P30 SUSTAINABLE IMPLEMENTATION OF ADVANCE CARE PLANNING IN A GENERAL MEDICAL UNIT

A Lam*, J Tan, R Ng. *Tan Tock Seng Hospital, Singapore, Singapore*

10.1136/spcare-2019-ACPICONGRESSABS.115

Background Singapore has a growing ageing population with an increase in chronic progressive illnesses. The need for advance care planning (ACP) has become increasingly important. It has been found that ACP is better accepted by the patient when offered by their doctor. Unfortunately, many institutions have struggled to get the main stakeholders involved.

Our aim was to integrate ACP into daily clinical practice- a systematic and sustainable model for ACP implementation in a general medical unit in an acute hospital, targetting the population who would most benefit from it.

Methods Implementation involved a three-pronged approach of promoting awareness, facilitator training and formal screening, using triggers- age >75 years, poor premorbid function and more than 3 recurrent admissions in a year. These triggers apply to our target group, and their simplicity makes it easy for clinicians to remember and implement. Reminders were relayed via email to the teams involved in the care of the patients, to initiate ACP discussions.

Results The implementation of ACP in the medical unit, occurred in phases.

From 2013–2014, the number of ACP discussions doubled with promotion of ACP and facilitator training.

From 2015–2016, the numbers increased by 60% after introduction of formal screening for new admissions using our three key triggers.

In 2017, these numbers were maintained even after we stopped formal screening and email reminders.

Conclusion ACP rates increased, using the three-pronged approach of implementation, with improved sustainability and consistency.

Future initiatives may focus on refining the triggers, and incorporating them into medical records systems.

P31 CURRENT STATUS, NEEDS AND BARRIERS TOWARDS ADVANCE CARE PLANNING (ACP) IN NURSING HOMES

¹T Henking*, ¹L Best, ¹E Heizmann, ²B Oorschot van, ¹S Neuderth*. ¹University for Applied Sciences Würzburg-Schweinfurt, Würzburg, Germany; ²University Hospital Würzburg, Würzburg, Germany

10.1136/spcare-2019-ACPICONGRESSABS.116

Background and objectives Fostered by a legislative initiative in 2015, German nursing homes face the challenge to implement ACP- structures. Project background is to conceptualize and evaluate a practicable ACP-concept for the region Würzburg (130.000 inhabitants, Bavaria) with 12 nursing homes. In advance of a concept development, the current status of advance care practices in nursing homes, requirements of nursing homes and possible barriers were assessed.

Methods Written survey addressed to directors of 12 nursing homes in Würzburg. The questionnaire focusses – amongst others – on structural data (number of nursing places, nursing level of residents, qualifications of staff members ...), regional networking (cooperation with general practitioners, hospitals, hospices ...), reasons for and extend of hospital admissions and reanimations, dealing with cardiac arrest, kind and amount of

documentation of residents will related to end of life care, professions with function in ACP, possible barriers towards ACP and need for further support in implementing ACP.

Results NH are still not prepared for implementing an ACP-Concept. Development of structures and support are as necessary as development of human resources and establishment of cross-provider networks. Misperceptions about legal requirements, uncertainties in communication and little time are some further barriers that have to be addressed in an ACP-concept.

Conclusion The sustainable implementation of a viable ACP-concept assumes the development of structural and personal resources and has to address popular misperceptions and communicative barriers.

P32 AN EXAMINATION OF ACP IMPLEMENTATION IN AN ACUTE HOSPITAL – TOO LITTLE, TOO LATE?

E Chua*. *Tan Tock Seng Hospital, Singapore, Singapore*

10.1136/spcare-2019-ACPICONGRESSABS.117

ACP has been part of holistic care in Singapore since 2011. When patients do not have an ACP, healthcare teams often rely on surrogate decision-makers to determine patient's values and preferences. Several studies have been done and demonstrated a discordance of 26–35% between patients and their surrogates in decisions on CPR and extension of life. There are no national statistics on the number of ACPs that are done by surrogates. There are few studies to demonstrate the concordance of ACP at the end-of-life.

A retrospective analysis was done for patients admitted to General Medicine Department in Tan Tock Seng Hospital in 2015, who had an ACP on admission. The aim was to determine how many ACPs involved patients, secondary aims were assessment of ACP concordance at the end-of-life care.

Our study involved 56 patients, 16.07% of the ACPs involved the patient. ACP discordance was highest in those who had chosen home as the preferred place of death (PPOD), with 69.23% passing away in the acute hospital instead of at home. 82.6% died within 1 year of the ACP and 39.47% died during the hospitalization when the ACP was first done.

ACP requires involvement of the patient to ensure an accurate reflection of their values and preferences. The biggest discordance in the ACP is in the PPOD. There are many factors that cause PPOD discordance. More training and support is needed in nursing homes and home medical services to allow patients to pass away peacefully in a place of their choice.

P33 'TO TALK ABOUT IT, THAT'S A PROBLEM ...'. ANALYSIS OF NEEDS CONCERNING ADVANCE PLANNING WITH REGARD TO END-OF-LIFE DECISION MAKING

¹T Henking*, ¹L Best, ¹E Heizmann, ²B Oorschot van, ¹S Neuderth*. ¹University for Applied Sciences Würzburg-Schweinfurt, Würzburg, Germany; ²University Hospital Würzburg, Würzburg, Germany

10.1136/spcare-2019-ACPICONGRESSABS.118

Background In Germany ACP has only gained importance in recent years. It is still a long way to a nationwide implementation. A legislative initiative from 2015 focusses the

development of supportive ACP-structures in the field of nursing homes (NH). In the region Würzburg (130.000 inhabitants, Bavaria) there is no ACP-program provided. Major purpose of the project is the conceptualization, implementation and evaluation of an effective, target group-specific concept. Within the project needs of nursing home residents (NHR) concerning the process of ACP are reconstructed, barriers of sustainable implementation of ACP are identified.

