educational materials on ACP and exclusion of ACP in clinical notes. After multiple interventions over 6 months, mean monthly completed ACP documentation rose from baseline of 5.5% to 28.8%, with highest achievable completion of ACP documentation at 50%. Though the target of completed ACP documentation was not met, there was an increase in the number of ACP discussions and documentation conducted by the department with increase awareness. This promotes a community of practice where ACP is offered readily.

Conclusion Changes in work processes and incorporation of ACP as part of clinical service delivery can improve ACP engagement in patients with dementia and their caregivers.

P45 PHYSICIANS' PERCEIVED ACCEPTABILITY OF A QUESTION PROMPT LIST FOR DEMENTIA AT THE END OF LIFE

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Background Question prompt lists can support communication between patients, relatives and professional caregivers. Examples of questions encourage to ask about topics that are relevant to patients and relatives, which may, for example, enhance participation in decision making and improve outcome. We developed a question prompt list about end of life for people with dementia and their relatives. Physicians' endorsement of its use and perceived acceptability is essential for effective implementation.

Methods In 2018, we surveyed 65 physicians (elderly care physicians and general practitioners) to evaluate the list. The survey was based on decision aid evaluation methodology including a validated acceptability scale ranging 15–75 with scores of 45 and meaning the aid is acceptable. Subsequently, we interviewed those physicians with either very high or very low acceptability scores.

Results The mean acceptability score was 51, but the physicians differed substantially in their evaluations of acceptability (SD 11). One third (32%) felt unable to answer the questions in the question prompt list. The interviews indicated this was bothering for some, and we explored this using the quantitative data. With inability to answer all questions, acceptability was lower and more variable (46 SD 13 vs. 54 SD 8).

Conclusions When accompanied by physician guidance and training, the question prompt list may fill a gap in seeking ways to develop advance care planning specific to dementia. An improved version of the question prompt list will be tested as part of two innovative advance care planning interventions.

P46 IMPROVING THE QUALITY OF PREFERRED PLAN OF CARE DISCUSSION USING A COMPANION GUIDE FOR PATIENTS WITH ADVANCED DEMENTIA

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Background For patients with advanced dementia, preferred plan of care conversations helps to improve end of life

outcomes by creating an opportunity for their carers to discuss about the circumstances in which they would prefer to limit life prolonging treatments and instead opt for an approach that prioritizes quality of life.

A discussion aid provides patients and families with structured information about clinical choices and help enhance the clinical decision making.

This will improve time efficiency and quality of informed decision making by increasing disease specific knowledge, reducing decisional conflict and promote evidence-based treatments.

Objectives Use of a discussion guide to improve the quality of discussion for patients with advanced dementia.

Methodology This study was a cross sectional study conducted in August 2018. The target population are physicians in the department of Geriatric Medicine, Tan Tock Seng Hospital. A discussion aid was designed to present balances, evidence-based information about risk, benefits and alternatives of clinical decisions to aid in discussion of end of life care in patients with advanced dementia.

Results Of the 43 physicians surveyed, 30% of them strongly agreed; 62% agreed; 4% Neither agree nor disagree and 2% disagree that the discussion aid will improve quality of ACP discussions.

Conclusion Most of the physicians surveyed felt that the discussion guide will improve the quality of communication and ACP discussion in patients with advanced dementia. They are also likely to use this guide for future ACP discussions.

P47 IMPACT OF THE MENTAL CAPACITY ACT ON PLACE OF DEATH IN HEART FAILURE PATIENTS WITH OR WITHOUT COMORBID DEMENTIA

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Background The Mental Capacity Act (MCA) came into force in England in 2007 to foster surrogate decision making, considered particularly relevant to advance care planning for those at the end of life. This study examined the impact of the MCA on the place of death (PoD) for heart failure (HF) patients sometimes affected by the loss of capacity.

Methods A national population-based retrospective cohort study of death registry data (DRD) in England, 2001–2016. All patients dying from HF (ICD-10: I50) were included. Capacity status designation was based on documentation of dementia (ICD-10: G30, F01, F03) as a comorbidity on DRD. Using binomial regression analysis, we compared PoD of HF decedents with and without comorbid dementia before and after MCA enactment.

Results 113,773 HF patients were included of whom 7,473 (6.5%) had dementia, these tending to be older, female, and with more comorbidities. 66% and 19% of HF patients with capacity died in the hospital or care home, respectively, the two commonest PoDs; in contrast, corresponding figures for those without capacity were 49% and 43%. Hospice as a PoD was rare ($\leq 0.5\%$) in both groups. Over the above period encompassing MCA implementation, PoD for HF patients with capacity shifted from hospital to home or care home (adjusted prevalence ratio (APR): 1.024[95% CI: 1.021–1.026]; $p < 0.001$); this trend less evident in those lacking capacity (APR: 0.995[0.981–1.010]; $p = 0.51$).

