

care planning documents with the focus on advance health directives, the Advance Care Directive in Queensland. Accessibility, validity, and appropriateness of advance health directives was assessed. Preferred place of death was compared to actual place of death. The analysis used proportions, binomial confidence intervals and univariate logistic regression.

Results 52% of patients were male and the median age was 74 years. Most patients had a cancer diagnosis (85%). The prevalence of advance health directive completion at the time of referral was much higher than other Australian studies (27%). Referrers completed more advance health directives (27%, CI 19.8, 34.5) than community palliative care service (9%, CI 4.5, 16.1); however, had lower upload rates to the electronic medical record (42.5% vs 80%) and 29% were invalid. The strongest predictor of advance health directive completion was preparation of other advance care planning documents. Community palliative care completed more acute resuscitation plans than referrers (44% vs 25%). Completion of an acute resuscitation plan reduced advance health directive completion ($p = 0.49$). Home was the preferred place of death for 47% of patients. 64% of patients died at their preferred place of death.

Conclusion This study has a higher prevalence of all types of advance care planning compared to other Australian studies including advance health directives. The community palliative care service had a lower prevalence of advance health directives when compared to referrers. Accessibility remains low with less than half uploaded to the electronic medical record. Almost a third of advance health directive completed prior to referral uploaded to the electronic medical record were invalid highlighting the need to review these documents. The higher prevalence of acute resuscitation plan than advance health directive may be because of a lack of designated time, resources, and funding for opportune completion. A home death remains the goal for most patients.

OP-14 PERSONAL VALUES AND ITS IMPACT ON DECISION MAKING IN CANCER PATIENTS AND CAREGIVERS

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Background For many, a cancer diagnosis signals death's inevitability and elicits existential concern. In the quest for life prolongation, patients seek futile life-sustaining treatments, fail to appreciate a declining trajectory and lack the opportunity to seek information or plan meaningfully for their future. Advance care planning (ACP) is a process that supports adults at any age or stage of health to plan for future care through an understanding and sharing of personal values, life goals and preferences. An increased emphasis is now placed on exploring personal values to ensure alignment with the choices made relating to treatment and end-of-life desirables. Interventions that incorporate a values-based paradigm remain underdeveloped.

Method Using a multi-method research design, we developed a novel intervention using the video vignette technique and incorporated the dyadic approach to examine participants' perceptions, beliefs and attitudes. A randomised controlled trial formed the analytical core of this study, with a secondary

qualitative component. Cancer patient-caregiver dyads were randomised to a values-based video vignette intervention or usual care. We hypothesised that those exposed to the video intervention would be more likely to complete an ACP.

Results One hundred and thirteen cancer patient-caregiver dyads were recruited and randomised. Our findings described older participants as more likely to identify with values. Furthermore, we highlight that the mutuality of dyadic relationships in care planning may be conceptualised at three levels: communication, reciprocal influence and patient-caregiver congruence. In eliciting personal values, cancer patients concurrently postured stances of vulnerability and resilience, in keeping with conflicting emotions and experiences. Equanimity in the cancer patient was apparent with acceptance of frailty and finitude of life, sustained benevolence to others and the use of ritual at the end-of-life.

Conclusion We highlight that ACP requires contextualisation of individual situations and values and should focus on achieving meaningful outcomes beyond completing documents.

OP-15 PREVALENCE OF ENDURING POWER OF ATTORNEY AND ADVANCE HEALTH DIRECTIVE DOCUMENTS AMONG CULTURALLY AND LINGUISTICALLY DIVERSE PATIENTS RECEIVING COMMUNITY PALLIATIVE CARE: A STUDY IN QUEENSLAND'S MOST POPULATED HEALTH SERVICE

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Background Advance Care Planning (ACP) is vital to ensure patients' wishes are respected in healthcare decisions, particularly in the context of palliative care.¹ ACP improves outcomes for patients and their families.²⁻³ However, there is limited knowledge of ACP prevalence among Culturally and Linguistically Diverse (CALD) populations, especially in community palliative care settings.⁴⁻⁵

Aims The primary aim was to determine the prevalence of Enduring Power of Attorney (EPOA) and Advance Health Directive (AHD) within CALD populations versus general population receiving community specialist palliative care services (CSPCS). The secondary aims were to evaluate the prevalence of the above documents 6 months post referrals to a community specialist palliative care service and identify factors influencing completion.

