

were readmitted appropriately as judged by their original PEACE document in 3 months.

At Site 2, 12/37 patients discharged over 4 months were sent with a PEACE document. 25% (N=3/12) of patients with a PEACE document were readmitted within 6 months, only 8% (N=1/12) inappropriately. 56% (N=14/25) of nursing home residents discharged without PEACE in the same period were readmitted.

Our findings suggest that PEACE may reduce inappropriate readmissions. The results also suggest that PEACE is useful in supporting further ACP after transfer to care homes.

# 114 ADVANCE CARE PLANNING (PEACE) FOR CARE HOME RESIDENTS IN AN ACUTE HOSPITAL SETTING: IMPACT ON ONGOING ADVANCE CARE PLANNING AND READMISSIONS

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PEACE (Proactive Elderly Advance CareE) is an advance care planning (ACP) developed at two acute hospital sites in London, UK, for care home (nursing) residents prior to discharge. Patient's preferences are documented, or in the cases of mental incapacity, best interests decisions are made, to give clinical advice and escalation decisions for future medical care. The document is sent on transfer back to nursing homes, as agreed with GPs and care homes.

At Site 1, 20 patients were discharged with PEACE and 80% (N=16/20) were followed up at 2 weeks after transfer. 69% (N=11/16) of PEACE documents were in place in the nursing notes. ACPs had further been developed from PEACE in 73% (N=8/11). None of these residents were readmitted to the discharging hospital to date. However, of those residents whose ACPs were not further developed, 37.5% (N=3/8) were readmitted inappropriately (palliative plans), and 25% (N=2/8)