

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

especially amongst those with a non-malignant diagnosis, more clearly needs to be done.

Recommendations from this study suggest staff require palliative and end of life care training, including identifying when death is approaching, along with communication skills training in order to instigate timely conversations with patients and their family members. In addition, further research in this area is highly recommended.

**P-182** **RETROSPECTIVE SURVEY OF PRACTICE OF CARE PROVIDED TO PATIENTS WITH NEURODEGENERATIVE CONDITIONS**

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**Background** Palliative care involvement in supporting patients with a neurodegenerative condition has increased. There are no set standards of what support palliative care services specifically should provide for these patients. There are several sources available that outline recommended areas to be addressed (Olivera, Borasioc, Caraceni, et al. *Eur J Neurol*. 2016; 23(1):30–8; Vincent Scott, Lisney. *Multiple System Atrophy pathway*. MSA Trust, 2015; PSPA. A professionals guide to progressive supranuclear palsy. 2020). Overall themes from these sources are:

- Good advance care planning (ACP).
- Capacity assessments.
- Symptom assessment and control (SC).
- Psychological support.
- Carer support.
- MDT access.
- Home environment modification.
- Access to hospice services.

**Aims** To benchmark our service against the above recommendations. To identify gaps and propose ways in which to fill these gaps for the future.

**Methods** Stage 1. Literature review and correspondence with tertiary neurology centres. Identification of assessment criteria, creation of data collection proforma and method for analysis, e.g. for SC reviewing the use of the standard Integrated Palliative care Outcome Scale (IPOS) (Murtagh, Ramsenthaler, Firth, et al. *Palliat Med*. 2019; 33(8):1045–1057) and assessment for symptoms using IPOS for long-term neurological conditions (LTNC) (Wilson, Hepgul, Saha, et al. *Sci Rep*. 2019; 9(1):4972). Stage 2. Random selection of patients' electronic notes over previous 2 years reviewed, and results analysed.

**Results** Ten sets of patient notes analysed, with diagnoses; Parkinson's disease, multiple system atrophy or progressive supranuclear palsy. Holistic teams involved per patient; range 3–10. SC; IPOS in 1 year 90%, but assessment of saliva issues or spasms only 30%. Carer needs; offered assessment 87.5%. Psychological needs assessed and supported 100%. MDT discussion; 90%. Assessment of home environment; 100%. Cognition; formal cognitive assessments done 0%, comment on cognition 70%, appropriate capacity assessments done 67%. ACP; identifying need to discuss resuscitation 100%, good ACP discussion 78%, ACP revisited in past year 67%, treatment escalation plan recently updated 40%, gastrostomy discussions 40%.

**Conclusions** Areas of good practice and areas for improvement identified. Suggestions being worked on include introduction of the IPOS for LTNC and cognitive assessments.

**P-183** **WITHDRAWAL OF MECHANICAL VENTILATION IN MOTOR NEURONE DISEASE: AN UPDATED EVALUATION OF PRACTICE**

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**Background** Withdrawing mechanical ventilation at the request of a patient with motor neurone disease is complex and challenging. In 2015, the Association for Palliative Medicine (APM) published widely endorsed guidance for healthcare professionals (Faull. Withdrawal of assisted ventilation at the request of a patient with motor neurone disease. APM). We will discuss the updated results of an anonymised data set provided by professionals who have utilised the guidance across the United Kingdom.

**Methods** Excel analysis of a core data set, defined in the APM guidance, and thematic analysis of free-text comments, submitted by UK-based healthcare professionals soon after withdrawal of mechanical ventilation in any care setting, including inpatient hospice and at home. This is an updated analysis following previously published work (Faull, Wenzel. *BMJ Support Palliat Care*. 2022; 12(e6):e752–e758).

**Results** Eighty-one data sets were submitted by fifty-eight professionals from across the UK. Frequency and dosage of opioid and sedative medication required pre- and post-withdrawal of the mechanical ventilation was similar to that shown in previous analysis. Ten patients lived for longer than eight hours following withdrawal of mechanical ventilation. These patients were of varying ages and had varying dependency on mechanical ventilation prior to withdrawal. All ten patients were using non-invasive ventilation as opposed to tracheal ventilation.

**Discussion** The updated results of this evaluation of practice provide new information on patients who have a prolonged time to death following withdrawal of mechanical ventilation in motor neurone disease. We will discuss the reported experiences of healthcare professionals, as well as the experiences of family members and the implications for service delivery particularly when there is a longer time to death following withdrawal.

**P-184** **MUSIC AND MOVEMENT FOR PEOPLE WITH PARKINSON'S DISEASE AND THEIR CARERS: A DALCROZE EURHYTHMICS PILOT STUDY WITHIN A HOSPICE ENVIRONMENT**

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There is a growing call for embodied, non-invasive approaches to rehabilitation which can improve social relationships as well as psychological and physical wellbeing. This call is supported by an emerging evidence base demonstrating the impact of psychosocial approaches, including music and movement,