between patients and proxies has been known in the West and this study investigated how perspectives differ in an Asian context.

Methods Twenty ACP discussion sheets completed with the patients, with or without a proxy decision maker and 20 ACP discussion sheets completed only with proxy, without the patient, were chosen at random for analysis. Thematic analysis was used to identify salient themes from both sets of discussion sheets and compared to understand the differences between decisions made by patients and proxies.

Results While overarching ideas on suffering and living well remain largely similar between the groups, there were marked differences in the area of medical interventions, place of care and religion. More proxies wanted comfort measures only for their loved ones, while patients tended to opt for additional interventions, such as intravenous medications or antibiotics. Similarly, while proxies preferred a trial of treatment at home or in a hospice before transferring to hospital, more patients wanted to be transferred to hospital immediately upon illness onset. Many patients mentioned religious beliefs as of importance whereas this was less mentioned by proxies.

Conclusions There are differences between the perspectives of patients and proxy decision makers in making ACPs. Future investigation should look at ways to align the proxy's perspectives with that of the patient especially in dyad pairs including means to reduce differences during ACP facilitation.

P38

INTEGRATIVE LITERATURE-REVIEW ON SHARED DECISION-MAKING, ADVANCE CARE PLANNING, INCLUDING VALUES AND PREFERENCES OF ELDERLY PATIENTS WITH SYMPTOMATIC AORTIC VALVE STENOSIS

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10.1136/spcare-2019-ACPICONGRESSABS.122

Background Only very few studies have been published on Shared Decision-Making (SDM) and Advance Care Planning (ACP) including high risk patients with aortic valve stenosis addressing transcatheter aortic valve replacement (TAVR), surgical valve replacement (SAVR) and palliative care as treatment options. Therefore, the aim of this study is to strengthen the basis for further investigations on this increasingly important theme.

Methods We currently perform a computerized integrated literature review of MedLine (PubMed), EMBASE and Cochrane databases, including among others the MeSH terms *aged, frail, aortic valve stenosis, advance care planning*, and sensitive search filters on health outcomes such as patient values and health care related quality of life. Qualitative and quantitative studies are both included. For quality evaluation we will use the method of systematic review developed by Hawker et al. (2002) and based on the Critical Appraisal Program (CASP) tool for qualitative research. Since a great variability of the study types can be expected, they will be systemized using thematic analysis approach.

Results We will present the ethical and practical relevance of this specific topic with regard to Advance Care Planning and Shared Decision-Making and present first results of our integrated literature review.

P39

COLLUSION, ADVANCE CARE PLANNING AND THERAPEUTIC PRIVILEGE – PATERNALISM VIA THE BACK DOOR?

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10.1136/spcare-2019-ACPICONGRESSABS.123

Collusion in the healthcare setting occurs when a patient's loved ones seek healthcare professionals' cooperation in hiding or moderating the disclosure of a serious illness from the patient with capacity to make their own healthcare decisions. Collusion more commonly occurs in patients who are older, perceived as vulnerable and in need of protection from the harsh truth. When collusion occurs, the patient is excluded from the decision-making process, their autonomy is suspended, and advance care planning is not even an option. Collusion may be justifiable if the doctor exercises therapeutic privilege and withholds diagnostic and/or prognostic information from the patient because of concerns that the patient may be seriously harmed physically or psychologically, if informed. The highest court in Singapore in the recent case of *Hii Chi Kok v Lucien London Ooi* expanded the concept of therapeutic privilege. The court endorsed the view that therapeutic privilege should not be abused by doctors to prevent patients with mental capacity from deciding for themselves just because the doctors think their choice is not in their best interests. However, it seemed to leave the door open for the possibility of triggering the therapeutic privilege if the patient is impaired in their decision-making capabilities, although still possessing mental capacity, and refuses low-risk beneficial treatment because they misunderstand the rationale treatment for it, even with appropriate assistance. Are there limits to an individual refusing beneficial treatment? Is this compatible with respecting an individual's right to make an unwise decision? Where should the line be drawn?

P41

EFFECTIVENESS OF ACP TO IMPROVE PATIENT-CENTRED CARE: STUDY PROTOCOL OF A CLUSTER-RANDOMISED INTERVENTION TRIAL FOCUSING ON NURSING HOME RESIDENTS (BEVOR-STUDY)

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10.1136/spcare-2019-ACPICONGRESSABS.124

Background Advance Care Planning (ACP) has been shown to increase prevalence of advance directives in German nursing homes (n/h) and therefore been introduced by recent legislation for n/h residents covered by sickness funds. However, clinical benefits and costs of ACP for n/h residents have not been studied in German speaking countries yet.

Methods cRCT in 4 study centres, each comprising 11 n/h (3.520 n/h residents altogether). 22 n/h will be randomised to the ACP intervention, the other half continue with usual care. The complex ACP intervention consists of comprehensive

qualification of ACP facilitators and family physicians, education of all regional health care actors relevant for the care of n/h residents, and coordination within and between participating institutions.