Abstract OP-15 Table 1 Sample characteristics†(n=576)

Characteristic	No. (%)
Age (Years)	
<65	102 (18)
≥65	474 (82)
Median (IQR)	78 (69, 85)
Sex	
Female	265 (46)
Male	311 (54)
Mortality rate (6 months post-referral)	
Deceased	242 (42)
Alive	334 (58)

Geography [‡]	
City	440 (75)
Regional	120 (21)
Remote	16 (2.8)
Relationship Status	
Never Married	40 (7)
Partnered	371 (64)
Separated	165 (29)
Country of Birth	
Mainly English-speaking regions	463 (80)
Non-English speaking regions	113 (20)
Primary Language	
English	521 (95)
Other	55 (5)
Religion	
Undocumented	219 (38)
Christian	340 (59)
Other	17 (3)
Pre-referral Hospitalisation (within 90 days)	
No	130 (23)
Yes	446 (77)
Primary Diagnosis	
Malignant	409 (71)
Non-Malignancy	167 (29)
Referral Source	
Primary Care	211 (37)
Hospital	365 (63)
Parenthood Status	
Non-Parent	47 (8)
Parent	526 (92)
Living Arrangement	
Alone	105 (17)
With Others	471 (83)
Palliative Care Phase	
Stable	181 (31)
Unstable	44 (8)
Deteriorating	341 (59)
Terminal	10 (2)
AKPS [§]	
<50	156 (27)
≥50	420 (73)
Median (IQR)	60 (40, 70)
RUG-ADL	
<14	439 (76)
≥14	137 (24)
Median (IQR)	5 (4, 13)

[†]Reported as frequency (percentage) for categorical variables, and median and IQR (Inter-quartile range) for continuous variables.
[‡]Remoteness was determined by correlating postcode with 'Australian Remoteness Classification Guide' published by ABS.
[§]AKPS <50 was used as a cut-off point as it correlates with an ECOG performance status score of 3, which indicates poor suitability for systemic therapy and corresponds to a median survival of approximately 3 months for patients with advanced cancer.

Abstract OP-15 Table 2 Presence of EPOA at the time of referral

Characteristic	Not Present [†] N=452	Present [†] N=124	p-value [‡]
General population	357 (77)	106 (23)	0.2
CALD (Little to No Diversity)	50 (81)	12 (19)	
CALD (Moderate to High Diversity)	45 (88)	6 (12)	

[†]n(%)
[‡]Pearson's chi-squared test

Abstract OP-15 Table 3 Presence of AHD at the time of referral

Characteristic	Not Present [†] N=512	Present [†] N=64	p-value [‡]
General population	403 (87)	60 (13)	0.017*
CALD (Little to No Diversity)	60 (97)	2 (3)	
CALD (Moderate to High Diversity)	49 (96)	2 (4)	

[†]n(%)
[‡]Pearson's chi-squared test
 *Statistically significant

Abstract OP-15 Table 4 Presence of EPOA 6 month post referral

Characteristic	Not Present [†] N=439	Present [†] N=137	p-value [‡]
General population	346 (75)	117 (25)	0.2
CALD (Little to No Diversity)	50 (81)	12 (19)	
CALD (Moderate to High Diversity)	43 (84)	8 (16)	

[†]n(%)
[‡]Pearson's chi-squared test

Abstract OP-15 Table 5 Presence of EPOA 6 month post referral

Characteristic	Not Present [†] N=506	Present [†] N=70	p-value [‡]
General population	397 (86)	66 (14)	0.008*
CALD (Little to No Diversity)	60 (97)	2 (3)	
CALD (Moderate to High Diversity)	49 (96)	2 (4)	

[†]n(%)
[‡]Pearson's chi-squared test
 *Statistically significant

Methods An observational retrospective cohort study was conducted on patients referred to a major metropolitan CSPCS between 1st January 2022 to 1st January 2023. Data on EPOA and AHD presence, clinical and demographic factors were collected. Statistical analyses compared groups with different cultural and linguistic backgrounds and assessed influencing factors (table 1).

