Patients were seen from both inpatient and outpatient setting in 2017 and mainly from outpatient setting from January to June 2018.

115 patients were enrolled out of 1410 patients in 2017 and 84 patients out of 1434 in 2016. This represented 2.3% increase in enrolment rate. From January to June 2018, 376 patients were seen and 69 patients enrolled. Average yield from June 2013 to December 2016 was 5.4%, which was considered low. Patients yield increase from 8.2% in 2017 to 18.4% within the first 6 months of 2018. In 2013 to 2016, we only managed to enrol 6 patients per month. The enrolment rate increase to 10 patients per month in 2017 and 12 patients per month in 2018.

There is a significant increase in ACP enrolment rate after shifting our focus from inpatient to outpatient setting. Patients and their caregivers are not ready for ACP conversations during hospitalisation as patients could be too sick to engage in the conversations. They are more willing and receptive to have ACP conversations when they are in outpatient setting. Moving forward, the ACP team will continue to work with primary care providers to offer ACP to patients who need them earlier in their disease trajectory.

P52 OPPORTUNITY TO PRACTICE ADVANCE CARE PLANNING AS REGARDED BY NURSES CARING FOR PEOPLE WITH CHRONIC ILLNESSES IN JAPAN

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Purpose As the Japanese population ages and advanced medical care progresses, there is an increasing need to consider ACP for people living with chronic illnesses. Nurses assume an important role in the advancement of ACP. The purpose of this study is to clarify the opportunity to put it into practice as perceived by nurses who are providing nursing care for patients with chronic illnesses.

Methods A quantitative study design was employed using a self-administered questionnaire survey. The questionnaire consisted of one to five Likert scales, and was sent via post to 1,855 addressees including all the Certified Nurse Specialists in Japan engaged in nursing care of people with chronic illnesses. 693 nurses responded.

Results The scores were high for "Setting up a meeting as required (during hospitalization)" (4.50 ± 0.62), "Setting up a meeting as required (as an outpatient)" (4.43 ± 0.69), "At the time of discharge (including the meeting to discuss treatment details with the patient and personnel involved in their treatment)" (4.17 ± 0.83), and "When providing regular treatment or nursing care (during hospitalization)" (4.11 ± 0.82).

Discussion The items raised as an opportunity to practice ACP, namely, "As required" and "When providing regular treatment or nursing care" are due to the characteristics of chronic illnesses, which require a long period of recuperation and carry uncertainty in the illness trajectory.

P53 STUDY PROTOCOL FOR A RANDOMIZED CONTROLLED TRIAL ON THE EFFECTIVENESS OF ADVANCE CARE PLANNING (ACP) IN GENERAL PRACTICE

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Background General practice is an optimal setting for ensuring timely initiation of ACP discussions. A multi-component ACP intervention developed for the general practice setting, aimed at patients with chronic life-limiting illnesses and their general practitioner, has been pilot tested. The aim of this study is to evaluate the effectiveness of this intervention and to evaluate its implementation by means of a process evaluation.

Methods/Design Using a cluster-randomized controlled trial (RCT) (randomization at the practitioner level, $n=53$ practitioners per condition, $n=133$ patients per condition), we will compare the structured ACP communication intervention to usual care, employing baseline measures (T0), and follow-up at 6 months (T1) and 12 months post-baseline (T2). Primary endpoints are quality of communication about end-of-life care and concordance between patients' preferences and received care at the end of life (as reported by the family caregiver if the patient died). Other patient or caregiver-reported outcomes include health-related quality of life, anxiety and depression, quality of end-of-life care, and quality of death and dying. Following the RE-AIM framework, structured diaries for trainers and general practitioners, as well as qualitative interviews with general practitioners, patients and family caregivers are among the measures used for the process evaluation.

Discussion After this Phase III RCT, we will be able to present a well-tested and evaluated ACP intervention that can be implemented in general practice. The results of the process evaluation will provide insight needed to allow adaptation of the intervention for a greater variety of national and international contexts.

P54 HOW PATIENTS AND RELATIVES PERCEIVE THE CONCEPT OF ADVANCE CARE PLANNING: AN INTERVIEW STUDY

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Background The EAPC consensus concept defines Advance Care Planning (ACP) as enabling persons to identify goals and preferences for future treatments and care, and to discuss, record and review these. However, this concept is defined by professionals. It is unknown how patients and relatives conceptualize ACP, however, this would be useful for (online) information provision on ACP.

Aims To explore what patients and relatives consider important in ACP and how they would search for ACP information on the internet.