directives. Seventeen clients engaged in end of life conversations with the RN and did not require further intervention. Interviews with clients demonstrated satisfaction with the outcome. Staff highlighted concerns with delivering the information relating to personal discomfort and professional capability. Tools and processes for community ACP were developed with recommendations for sustainable implementation.

Discussion The evaluation highlighted client and staff recommendations which include staff education and change management processes required to align culture and meet client needs.

Conclusion This project has been effective in highlighting the role of ACP within a large national primary health care organisation, and understanding the requirements of sustainable and systemic implementation.

118 ADVANCE CARE PLANNING IN A COMMUNITY SETTING FOR PEOPLE WITH CHRONIC DISEASE

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Background The Silver Chain Group, one of Australia's largest primary health care providers, recognised that it is in a unique position to offer Advanced Care Planning (ACP) to large numbers of clients in their own home.

Aim The project aim was to develop a process and tools for the introduction of ACP within the community for people with chronic disease.

Methods Clients with chronic disease and receiving community nursing services were invited to participate. Specific tools and processes were developed. Registered Nurses (RNs) provided clients with information and referral to the project nurse. Clients were visited at home to facilitate ACP conversation, liaising with GPs, and assist with completion of documentation where required. Data including demographics and outcomes of interviews with clients and staff were collected and analysed.

Results Thirty-three clients were visited and engaged in advanced care planning; 12 completed advanced health