		Resus status & Treatment Escalation Plan in toolbar	Valid e-form in place	Made by a senior doctor (SpR or above)	Documented discussion with patient/ relatives	Documented communication to MDT	Decision made within 24 hours of admission	DNACPR communicated to GP on discharge
Cycle 1	DNACPR (n=133)	133 (100%)	113 (85%)	115 (86%)	91 (68%)	17 (13%)	82 (62%)	27 (79%)
Cycle 2	DNACPR (n=126)	126 (100%)	126 (100%)	117 (93%)	89 (71%)	72 (57%)	91 (72%)	71 (90%)

Abstract 43 Figure 2 Data comparison pre and post interventions

Difficulty and distress when negotiating this transition can also be a barrier for patients and their families in engaging with the process of advanced or anticipatory care planning (Lund, Richardson & May, 2015). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 2011) is a promising but under-researched psychological intervention for supporting terminally-ill cancer patients (Arch & Mitchell, 2015). We developed and are pilot-testing a brief ACT-based intervention to improve quality of life and psychological acceptance for this group. A multiple baseline, single-case, non-controlled design is used. Ten participants have been recruited. Each receives five sessions with an ACT-trained facilitator, in the hospice setting. Quality of life, distress, and ACT-process changes are self-reported, weekly. Psychological flexibility and overall health are measured daily. The attrition rate is 60%. One participant demonstrated measurement floor and ceiling effects, but small increases in psychological acceptance. Two participants demonstrated small changes in quality of life and psychological flexibility, with some level of distress reduction. Finally, one participant shows tentative improvements in psychological flexibility, despite overall health remaining low. Participant interviews and three staff focus groups provided feedback on acceptability and feasibility. This study will complete in August 2019. Findings to date suggest that ACT may be beneficial for patients transitioning to palliative care, but high drop-out and measurement issues raise feasibility questions.

44 IPU OR ITU? IT ALL STARTS WITH PCT (PALLIATIVE CARE TRAINING)

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10.1136/spcare-2019-mariecuriepalliativecare.44

Background Impending death is not well recognised.¹ Due to improvements in technology and medicine, people are living longer with more complex health conditions² and because of this, the death of a patient is an experience that many people entering a healthcare profession will have little of. As death occurs in any setting, at any time, it is vital that all healthcare professionals regardless of the setting they go on to work in, have adequate Palliative Care Training (PCT).

Aim To understand what current training is available on the recognition of dying at undergraduate level.

Methods An information gathering exercise of the following UK undergraduate courses: medicine, nursing, social work,

physiotherapy, occupational therapy. All courses received an email asking what training was provided in recognising and communication of dying and what time was dedicated to this. **Results** 73/198 courses responded (37%). 18/20 medical courses provided training in recognising dying with a median of 2 hours dedicated, and 17/20 in the communication of dying with a median of 3 hours dedicated. 80% (43/54) of nursing and allied health professional courses provided some form of training in end-of-life care. Many of these courses expressed frustration at the lack of resources, funding, and time to include more training. Those with more time dedicated to PCT often had a 'champion' to advocate for it.

Conclusion Training in end-of-life care was inconsistent and variable across courses and professions. Further work on how we can support the champions in progressing PCT input on the courses is needed.

45 REQUESTED WITHDRAWAL OF PEG FEEDING IN A PATIENT WITH MOTOR NEURONE DISEASE AND THE ROLE OF THE HOSPICE INPATIENT UNIT

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10.1136/spcare-2019-mariecuriepalliativecare.45

Motor Neurone Disease (MND) is an incurable, progressive condition with an average prognosis of 2–3 years from onset of symptoms (Worms, 2001; Oliver 2019). NICE guidance (2016) recommends that a health care professional with expertise in palliative care should be an integral part of the MDT in managing often rapidly progressive symptoms, psychological distress and complex future care planning. