P10 ADVANCE CARE PLANNING IN VICTORIAN HEALTH SERVICES: 2014- 2018 SURVEY RESULTS AND EVALUATION

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Background The Victorian Advance Care Planning Strategy 2014–2018 (the Strategy) was launched in March 2014.

The Strategy aimed to ensure all Victorians have the opportunity to express their preferences for future treatment and care and provided a clear framework Victorian public health services. The strategy set out four priority actions:

- Enabling the person;
- Increasing workforce capacity;
- Establishing robust organisational systems; and
- Ensuring an evidence base and quality approach.

Methods A benchmarking survey was conducted in 2014 and a summative survey in 2018.

The surveys used the on-line survey administration tool - Survey Monkey (www.surveymonkey.com) with approximately forty questions across the four priority action areas.

Chief Executive Officers (CEO) at 84 publicly funded health services were contacted and asked to nominate one person from their health service, preferably with advance care planning experience, to complete the survey. There was over a 90% response rate.

Results Survey results found: significant increase in advance care planning programs; strong and increasing level of health services' executive support; an increase in the use of advance care planning alerts in clinical data; increasing advance care planning education; and organisational practice and policy improvements.

Conclusion The results have confirmed the importance of a state-wide strategy and the development of state-wide resources such as an advance care directive form template and the development of a common advance care planning barcode. This paper will explore the progress being made in public health services and identify the lessons learned, gaps and challenges for future policy development.

P11 IDEAL AND REALISTIC ADVANCE DECISIONS

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Background The Patient Autonomy Law was passed on December 18, 2015 in Taiwan and will be valid on January 6, 2019. Advance care planning is the legal duty before signing an advance decision. As a medical center participating in the pilot study, we collect 99 advance decisions made after advance care planning. However, the 99 advance decisions looked the same because all the people refuse life-sustaining treatment and artificial nutrition and hydration. It's revealed a question that advance decision is too vague to be implemented under clinical scenario. This study will discuss how to make advance decision more useful in the clinical situations.

Method Analysis the nature of advance decision by the factors which influence one's decision-making process.

Results People tend to express a vague value rather than a precise decision about medical choices. Previous decisions may

not be accurately used in complex and specific clinical situations. The decision supposed to be made rationally but patient has the emotional needs during the process of receiving information and making decisions. If the patient's mental capacity declined, whether the patient's critical interest is still the same is argued. Conflicts were found between the personality identity and the experiential interest sometimes.

Conclusion Value-oriented advance decisions are intended to be acquired ideally. However, advance decisions are not a history book of value. It is simply a plan before death, a collection of treatment preference. Therefore, advance decisions need to be translated, weighed and clarified by health care providers while implementation.

P12 ASSESSING THE USABILITY OF A WEB-BASED ADVANCE CARE PLANNING EDUCATION TOOL FOR ADULTS: A PILOT STUDY

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Background Our previous study suggested that elderly Japanese people find it difficult to discuss with family and health-care professionals about end-of-life (EOL). To address this issue, we have developed a prototype for a web-based Advance Care Planning (ACP) education tool. This tool has five components: (1) EOL simulated experience program, (2) thoughts about EOL vignettes, (3) wishes about truth telling, (4) EOL care preferences, (5) my favorite life. We evaluated whether this online educational tool encouraged ACP for a sample of community-dwelling adults.

Methods Ten participants (mean age: 63.8 years) were requested to use it for one month. Data was collected from the entries on the tool website, and a semi-structured interview was conducted later. The percentage of each completed ACP component was calculated. The qualitative data was analyzed by the thematic analysis. IRB approval was obtained from the researchers' institution.

Results The highest percentage of completed ACP component was "EOL care preferences". Ways to foster ACP with the tool yielded four main themes: understanding of ACP, embarrassment due to ACP, my preferred procedure of ACP, and advantages and disadvantages of the web-based tool.

Conclusion This tool encouraged the adults who had not previously considered ACP to recognize the importance of thinking about EOL, they are still healthy though. However, fostering ACP was connected to depression, depending on the individual's readiness in thinking of his own death. Hence, future research will be applied to improve this tool and make it more user friendly for a large number of the adults.

P13 ADVANCE DIRECTIVES REQUESTING EUTHANASIA IN THE NETHERLANDS

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The Dutch Termination of Life on Request and Assisted Suicide Act (WtI) came into force in 2002. Based on this act, euthanasia, although a criminal act under the Dutch Penal

Code, is justified if performed by a physician complying with specified due care requirements. A review committee assesses in every case whether physician-assisted dying has been carried out in accordance with these requirements. If there is reason for doubt, the case is handed over to the Public Prosecutor who judges whether there are grounds for prosecution.

