

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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10.1136/spcare-2019-ACPICONGRESSABS.103

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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10.1136/spcare-2019-ACPICONGRESSABS.104

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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10.1136/spcare-2019-ACPICONGRESSABS.105

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