Methods The study includes problem-centered interviews with NHR (n=24). Maintopics of the interviews: requirements regarding to EoL, communication about needs at EoL, documentation of advance planning, decision-making/-behavior concerning EoLC. Data are analyzed by content analysis.

Results NHR have a lack of knowledge relating to scope, reach and potential objects of advance planning for EoL(C) even they have already prepared an advance directive or a power of attorney. Often there is no differentiated reflection of own needs even they remark the wish of self-reflection concerning preferences for their EoL. NHR express the wish to compare notes with non-professionals and at eye level, trustful dialogue partners on EoL-topics and decision-making (informal dialogue). Otherwise, the recording of decisions and responsibilities regarding to the EoL takes place within the family-network and in the dialogue with health professionals (formal dialogue).

Conclusion A viable ACP-concept has to close the gap between informal and formal dialogues by creating trustful dialogue spaces and identifying trustful dialogue-partners.

P35 EXPERIENCES WITH APPROACHES TO ADVANCE CARE PLANNING WITH OLDER PEOPLE: A QUALITATIVE STUDY AMONG DUTCH GENERAL PRACTITIONERS

J Glaudemans*, E Moll van Charante, J Wind, J Oosterink, D Willems. *Amsterdam UMC, Amsterdam Public Health research institute, location AMC, Amsterdam, Netherlands*

10.1136/spcare-2019-ACPICONGRESSABS.119

Background Advance care planning (ACP) is still used with only a minority of older patients due to a lack of knowledge regarding appropriate approaches to ACP with older people. General practitioners (GPs) may play a key role in ACP with older people. We explored their experiences with different approaches to ACP with older patients in daily practice.

Methods A qualitative study among a purposive sample of 19 Dutch GPs based on semi-structured interviews.

Results Approaches to ACP with older patients can be divided into two categories: systematic and ad-hoc. Systematic approaches consisted of discussing a fixed combination of topics during group information meetings, intakes, comprehensive geriatric assessments, and periodic assessments with community-dwelling older patients who are frail, cognitively impaired, or aged >75, and with older patients living in residential care homes. Meetings were aimed at making agreements in anticipation of future care, at providing information and at encouraging older people to take further steps in ACP. With ad-hoc approaches, respondents discussed only one or two topics related to the near future with deteriorating patients or when patients or family-initiated ACP. Systematic and ad-hoc approaches were used simultaneously or sequentially. Due to a lack of time and knowledge respondents seemed to underuse many occasions and topics.

Conclusions Awareness of appropriate systematic and ad-hoc approaches to ACP, and the focus on providing information and encouraging older people to take further steps in ACP can support GPs and improve older patients' access to ACP.

P36 DEVELOPMENT OF THE STADPLAN INTERVENTION ON ADVANCE CARE PLANNING IN CARE DEPENDENT COMMUNITY-DWELLING OLDER PERSONS IN GERMANY

¹Ä Kirchner*, ¹H Langner, ¹G Meyer, ²R Schnakenberg, ³K Silies, ⁴Y Chuvaryan, ²F Hoffmann, ³S Köpke, ⁴J Köberlein-Neu, ¹A Berg. ¹Martin Luther University Halle-Wittenberg, Halle (Saale), Germany; ²Carl von Ossietzky University, Oldenburg, Germany; ³University of Lübeck, Lübeck, Germany; ⁴University of Wuppertal, Wuppertal, Germany

10.1136/spcare-2019-ACPICONGRESSABS.120

Background The STADPLAN project is a multicentre, cluster-randomised controlled trial on advance care planning (ACP) in older people receiving professional home care. The aim of the intervention is to encourage patients to deal with the topic of ACP in a structured way, to nominate a surrogate decision maker and to regularly discuss own preferences and wishes with this person.

Methods Following the MRC framework for complex interventions, we systematically adapted the intervention components of existing ACP programmes to the needs of community nursing care in Germany. The design of the modelled multi-component intervention was guided by the Behaviour Change Wheel method. Experts reviewed and discussed the proposed intervention programme.

Results The complex intervention addresses patients aged ≥ 65 years, nursing professionals and general practitioners comprising:

1. A minimum of two guideline-based conversations led by qualified nurses to be offered to dyads of patients and relatives.
2. A two-day training course including practical exercises to prepare nurses for the conversations.
3. Written information about ACP provided to patients, aiming to encourage patients to reflect on and write down own wishes and health care preferences in various situations. The information offers further local counselling options for the preparation of ACP documents.
4. Participants' general practitioners will receive concise written information about the study.

Conclusion The acceptance, feasibility, and comprehensibility of the complex intervention are currently piloted in four home care services including 120 patients. Results are expected in early 2019 and will be used to optimise the intervention before the efficacy trial.

P37 DIFFERENCES IN THE PERCEPTIONS OF END-OF-LIFE CARE PREFERENCES BETWEEN NON-DYAD PATIENTS AND PROXIES IN AN ASIAN CONTEXT

EJ Koh, CC Yu*, JA Low. *Geriatric Education and Research Institute, Singapore, Singapore*

10.1136/spcare-2019-ACPICONGRESSABS.121

Background In Singapore, Advanced Care Planning (ACP) for patients who lack mental capacity is often conducted with the patient's family or proxy. The mismatch of perspectives