One of the current challenges in the Netherlands is the significance of an advance directive requesting euthanasia. Section 2 (2) of the WtI allows physicians to carry out euthanasia on patients lacking mental capacity based on an advance directive requesting euthanasia drawn up at a time the patient was still competent. The due care requirements apply 'to the extent allowed for by the actual situation'. Uncertainty exists about the interpretation of the wording.

This study examines the legal status and practice of advance directives requesting euthanasia, focusing on the question how the due care requirements can be met in case of advance directives concerning late stage dementia patients. The legislative history and case law offers advice how to assess the due care requirements but do not seem to provide enough guidance for a careful and practical application of the advance directive. The legal position of the advance directive requesting euthanasia is complex and in need of assessment.

P15 TALKING ABOUT HEALTHCARE DECISIONS WITH END-OF-LIFE PATIENTS: WHAT DO NURSES FEEL?

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Objective To know the emotions of community nurses when they talk to end-of-life patients about health care decisions for their future

Design: Qualitative methodology.

Location: Basic health zone. Jaén.Spain

Participants: Community nurses who care for people at the end of life.

Main interventions Fourteen recorded interviews after informed consent. Analysis: transcription of speeches, coding of texts and grouping in categories.

Results Nurses' emotions include discouragement, worry, sadness, anxiety, insecurity, bewilderment, anger, compassion or frustration. These affective phenomena appear after negative experiences such as deception or difficulty in certain situations, lack of resources to face dialogical processes of health decisions planning or acknowledging the other's suffering. The presence of such emotions leads the professional to adopt avoidance attitudes to elude a reality that causes them emotional distress. There are also participants who feel tranquility, respect, security, satisfaction or affection. These emotions are related to positive experiences, which generate a proactive attitude in the professional and promote actions that improve the quality in care at the end of life.

Conclusion Knowing the present emotions in the clinical relationship can help the professional. When the professional manages properly his/her emotions there is a better healthcare provision at the end of life. It is necessary to improve nurses' emotional competencies through affective education.

P18 ADVANCE CARE PLANNING (ACP) DISCUSSIONS: WHAT DO THEY REALLY COST?

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Background Understanding both costs and consequences of ACP programs is important. Available economic analysis have typically reported the consequences but not the prevalence, frequency, duration and with whom ACP discussions take place.

Methods We conducted an economic analysis of ACP discussions alongside a trial evaluating ACP videos, across three clinical settings (cancer, heart and kidney disease) and 18 sites in Alberta, Canada. We administered a Health Services Inventory monthly for three months. Participants were asked to recall ACP discussions with professionals from healthcare, legal, financial and spiritual sectors.

Results 241 participants (36.1% female; average age, 66 ± 12.2 years) were interviewed at baseline with 95.0% follow-up over the three months. Participants across cancer (n=36), heart disease (n=24), and renal disease (n=40) settings had in total 100 ACP discussions with professionals from healthcare (n= 58), spiritual (n= 14), legal (n=19) and financial (n=9) sectors. The discussions averaged 20.4 minutes and resulted in completion of 16 Goals of Care Designation GCDs, 14 Personal Directives and 9 financial documents. Discussions mostly occurred outside home (n=82, 80.4%) and patients were almost always accompanied by a family member/friend (n=99, 97%).

Conclusion(s) Compensating professionals to engage in ACP discussions represents a substantial segment of ACP program cost. Patients and their family/friends also incur costs travelling to and taking time for appointments. Assessing cost-effectiveness of ACP requires program costs in addition to consequences. Patient engagement likewise benefits from understanding the nature and personal costs of these discussions. These data may help professionals advocate for commensurate compensation

P19 THE USE OF ADVANCE CARE PLANS IN PATIENTS ADMITTED TO A PUBLIC HOSPITAL

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Background This study followed the clinical history of a cohort of patients with a published Advance Care Plan (ACPlan) and examined the influence of the patient's clinical and demographic characteristics on the content of the ACPlan. The concordance between the instructions in the ACPlan and the care received during admissions and/or end of life care in a public hospital was also investigated.

Methods 149 patients with a published ACPlans between 10/09/2014 and 31/09/2017, and an admission to Christchurch Hospital within that timeframe, were randomly selected from the ACP database (n=1939). The electronic and written clinical records of each hospital admission of the patients (n=411) were reviewed to record demographic characteristic and assess competence. For those who lacked capacity, further review