

consists of four sessions (two with the patient alone, one with the care giver alone, one together) that address potential barriers to discuss end of life issues (e.g. negative expectations concerning EoL issues and ACP) and two regular ACP sessions. Primary endpoint is the patient health-related QoL (FACIT-PAL). Secondary endpoints are general QoL; distress; acceptance; depressiveness; evaluation of the intervention; care-givers: health-related and general QoL. Patients' QoL is evaluated every second month for one year. In the event of the patients death, care-givers are asked to answer questions about concordance of advance care planning with actual care and the patients quality of dying.

Results Until 11/18, 75 patients have been randomized, 13 patients finished the intervention, 21 patients died, denial rate is at approx. 55%.

Conclusion This study tries to implement ACP in a palliative cancer setting in Germany. The efficacy and effectiveness of a novel collaborative ACP intervention are evaluated.

P58

ADVANCE CARE PLANNING IN GLIOBLASTOMA PATIENTS: DEVELOPMENT OF A DISEASE-SPECIFIC ACP PROGRAM

¹L Fritz*, ¹H Zwinkels, ^{1,2}J Koekkoek, ^{3,4}J Reijneveld, ¹M Vos, ^{1,2}L Dirven, ⁵R Pasman, ^{1,2}M Taphoorn. ¹Haaglanden Medical Center, The Hague, Netherlands; ²Leiden University Medical Center, Leiden, Netherlands; ³Amsterdam University Medical Centers (location VUmc), Amsterdam, Netherlands; ⁴Amsterdam University Medical Centers (location Academic Medical Center), Amsterdam, Netherlands; ⁵Amsterdam University Medical Centers, Vrije Universiteit Amsterdam, Amsterdam Public Health research institute, Expertise center for Palliative care Amsterdam, Amsterdam, Netherlands

10.1136/spcare-2019-ACPICONGRESSABS.141

Background It is unknown if implementation of an Advance Care Planning (ACP) program is feasible in daily clinical practice for glioblastoma patients. We aimed to develop an ACP program, and assessed the preferred content, the best time to introduce such a program in the disease trajectory, and possible barriers and facilitators for participation and implementation.

Methods A focus group with health care professionals (HCPs) as well as individual semi-structured interviews with patients and proxies (of both living and deceased patients) were conducted.

Results All predefined topics were considered relevant by participants, including the current situation, worries and fears, (supportive) treatment options, and preferred place of care/death. Although HCPs and proxies of deceased patients indicated that the program should be implemented relatively early in the disease trajectory, patient-proxy dyads were more ambiguous. Several patient-proxy dyads indicated that the program should be initiated later in the disease trajectory. If introduced early, topics about the end-of-life should be postponed. A frequently mentioned barrier for participation was that the program would be confronting, while a facilitator included access to information.

Conclusion This study resulted in an ACP program specifically for glioblastoma patients. Although participants agreed on the content of the program, the optimal timing of introducing such a program was a matter of debate. Our solution is to offer the program shortly after diagnosis, but let patients and proxies decide which topics they want to discuss. The impact of the program on several patient- and care-related outcomes will be evaluated in a next step.

P59

CHANGES IN END-OF-LIFE DECISIONS BETWEEN PATIENTS WITH ADVANCED CANCER AND THEIR FAMILY MEMBERS AFTER IMPLEMENTATION OF THE NURSING PROGRAM

M Watanabe*, M Masujima. Chiba University, CHIBA, Japan

10.1136/spcare-2019-ACPICONGRESSABS.142

Background Patients with advanced cancer and their family members tend not to adequately communicate with each other about the end of life in Japan. Previous studies have clarified that the obstacles for conversation are mostly posed by family members. Thus, the authors developed a nursing program for family members of patients with advanced cancer to promote End of Life Discussion (EOLD). This study aimed to clarify changes in EOLD between patients and their family members after implementation of the nursing program.

Methods The researchers performed three interview sessions, based on the manual for nursing practices and the guidebook for family members, which were established by the researchers. The interviews were recorded, and the data was analyzed qualitatively and inductively. This study was conducted with approval by the Ethical Review Board of the affiliated institution of the researcher.

Results The research participants were ten family members of patients with advanced cancer (seven females, forty to eighty-nine years of age). The twelve categories were extracted regarding changes in EOLD between patients and their family members, including the following: They realized the necessity to discuss the end of life. They were able to discuss subjects that they had been concerned about. They wrote down what they discussed. They were highly motivated to continue talking about the end of life.

Conclusion This research clarified that varied effects on the promotion of EOLD can be expected from this nursing program according to the situation and conversation of each patient and their family members.

P61

THE EFFECT OF PRIORITISING TREATMENT GOALS ON DECISION SELF-EFFICACY AMONG OLDER PATIENTS WITH CANCER IN A PALLIATIVE SETTING (OPTION-STUDY)

ME Stegmann*. Universitair Medisch Centrum Groningen, Groningen, Netherlands

10.1136/spcare-2019-ACPICONGRESSABS.143

Background In the Netherlands, the General Practitioner (GP) is generally not involved in treatment decisions in cancer. However, the GP often has a long history with patients and can help to explore patients' values, especially in older patients. This can help the patient prepare for shared decision making with the oncologist. The aim of this randomised controlled trial is to study the effect of a conversation about treatment goals between GPs and patients on self-efficacy just after the diagnosis of non-curable cancer.

Methods We included patients aged ≥ 60 years with a diagnosis of non-curable cancer, who have heard the treatment options from their oncologists. In the intervention group, patients consulted their GP using an Outcome Prioritisation Tool (OPT) to discuss the prioritisation of treatment goals (staying alive, maintaining independence, reduce pain, reduce other symptoms). The control group received care as usual.