

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,