was undertaken to determine treatment given and concordance with the ACPlan.

Results Median age was 78 years. 57% were female, 43% male. The study showed a 98.3% concordance rate regarding the Goal of Care, and 85.7% concordance rate regarding the specific treatment preferences. A Do-not-attempt-CPR form was in place in 60.2% of the records of patients who did not want to receive CPR. Of the patients who died during the study period (n=55) 37.5% died in their preferred location, while 18.8% did not state a place of death preference.

Conclusion(s) Although the study population was limited, the results add to the evidence that ACPlans encourage the wishes of hospitalised patients to be recognised and used to guide care.

P20

QUALITY REVIEW PROCESS FOR ELECTRONIC ADVANCE CARE PLANS IN CANTERBURY, NEW ZEALAND

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10.1136/spcare-2019-ACPICONGRESSABS.106

Background An Advance Care Plan (ACPlan) that is ambiguous, contradictory or difficult to interpret can undermine confidence in the ACP process, lead clinicians to question the value of ACP and reduce the likelihood a person's ACP wishes will be honoured.

In Canterbury, a quality process has been developed to ensure ACPlans published to the electronic medical record (EMR) are clinically interpretable and any advance directives (AD) contained within the document meets NZs criteria for validity.

Methods a two-step process has been developed

Step 1 - Administration review to ensure the plan has been entered onto the EMR; the signed scanned copy matches the EMR version; there are two signatures – that of the person creating the ACPlan and the health care professional (HCP) supporting them.

Step 2 - Clinical review to ensure the content of the ACPlan is consistent with any ADs contained in the document and the plan is clinically interpretable.

If an ACPlan does not meet the quality parameters, it is returned for review and amendment. This process enables the ACP team to engage with the HCP leading the process, provide individual feedback and support them to improve the quality of plans submitted in the future.

Results Numbers of ACPlans published continue to grow (2014 n=118; 2015 n=354; 2016 n=519; 2017 n=772). While the percentage of plans requiring support from the ACP team to meet publishable criteria is falling (2014=31%; 2015=32%; 2016=27%; 2017=20%).

Conclusion(s) The quality review process established in Canterbury supports the creation of clinically interpretable ACPlans.

P21

ADVANCE CARE PLANNING FACILITATOR TRAINING FOR MEDICAL STUDENTS: MORE THAN A DROP IN THE OCEAN

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Background Healthcare professionals (HCP) often feel insecure and therefore hesitate to start ACP conversations with patients. And patients often feel reluctant to initiate ACP-conversations. Trying to discontinue this vicious circle we developed an elective ACP course for medical students.

Methods The course was developed on the base of the German facilitator-curriculum, which was revised in 2017 to include intensive role-play supported by the use of standardized-patients (SP). We adapted the facilitator curriculum to the students' experience and early stage of medical training. Course preparation comprised a letter of motivation and 10 CME questions referring to an ACP journal paper. The course is divided into 2 parts, each lasting 32 hours and including 10 hours of SP-training in groups of 2 or 3.

Results In August 2018, 7 students joined part 1 of the new ACP-course. All 7 students were in their 2nd year of medical training, the age range was 20–42 yrs, 3 were female. 5 happened to have a Muslim background which added an unexpected cultural component to the course. 4 had worked in other disciplines in healthcare before. Their motivation to participate ranged from traumatizing personal experiences to practical reasons. Their attitudes towards patient-centeredness and ACP-facilitation strongly changed from a traditional-paternalistic towards an autonomy-oriented view. At the end, student performance varied from moderate to very good.

Conclusion(s) Discussing legal and ethical basics of ACP conversations, and practicing ACP with SP, were judged by the students as highly relevant, both personally and professionally.

P22

INTEGRATION OF ACP INTO PRIMARY CARE. THE CANTERBURY EXPERIENCE

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10.1136/spcare-2019-ACPICONGRESSABS.108

Background In 2013 a project was developed for the provision of formal Advance Care Planning (ACP) processes in the Canterbury Health System.

A key component of the project was facilitating general practice to engage with and support patients to undertake ACP conversations and develop electronic advance care plans (eACPlans).

Methods Integrating ACP into the primary care system in Canterbury required a multifaceted, cross system approach, with each component supporting and enhancing the other.

Practice engagement and education including practice visits, phone support, ACP processes on the clinical website, presentations, training, one-to-one support/mentoring

Consumer engagement and education including community presentations, radio interviews, articles in local publications, a consumer website & community ACP champions. Increasing the community's knowledge and desire to create plans, has been the impetus for many practices to engage with ACP.

Systems and processes including electronic sharing of eACPlans, a subsidy to support practice teams adopt ACP and dedicated ACP facilitators & administrators to support the process.