Results Of 576 eligible patients, 20% were classified as being in a CALD population, 69% were in progressive palliative care phases (phase 2–4) and 42% had died within 6 months following referral. No significant difference in EPOA prevalence between CALD groups (12–19%) versus the general population (23%)(p = 0.2). AHD prevalence was significantly lower in CALD populations (3–4%) compared to the general population (13%) (p = 0.017). Minimal increases in the presence of each document were observed in both groups 6 months post-referral. EPOA uptake is negatively associated with progressive palliative care phases (OR 0.058, 95% CI 0.38–0.87, p = 0.009) and regional geographical distribution (OR 0.53, 95% CI 0.29–0.90, p = 0.024) (tables 2–7).

Conclusions There are significant disparities in ACP uptake amongst CALD populations. Marginal increments observed post-referral underscore the critical need for early proactive ACP discussions. Enhanced healthcare provider training and targeted interventions addressing cultural and linguistic barriers are essential for achieving equitable uptake of ACP.

Abstract OP-15 Table 6 Factors associated with having an EPOA[†]

Characteristic	Odds Ratio	95% CI [‡]	p-value
Age (Years)			
<65 [§]	1		
≥65	1.34	0.79–2.40	0.3
Sex			
Female [§]	1		
Male	1.18	0.79–1.77	0.4
Geography			
City [§]	1		
Regional	0.53	0.29–0.90	0.024*
Remote	0.46	0.07–1.67	0.3
Relationship Status			
Never Married [§]	1		
Partnered	1.00	0.47–2.30	>0.9
Separated	0.80	0.35–1.93	0.6
Religion			
Other [§]	1		
Christian	0.84	0.56–1.25	0.4
Pre-referral Hospitalisation			
No [§]	1		
Yes	0.75	0.48–1.20	0.2
Parenthood Status			
Non-Parent [§]	1		
Parent	1.18	0.58–2.67	0.7
Palliative Care Phase			
Stable [§]	1		
Unstable, Deteriorating & Terminal	0.58	0.38–0.87	0.009*
AKPS			
<50 [§]	1		
≥50	1.09	0.70–1.73	0.7
RUG-ADL			
<14 [§]	1		
≥14	0.68	0.4–1.10	0.12

[†]Binary logistic regression[‡]Confidence interval**Abstract OP-15 Table 7** Factors associated with having an AHD[†]

Characteristic	Odds Ratio	95% CI [‡]	p-value
Age (Years)			
<65 [§]	1		
≥65	2.23	1.01–5.92	0.070
Sex			
Female [§]	1		
Male	0.78	0.46–1.31	0.3
Geography			
City [§]	1		
Regional	1.17	0.61–2.12	0.6
Remote	0.54	0.03–2.78	0.6
Relationship Status			
Never Married [§]	1		
Partnered	1.21	0.46–4.20	0.7
Separated	0.90	0.30–3.30	0.9
Religion			
Other [§]	1		
Christian	1.48	0.86–2.61	0.2
Pre-referral Hospitalisation			
No [§]	1		

Yes	1.05	0.57–2.03	0.9
Parenthood Status			
Non-Parent [§]	1		
Parent	0.85	0.37–2.30	0.7
Palliative Care Phase			
Stable [§]	1		
Unstable, Deteriorating & Terminal	0.63	0.37–1.09	0.095
AKPS			
<50 [§]	1		
≥50	0.87	0.50–1.56	0.6
RUG-ADL			
<14 [§]	1		
≥14	0.64	0.31–1.21	0.2

[†]Binary logistic regression[‡]Confidence interval[§]Reference group

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OP-16

AMBULANCE TRANSPORT TO HOSPITAL IN PATIENTS WITH A PALLIATIVE AMBULANCE MANAGEMENT PLAN (AMP)

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Background Many palliative patients prefer to receive care at home rather than attend hospital (Evans *et al.*, 2006). Most community palliative care services are unable to provide 24-hour in-person care, therefore ambulance services are often called to assess palliative patients in acute situations. Palliative ambulance management plans (AMPs) are documents created in collaboration with patients and their families. These documents assist ambulance personnel in the acute care of patients with life-limiting illness by outlining the patient's goals of care regarding transport to hospital versus best supportive care at home, and by providing guidance on the provision of symptom management at home.

Objectives The aims of this study were to assess whether patients' AMP goals of care regarding transport to hospital were being followed, to describe the common indications for ambulance attendances and transport to hospital in patients with AMPs, and to identify outcomes for the patients who were transported to hospital.

Method This was a retrospective study describing the use of AMPs in the Hutt Valley region, New Zealand. Patients in the Hutt Valley health district with an AMP created between