

without anaemia. It reduces quality of life, functional status and is a risk factor for hospital admissions (Nunez-Gil, Peraira-Moral. *ESC Council for Cardiol Pract.* 2012; 10(16):1–4). Intravenous iron is well-tolerated and effective. It improves breathlessness, fatigue and quality of life (Anker, Comin Colet, Filippatos, et al. *N. Engl. J. Med.* 2009;361:2436–2448; Ponikowski, Kirwan, Anker, et al. *Lancet.* 2020; 396:1895–1904).

Aim To set up a service to give palliative IV iron to HF patients, to deliver this care closer to home and support the NHS.

Methods Patients were discussed at HF MDT to assess suitability for referral, initially during the pandemic when patients had difficulty accessing this treatment in hospital. A policy and Standard Operating Procedure were written to ensure safety of patients receiving treatment. The Lead Nurse for the IV Day Care Service screened referrals, carried out holistic pre-assessments, was responsible for running the service, provided follow up and ensured other hospice services were offered.

Results From March 2022 to April 2023, 42 patients were referred. 20 did not meet the referral criteria. 23 iron infusions were administered with no adverse reactions. 17 patients received treatment. Of these, 8 required a second dose although two patients were unable to receive this as they became acutely unwell. Three patients who completed treatment chose to access other hospice services. Three patients were referred to the inpatient unit due to pre-assessment highlighting overwhelming symptoms. This avoided admissions to hospital. One patient received IV iron as an inpatient.

Conclusion Administration of intravenous iron in a hospice day unit is safe and will improve symptom control as well as reducing hospital admissions. It introduces the concept of hospice care to HF patients in a non-threatening way, demystifying what we do and reframing the organisation as one that can improve quality of life, rather than being focused on death.

P-180 IMPLANTABLE CARDIOVERTER DEFIBRILLATORS AND THEIR MANAGEMENT AT THE END OF LIFE: THE EXPERIENCE OF A HOSPICE TEAM

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Background Increasing numbers of patients with Implantable Cardioverter Defibrillators (ICDs) are being referred to the hospice; they may not be identified early enough to enable deactivation in an outpatient setting. There are differences in the two local hospitals' community deactivation provision. A magnet may be needed for emergency deactivation at the end of life to prevent unnecessary shocks. One in three people with ICDs will receive multiple shocks in the last days of life; these can be painful, futile and distressing for patients and their families (Kinch Westerdahl, Sjöblom, Mattiasson, et al. *Circulation.* 2014; 129(4):422–9). Integrated working with local cardiology services is important for optimal patient care (Hodson, DeCoursey, Karwatoski, et al. *BMJ Support Palliat Care.* 2019; 9:A4).

Aims To highlight the increasing number of patients with ICDs and identify the complexities that arise. To improve early identification of these patients and ensure staff are

confident to initiate timely advance care planning conversations. Ultimately, to improve pathways, enabling ICD deactivation at an appropriate time and place.

Methods Collection of data over two years on referral identification, time from deactivation request to actual deactivation and case studies illustrating patient journeys to deactivation and death. Teaching session to clinical staff to present data.

Results 22 pts referred to hospice with active ICD (16 in year 2).

6/22 documented ICD on referral.

16 deactivated since referral: 3 discharged, 13 died.

5/16 deactivated at home.

1/16 deactivated on hospice IPU.

5/16 deactivated using emergency magnet at home (despite deactivation being requested; range 7–17 days prior).

3/16 deactivated whilst inpatient in hospital.

2/16 deactivated in cardiology outpatients.

1 received multiple shocks in week prior to death.

Conclusions Consistent with other centres (Nolan, Smyth, Nash, et al. *Heart.* 2019;105:A3-A4), an increasing number of people with active ICDs are being referred to the hospice. They are often not identified early enough to allow timely discussions and deactivation. Staff value education and support on managing emergency magnet placement at the end of life. Resource boxes are now in place across hospice sites. The resource boxes contain local guidelines, contact numbers and emergency magnets and tape. Further liaison is planned with the two local pacing teams.

P-181 RETICENCE IN THE FACE OF DEATH: COMMUNICATION EXPERIENCES OF BEREAVED RELATIVES IN ACUTE STROKE CARE

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This research study sought an understanding of the availability, provision and delivery of palliative and end of life care in a stroke ward, whilst exploring thoughts and views about the quality of palliative and end of life care practices. The study aimed to determine whether palliative and end of life care needs for both patient and family members were met; whilst also examining the transition from acute to palliative and end of life care within an acute stroke ward. This study drew together the experiences of bereaved family members of patients cared for within an acute stroke ward. Adult primary relatives of patients who died in hospital following an acute stroke were interviewed using a 16 question semi-structured interview schedule.

Data from 6 participants were analysed using Attride-Strling's (2011) analytic framework with data presented utilising two global themes: The Family Experience and Dying & Death. Amongst the findings was evidence of variable communication between professionals, patients and family members, especially in relation to conversations around dying and death. Whilst there is a strong evidence base supporting the benefits of end-of-life conversations (Brighton and Bristowe. *Postgrad Med J.* 2016; 92: 466–470; Ekberg, Parry, Land, et al. *BMC Palliat Care.* 2021; 20(186): 1–12), mirrored alongside some improvement in local palliative and end of life care provision