Conclusion The majority of physicians indicate that they can adequately estimate a patient’s limited life expectancy and that they tend to discuss patients’ wishes if they have a poor prognosis. Information transfer concerning patients’ wishes for treatment and care can be improved.

Methods Qualitative descriptive study of 30 patients and 30 care partners affected by PD within a multi-site, randomized clinical trial of neuropsychiatric care compared to standard care. Participants were individually interviewed about perspectives on ACP, including prior and current experiences, barriers to ACP, and suggestions for integration into care. Interviews were analyzed using theme analysis to identify key themes.

Results Four themes illustrate how ACP is perceived and integrated into clinical care: 1) variation in personal definitions of ACP in the context of PD; 2) barriers to engaging in ACP with PD; 3) role of care partners as active participants in ACP; and 4) influence of a palliative care approach on ACP. Taken together, the themes support clinician initiation of ACP discussions and interdisciplinary approaches to help patients and care partners overcome barriers to ACP.

Conclusions ACP in PD may be influenced by patient and care partner perceptions and misperceptions, symptoms of PD (e.g. apathy, cognitive dysfunction, disease severity), and models of clinical care. Optimal engagement of PD patients and care partners in ACP should proactively address misperceptions of ACP and utilize clinic teams and workflow routines to incorporate ACP into regular care.
Conclusion Overall, patients appreciate honest, personalized and attentive communication on a limited life expectancy enabling reflections and communications about ACP.

**OP67** PATIENT PERSPECTIVES ON INFORMATION PROVISION AND ADVANCE CARE PLANNING REGARDING IMPLANTABLE CARDIOVERTER DEFIBRILLATOR DEACTIVATION AT THE END OF LIFE

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Background Implantable Cardioverter Defibrillator (ICD) shocks can negatively influence the last phase of life. Advance care planning, timely and frequently discussing ICD deactivation with the patient, can help patients to make a well-informed decision about future ICD deactivation. Perspectives of patients on ICD deactivation are however largely unknown.

Methods Focus groups with ICD patients were conducted using a predefined topic list and were audiotaped and transcribed. Transcripts were analyzed using the constant comparative method.

Results Forty-one patients participated in a total of five focus groups. Average age was 64 years and 56% of patients were male. Many patients expressed a need for more information about ICD deactivation. Although most patients agreed that it would be appropriate to deactivate the ICD on a certain point in the disease trajectory, they had difficulties deciding on the right moment to do so, indicating the need to frequently re-assess their preferences. Possible circumstances in which patients would consider deactivating their ICD in order to avoid shocks were: a terminal stage of their disease, and a diminished quality of life. Arguments against deactivation were also mentioned, and mainly concerned not wanting to give up on life, both for themselves and for their family.

Conclusion(s) There is room for improvement in informing patients about ICD deactivation in the last phase of life. We found that patients’ perspectives towards ICD deactivation were highly personal and sometimes ambivalent. This emphasizes the importance of early and recurring discussions on this topic.

**OP69** EFFECTIVENESS OF ADVANCE CARE PLANNING IN IMPROVING END OF LIFE CARE FOR PATIENTS WITH ADVANCED HEART FAILURE

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Background Our primary aim was to assess, among advanced heart failure patients, effectiveness of Advance care planning (ACP) in ensuring end of life (EOL) care consistent with patient wishes. Secondary aims were to assess its impact on patients’ decisional conflict, discussion of care preferences with surrogates, illness understanding, anxiety, depression and quality of life.

Methods We conducted a randomized controlled trial of ACP (based on Respecting Choices Model) versus usual care in Singapore. 282 patients hospitalized with heart failure and NYHA III and IV symptoms were randomized to ACP (93) or control (189) arm. They answered up to 6 follow-up surveys conducted every 4 months. Primary outcome was assessed in the deceased sample (89; 23 in ACP, 66 in control arm). Both intention-to-treat and per-protocol analyses were done.

Results 63% of ACP arm received intervention. Deceased patients in ACP arm were no more likely to have their wishes followed for EOL treatments (35% in ACP vs 44% in control; p=0.47) but were more likely to have their wishes followed for cardiopulmonary resuscitation (83% in ACP vs 62% in control; p=0.12) though the difference was not statistically significant. At first follow-up, ACP patients had lower decisional conflict (β=-10.8, p <0.01) and were more likely to discuss preferences with their surrogate decision maker (β=1.3, p=0.04). Both arms did not differ on other patient outcomes. Per-protocol analyses showed similar results.