information, and finally completed a semi-structured interview assisted by the vignette technique. Qualitative inter-rater reliability was integrated.

Results Twenty-nine patients from the lung and gastro-intestinal tumour streams were approached with 18 completing the study. Participants initially had scant knowledge of ACP. On obtaining further information, their responses indicated that: For cancer patients, ACP is an individualised, dynamic, and shared process characterised by myriad variations in choices to actualise, relinquish, and/or reject its individual components. Actualisation of each component involves considering, possibly conversing about, planning, and communicating a decision, usually iteratively. Reactions can change over time and are informed by values, memories, personalities, health perceptions, appreciation of prognoses, and trust or doubts in their substitute decision makers.

Discussion/Conclusion Findings endorse the value of routinely, though sensitively discussing ACP with cancer patients at various times points across their disease trajectory. Nonetheless, ACP may also be relinquished or rejected and ongoing offers for ACP in some patients may be offensive to their value system.

15 UNDERSTANDING HOW CANCER PATIENTS ACTUALISE, RELINQUISH, AND REJECT ADVANCE CARE PLANNING: IMPLICATIONS FOR PRACTICE

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10.1136/bmjspcare-2013-000491.15

Background Although advance care planning (ACP) is recognised as intégral to quality cancer care, it remains poorly integrated in many settings. Given cancer patients' unpredictable disease trajectories and equivocal treatment options, a disease specific ACP model may be necessary.

Aims To examine how Australian cancer patients consider ACP and inform the development of an Australian Cancer Centre's ACP programme.

Methods A constructivist research approach drawing on the Medical Research Council framework for complex interventions. Participants described their initial understanding of ACP, received ACP

organisations who manage the community service, and the microcosm of community palliative care practice. The specific conditions identified related to policy, financial resources, size of the service, and staffing profile, documentation processes, and geographic context.
Discussion Nationally a consistent ACP policy environment alongside a supportive economic health care climate is required if ACP is to be routinised into health care services.
Conclusion Individual clinicians or small community services may demonstrate short-term success in ACP but long-term it is contingent on conditions of stable health care infrastructure, supportive national policy adequate funding and stable workforce.

17 PATIENT PREFERENCES AND ACTUAL TREATMENT IN OLDER PEOPLE AT THE END OF LIFE. A MORTALITY FOLLOW-BACK STUDY

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10.1136/bmjspcare-2013-000491.17

Background Respecting patients' preferences is seen as good palliative care.
Aim Studying actual treatments in relation to preferences for starting or forgoing treatment of older people at the end of life.
Methods Mortality follow-back study among relatives of deceased older people (2006–2009) of two cohorts representative for the older Dutch population (n=168) and for people with an advance directive (n=184). Preferences and actual treatment were studied for each of four treatments: starting or forgoing resuscitation, artificial nutrition/hydration, antibiotics, and artificial respiration.
Results In most patients who preferred receiving treatment this preference was followed (88% to 100% for different situations). In about half of the patients who preferred that a treatment would be forgone, the preference was followed (except artificial respiration: 12% concordance). The majority of people for whom no preference was known received treatment (59% to 79% for different situations). People with a known preference for receiving a specific treatment (as opposed to forgoing that treatment) had a higher chance of preference being followed (OR 7.4). People with a preference for forgoing a treatment had higher odds (OR 6.3), and people with a preference for starting a treatment had lower odds (OR 0.28) of treatment being forgone compared to people having no known preference.
Conclusions Concordance between preferred and actual treatment is high in older people who prefer treatment, and lower in people who prefer no treatment. Yet, making preferences for forgoing treatment known is useful as it increases the chance of treatments being forgone in those who wish so.

18 TALKING ABOUT END OF LIFE: MARKETING ADVANCE CARE PLANNING TO RESIDENTIAL AGED CARE FACILITIES

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10.1136/bmjspcare-2013-000491.18

Background Of the 143 932 Australians who die each year, 10% die in residential aged care facilities (RACFs). 25% of these deaths occur within 6 months of admission. Frequently residents are transferred to hospital at the end of life.
Aim To assist RACF staff to

- identify residents with irreversible deteriorating conditions.
- facilitate case conferences to record resident's and family's wishes
- record advanced care plans (ACPs)
- respond to and enact ACPs.

Methods The Talking about end of life programme was branded and marketed to RACFs resulting in an inundation of registrants. To translate theory to practice, training was delivered to link teams from each RACF. Tailored mentoring encouraged ACP, team building, ongoing education and death reviews. Pre and post intervention surveys revealed ACP practices.
Results Project results include increased numbers of ACPs and less residents transferred to hospital to die. Enablers and barriers to success were identified. Where ACPs were developed, staff experienced increased satisfaction in caring for residents in the terminal phase.
Discussion The need and desire for training in ACP and care of the dying within RACFs was evident by the overwhelming response. Willingness of general practitioners to discuss end of life issues was pivotal to success. Risks included sustaining the trained workforce and supportive systems. Direct benefits of ACP to residents and families needs further exploration.
Conclusion The programme's marketing strategy was successful. Training alone is not enough, a systems approach to modifying and improving practice is essential to ACPs becoming routine practice in RACFs.

19 IMPROVING HOME DEATH DOWN UNDER

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10.1136/bmjspcare-2013-000491.19