

Determining patient capacity was perceived fundamental by UK clinicians, whilst family's wishes took priority by JP clinicians. Both UK and Japan clinicians preferred to engage in withholding treatment discussions comparing to withdrawal. DNAR orders were routinely assessed in the UK, whilst performed only when 'disease worsening' in Japan. Balance between suffering and prolonging life was considered by both countries, albeit with different importance. Individual ICU culture, training in ACP and involvement of palliative care teams seem to influence variation in engagement and implementation of ACP practices in the different units. **Conclusions:** The context specific values in EoL care, communication and decision-making practices, alongside integration of PC care and ACP education should be considered when initiating ACP interventions for the ICUs in different countries.

Abstract: 2.046

Global Insights: Stakeholders' Perspectives on End-of-Life Care and Place of Death

S.H. van de Beek^{1,2}, J.T. van der Steen^{3,4}, Y.M. van der Linden⁵, I. Dias da Silva¹, M. Delalibera¹, D.A. Olet^{1,6}, E. Namukwaya^{1,7,8}, E. Belanger⁹, K. Eckels^{1,10}, B. Gomes^{1,11}, D.P. Touwen²

¹Faculty of Medicine, University of Coimbra, Coimbra, Portugal, ²Department of Ethics and Law, Leiden University Medical Center, Leiden, Netherlands, ³Department of Public Health and Primary Care, Leiden University Medical Center, Leiden, Netherlands, ⁴Radboudumc Alzheimer Center and Department of Primary and Community Care, Radboud University Medical Center, Nijmegen, Netherlands, ⁵Centre of Expertise in Palliative care, Leiden University Medical Center, Leiden, Netherlands, ⁶Institute of Hospice and Palliative Care in Africa, Hospice Africa Uganda, Kampala, Uganda, ⁷Palliative Care Education and Research Consortium, Kampala, Uganda, ⁸Department of Medicine, School of Medicine, College of Health Sciences, Makerere University, Kampala, Uganda, ⁹Center for Gerontology and Healthcare Research, Brown University, Providence, United States, ¹⁰Department of Occupational Therapy, Kansas University Medical Center, Kansas, United States, ¹¹Cicely Saunders Institute of Palliative Care, Policy and Rehabilitation, King's College London, London, United Kingdom

Background/aims: In end-of-life (i.e. EOL) care and policy the place where people receive care and die according to their wishes is an important indicator. However, it is unclear whether and how this indicator has a role in practice. This study examines the views of stakeholders (policy makers, clinicians, patient and caregiver representatives) on place of EOL care and place of death in the Netherlands, Portugal, Uganda and the USA.

Methods: We sampled people from the same stakeholder groups in each country (25 participants per country, 100 in total) and used a semi-structured interview guide. Audio recordings were transcribed verbatim in the original language and transcripts were inductively coded in English in Atlas.ti. Codes were assigned and analysed using thematic analysis. The developed code tree and themes were mapped per country and compared.

Results: Based on the 55 interviews executed so far, interview time ranged from 23-120 minutes. Preliminary findings show that across countries, the general ideal situation is to die at home. However, perceived EOL care availability and accessibility vary widely in the participating countries, as does the extent to which patients can choose for themselves. Stakeholders in each country mention the lack and availability of services as a barrier for achieving preferences for place of EOL care and death. The prevailing taboo on conversations about dying is also a recurring barrier to delivering EOL care at the preferred place. We will present fully analysed data on themes and perceptions, including how these vary by country.

Conclusions: Based on our results we will map how care is organised in relation to place of EOL care and death across two EU and two non-EU countries, including whether stakeholders feel a need to reform EOL

care. Findings will inform a subsequent longitudinal quantitative study on patients' EOL care pathways in the four countries, to provide insight into areas for improvement and stimulate development of new policies. This study is funded by the ERC.

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Multidisciplinary Approach to Patients with Metastatic Breast Cancer: A Mixed Method Study

V. Fusetti^{1,2}, C. Brunelli², S. Alfieri², G. Capri², C. Borreani², N. Bedini², E. Zecca², S. Lo Dico², M. Lusignani^{3,4}, A. Caraceni^{3,2}

¹Università degli Studi di Roma "Tor Vergata", Roma, Italy, ²Fondazione IRCCS Istituto Nazionale dei Tumori, Milano, Italy, ³Università degli Studi di Milano, Milano, Italy, ⁴ASST Grande Ospedale Metropolitano Niguarda, Milano, Italy

Background/aims: Multidisciplinary Cancer Clinics (MdCC) in Metastatic Breast Cancer (MBC) patients may help to address their complex symptoms and care requirements. Various MDCC options have been studied, but evidences on their impact on patient care experience (CE) remain scarce. We aim to evaluate the impact of Multidisciplinary MBC Unit model on patient care experiences compared to Monodisciplinary Cancer Clinic (mCC) for MBC.

Methods: This convergent mixed-method study integrated: A prospective observational longitudinal study assessing CE (ad hoc developed questionnaire, scale range 1-5), symptoms (ESAS-r scale range 0-10), and activation of Palliative Care (PC) and Psychology service. Qualitative interviews deepened patient satisfaction perspectives. Results are reported as CE and ESAS-r scales average values and percentages.

Results: Observational study: 80 patients (40 mCC, 40 MdCC); Qualitative interviews: 11 (7 mCC, 4 MdCC). Both reported high CE. MdCC improved CE for time to test (1.7 MdCC; 2.8 mCC) and for psycho-social care communication (2.8 MdCC; 1.8 mCC), while mCC was better in providing treatment information (2.8 MdCC; 3.6 mCC) and addressing doubts (1.7 MdCC; 1.2 mCC). Nurse Case Manager (NCM), despite not perceived as an integral team member by patients, ensured care continuity and networking among other professionals. Average symptoms at baseline differed between MdCC and mCC. Both Palliative Care (65% MdCC, 45% mCC) and clinical psychology services activation (22.5% MdCC, 15% mCC) were activated more frequently in MdCC patients. The presence of multiple professionals conveyed institutional commitment to patient well-being.

Conclusions: The MdCC improved CE in psychosocial care referral and perceived time-to-test intervals but increased communication complexity compared to mCC. Further investigation is needed to clarify the NCM's role and contribution.

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Implementation of Hospital Palliative Care Team in a Czech University Hospital

K. Vlckova^{1,2}, Z. Kremenova¹

¹Thomayer University Hospital, Prague, Czech Republic, ²Charles University, Prague, Czech Republic

Background/aims: In order to implement hospital palliative care team it is essential to educate staff about benefits of the palliative care team, to raise awareness of the service across system, and to know the needs of the primary care team. The aim of this paper is to present the process of implementing of hospital palliative care team in the setting of the Czech University Hospital.

Methods: In October 2022, the hospital palliative care team started to work for paediatric and adult patients. After half a year of work, an online questionnaire was sent out to assess the implementation process from the perspective of the hospital staff. The RE-AIM (Reach,