Primary hypothesis is a reduced rate of unwanted hospital admissions. Secondary hypotheses include increased rates of residents whose preferences are known and followed in pre-defined critical treatment decisions, residents dying in the n/h (versus in hospital) according to their preference, and residents, their families, and their caregivers who appreciate congruence between treatment wanted and delivered. Additionally, we plan a comprehensive process evaluation and a health economic analysis.

Conclusion While ACP has been repeatedly shown to be clinically effective in n/h, recent data from the Netherlands indicate it may not. Our trial, funded by the Innovation Fund of the Federal Joint Commission, will provide elaborate, 8 days facilitator qualification involving 24 hours of role plays with simulated patients, and it will be the first to study hospitalisation rate in all residents of participating n/h.

P42 ACP IMPLEMENTATION IN GERMANY: A PROGRESS REPORT OF THE POLITICAL FRAMEWORK AND ITS TRANSLATION INTO PRACTICE

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10.1136/spcare-2019-ACPICONGRESSABS.125

Background In December 2015, §132g was introduced into Social Code Book V. It provides financial coverage of advance care planning (ACP) for residents in long-term care institutions and institutions for persons with disabilities. At the end of 2017, the sickness funds and care home providers defined the details of the implementation in a mutual agreement.

Methods Policy analysis with description and critical reflection of the relevant regulations and the current status of ACP implementation in Germany.

Results Since early 2018, German care homes can get reimbursement for ACP-facilitators (1/4 full time equivalent for 100 residents), who can be either employed by the care home, by its carrier or by a regional cooperating partner. The mutual agreement specifies the structure and content of the planning process and defines the qualification requirements for ACP-facilitators, but not for facilitator trainers. Furthermore, the agreement calls for intra- and inter-institutional coordination, but does not provide for adequate workforce. Since 2016, there have been courses qualifying some 270 ACP-facilitators and 35 trainers, and several institutional ACP implementations. To promote the quality of the ACP-implementations, a German ACP-association (the DiV-BVP e.V.) was founded in 2017 to further develop facilitator and trainer curricula using simulated patient supported role plays, the contents of ACP-conversations, and of their adequate documentation.

Conclusions While §132g Social Code Book V provides a historic opportunity to implement ACP in German care homes, there are still major challenges to overcome, especially regarding facilitator qualification and institutional and regional implementation of the ACP system.

P43 PUTTING PIECES TOGETHER – A MULTIDISCIPLINARY TEAM IMPLEMENTING RESPECTING CHOICES IN A QUATERNARY HEALTH SYSTEM DEMONSTRATING REAL CHANGE AND SUSTAINABILITY

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10.1136/spcare-2019-ACPICONGRESSABS.126

The zenith of implementing the Respecting Choices systems approach to person centered and family oriented care is to provide person-centered decision making for each individual that honors current and future healthcare preferences. It is essential to understand that challenges exist for a quaternary health system to honor each individual's preferences. Challenges include but are not limited to; (1) assuring conversations are initiated and completed (2) broken or insufficient communication regarding healthcare preferences as result of conversations, and (3) difficulty in healthcare providers accessing information on preferences in real-time. This presentation will describe how a multidisciplinary ambulatory care team implemented this person centered decision making as foundational to achieving the quadruple aim. Outcomes include: For calendar year 2017: 334 enrolled. After enrollment: 90% had a person centered decision making conversation started, 80% had an Advance Directive uploaded into the EHR and 97% had a documented code status. Median survival after enrollment is 36 months with a overall cost of care reduction of \$455 per member per month during the time enrolled in the program. Further, 70 (43%) transferred to hospice with an average LOS in hospice of 50 days, and a median LOS in hospice of 29 days. This is compared to an overall hospice average LOS: 61.6 days and median LOS of 16 days. Likelihood to refer this program to others is 95%. Provider satisfaction is one of the highest of the 3600 providers in the delivery system.

P44 IMPROVING ADVANCE CARE PLANNING (ACP) DOCUMENTATION IN FREQUENT DEPARTMENT OF GERIATRIC MEDICINE (GRM) ADMITTERS WITH DEMENTIA IN AN ASIAN HOSPITAL

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10.1136/spcare-2019-ACPICONGRESSABS.127

Aim To improve the percentage of completed ACP documentation of eligible recurrent admitters (3 or more admissions within the last 1 year with no prior ACP documentation on admission) with background dementia to ward 7D under department of GRM from 7% to 60% within 6 months

Implementation Micro and macro flow charts were created to evaluate the processes in conduct of ACP. Root causes for reduced ACP documentation were identified via Ishikawa diagram and Pareto Chart. Through multiple PDSA (Plan, Design, Study, Act) cycles, the following interventions were conducted: creation of mandated workflow for ACP, reminders to offer ACP and incorporation of ACP in clinical delivery through documentation of ACP status in interim discharge summary and daily clinical problem list.

Results Root causes for low ACP documentation were ACP was not mandatory as part of clinical service delivery, lack of