Conclusions Our analysis suggests a limited impact of the MCA on PoD for HF patients lacking capacity, perhaps reflecting greater complexity of care required of that clinical cohort.

P48 ADVANCE CARE PLANNING LEAD TO BETTER DECISION MAKING FOR END-OF-LIFE CARE IN PATIENTS WITH PROGRESSIVE IDIOPATHIC PULMONARY FIBROSIS

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Idiopathic pulmonary fibrosis (IPF) is a progressive and ultimately fatal lung disease. The majority of IPF patients die in hospital settings in Japan not only due to severe symptoms but also late end-of life (EOL) decision. This report presents four cases where advance care planning (ACP) allowed patients to choose their own EOL setting. *Case 1* 70s male with IPF for 3 years with a stable condition but eventually worsen due to pneumothorax. Through ACP, he chose his home as the place of death. *Case 2* 60s male with IPF for 8 years but conditions eventually worsen due to severe pulmonary hypertension caused by pulmonary embolisms (PE). After ACP, he decided to remodel the house, allowing him to stay at home for 20 days before dying. *Case 3* 70s female diagnosed with familial IPF 3 years ago but conditions worsen due to acute heart failure due to PE. After recovering 7 months later, she decided to move to a nursing home through ACP. *Case 4* 70s male with IPF for 12 years, with existing malignant lymphoma, the condition gradually deteriorated leading to the decision to stay at a hospice through ACP.

In conclusion, ACP was helpful in the cases mentioned above as it gave the patients the power to make their own decision. Although, medical professionals tend to lean towards disease-centered management they understand the difficulties in deciding the best timing to discuss EOL issues so that patients will not lose hope too early on.

P49 HOW TO TRANSLATE AN ADVANCE CARE PLANNING (ACP) CONVERSATION IN A FUTURE CARE TREATMENT PLAN? THE ACP-NOPA WEB APPLICATION

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Background The application was developed 2016 in Switzerland. The tool combines the different concepts of ACP, shared decision making (SDM) and medical emergency planning. In step one all documents and decision aids to create a living will are provided. Depending on the specifications the patient made in the living will (especially concerning treatment intensity and last-place-of-care) during step 2 the tool supports the care team in discharge management and/or creating emergency plans. The underlying illness of the patient is considered by providing the likely symptoms and giving treatment suggestions for the case of an emergency situation.

Methods The tool and the underlying educational program were developed based on our experiences with the MAPS – trial (a randomized controlled trial) and palliative emergency planning to support professional care givers in conducting an

ACP conversation and creating a living will based on SDM and to translate both in concrete treatment planning and future treatment planning in case of decisional incapacity. The tool was implemented in the Kanton of Zurich and tested in a feasibility study with piloting teams.

Results We will present our concept and the results of the feasibility study.

Discussion Core competences of ACP, SDM, intensive and palliative care are combined in this web application to support professional care givers in creating highly individualized emergency treatment plans for severely ill, multimorbid or elderly nursing home patients. Providing caregivers with these combined competences is a good way to help patients to get their treatment of choice in their favorite place-of care.

P50 ADVANCE DIRECTIVES INCLINATION OF PATIENTS IN SINGAPORE – A QUALITATIVE STUDY

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This study aims to understand which of the advance directives (ADs) i.e. Advance Care Planning (ACP), Advance Medical Directive (AMD) and Lasting Power of Attorney (LPA) patients are more inclined to.

The study was conducted from March to September 2018 in our institution. Patients aged 21 to 99 were asked to complete a survey to evaluate their awareness, perceptions and receptions on the ADs.

Out of 150 patients, the awareness was 101 for LPA, 77 for AMD and 74 for ACP with 41.3%, 28.6% and 20.7% of them learnt about them through media respectively. 55 out of 101 patients considered doing LPA. 51 out of 77 patients considered doing AMD. 40 out of 74 patients considered doing ACP. 70% of those considering doing ADs are influenced by their family. 38.6% of them favoured LPA over ACP and AMD as financial arrangement is made. 30% of them prefer AMD to ACP as AMD is legal-binding. 36% of them prefer ACP to AMD as they get to discuss their healthcare preferences with their caregivers. 48% of them think it is too early to talk about end-of-life treatments. 51.3% of them do not know the process of doing ACP and AMD.

There is no significant trend showing which ADs are patients more inclined to. Healthcare providers could initiate ACP conversations when patients are at their early disease trajectory. Also, more can be done to increase ADs awareness especially ACP through media to educate public on their importance and processes.

P51 EVALUATION OF THE ADVANCE CARE PLANNING PROGRAMME IN A CARDIAC CENTRE IN SINGAPORE

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Our institution has initiated inpatient Advance Care Planning (ACP) programme since 2013. However, enrolment rate has been low. We plan to report our experience after extending ACP programme to outpatient setting in 2017.