Quality loop plans are reviewed to ensure patient's wishes are clinically interpretable and clinicians are confident to use plans to guide care. Plans that do not meet the quality

parameters are returned for follow up providing further opportunities for the ACP team to engage with the practice.

Results 87% of general practice teams in Canterbury have supported patients to create an eACPlans.

General practice teams create 80% of the Canterbury's eACPlans.

Increased multidisciplinary approach to plan creation.

Conclusion(s) A cross-system approach to implementation has facilitated the establishment of ACP in general practice.

P23 DEVELOPMENT AND IMPLEMENTATION OF A REGIONAL ELECTRONIC ACP PLATFORM IN THE SOUTH ISLAND OF NEW ZEALAND

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10.1136/spcare-2019-ACPICONGRESSABS.109

Background The South Island Alliance (SIA) strives for innovative and efficient health services by bringing together the five South Island District Health Boards (DHBs) to work collaboratively. ACP is a focus area for the SIA leadership team. The Health of Older People Service Alliance has been endorsed to provide oversight and leadership to support SI DHBs develop and embed electronic Advance Care Plans (eACPlans).

Methods a four step approach

Step 1 – Systems development: The creation of a single ACP platform in the electronic medical record enabling eACPlans to be created, shared and viewed across services and systems throughout the region.

Step 2 – Quality processes: A South Island Regional quality Verification (SIRV) team has been established to implement the SIRV processes and ensure the content of SI eACPlans, are clinically interpretable and can be confidently used by clinicians to guide care and ensure patient wishes are honoured.

Step 3 – Implementation support: Development of a regional workbook, communication releases & clinical pathway. Regular teleconference meetings are held to provide a platform for DHB ACP leads and SIRV team members to share ideas and develop 'broadly similar' approaches to support the roll out of the eACP.

Step 4 – Regional measures and reports:

Results Steps 1,2 & 3 have been implemented and the coordinated 'go live' date for the project has been agreed by the 5 DHBs for early December 2018.

Conclusion(s) Regional implementation of eACP in the SI is helping to optimise efficiency and encourage a broadly similar approach.

P24 PREDICTING LIFE EXPECTANCY TO AID IN ADVANCE CARE PLANNING

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Background Accurate timing of ACP is considered challenging. Available tools are not widely implemented, can be unfeasible to screen large populations, and require prior awareness to be used proactively in individual patients. We are developing an automated signaling tool for early

identification of patients who might benefit from ACP. In this talk, we will focus primarily on the model we created to predict life expectancy, which we consider to be a first step towards identifying these patients. Additionally, we will discuss further model development and deployment in a real-world setting.

Methods We used machine learning (ML) and natural language processing (NLP) techniques to train a recurrent neural network on 1234 medical records of deceased patients. We trained several models, and compared the best-performing model to doctor's performance on a similar task as described in the literature.

Results While doctors were correct in 20% of the cases (allowing an error margin of 33% around the actual moment of death), our best-performing model attained a prognostic accuracy of 29%. Being overly optimistic about life expectancy harms anticipation to end-of-life care. Our model was less likely to overestimate life expectancy (in 31% of the incorrect prognoses) than doctors (63%) were.

Conclusions Our research shows that ML and NLP offer a feasible approach to predicting life expectancy. The results are promising, given that our model is trained on a relatively small data set. Current work focuses on further model development with an increased dataset, and implementation of the tool in primary care facilities.

P25 FREQUENCY AND CONTENTS OF ADVANCE CARE PLANNING DISCUSSIONS IN PRIMARY CARE

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Background General practitioners (GPs) are well placed for identifying patients in need of advance care planning (ACP) and initiating ACP before acute deterioration in their illness trajectory. However, little is known about the frequency and contents of ACP discussions in primary care. We aimed to explore the frequency and contents of ACP discussions among patients, family members, and GPs.

Methods A multicenter, cross-sectional, observational study was conducted at 17 clinics with 22 GPs. In March 2017, each GP set an arbitrary day in advance and we enrolled all patients aged ≥ 65 years who visited the GPs on that day. We explored the frequency and topics of ACP discussions. We identified patients at risk of deterioration and dying based on the Japanese version of the Supportive and Palliative Care Indicators Tool (SPICT™).

Result In total, 382 patients with a mean age of 77.4 ± 7.9 years were included. Twenty-three patients (6.0%) had ACP discussions with their GP. Of 66 patients at risk of deterioration and dying, 13 patients (19.7%) had ACP discussions with their GP. The most common topic among patients overall was anticipated declines in activities of daily living (ADLs), but the topic of surrogate decision-makers was the most common with neurological patients.

Conclusion Primary care patients aged ≥ 65 years did not necessarily have frequent ACP discussions with their GP, but discussions were more common with patients at risk of deterioration and dying. The anticipated declines in ADLs was most frequently discussed topic among patients, family members, and GPs.