may facilitate ACP through informal and indirect introduction, adapting to family structures, and making in-the-moment decisions; (4) 'Building internal and external support' may integrate ACP into practice by raising awareness and removing potential legal risks. Recommendations are proposed based on four themes and Social Ecological Model.

Conclusion To promote ACP in LTCFs, it is important to capture spontaneous conversation triggers, recognise the integrity of guardianship and create a safe climate. Our findings inform our ACP development programme in China, and offers relevance to other Asian countries.

BOS3c.003 PRACTICING ADVANCE CARE PLANNING IN NURSING HOMES IN THE NETHERLANDS: AN ETHNOGRAPHIC STUDY

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10.1136/spcare-2023-ACP.23

Background Advance care planning (ACP) is paramount for nursing home residents, who are typically frail and of old age. In The Netherlands, medical care for nursing home residents is provided by so-called 'elderly care physicians' (ECPs). This study aims to gain insight in how ECPs practice ACP with nursing home residents in The Netherlands and their surrogate decision makers, in order to get a comprehensive understanding of ACP in the context of daily clinical routine.

Methods We conducted an ethnographic study at 8 locations of 2 nursing home organizations in The Netherlands. In total, 40 days of observation took place in February-March 2020 and August-November 2020 on wards for long-term stay. Field notes and day reports were written by the observer, who had regular debriefings with a senior researcher. After the observations, interviews were conducted with participating physicians (member check). Day reports and verbatim interview transcripts were coded and discussed by 3 researchers until consensus was reached.

Results ACP discussions were observed in 33 care plan evaluations, 6 nursing home admittances, and 6 other meetings between a physician and a nursing home resident's surrogate decision maker. Observations showed that ACP was a regular agenda item at biannual care plan evaluations. However, ACP discussions were short and did result in non-explicit treatment orders such as no hospital admission if the prognosis is bad. ACP discussions were mostly used to prepare residents and their surrogates for decisions on limiting medical treatments in the future.

Conclusions This ethnographic study shows that ACP discussions are common in nursing homes in The Netherlands. The present study did not provide enough longitudinal data to draw conclusions on the effect of the observed ACP discussions on actual treatment decisions in the future.

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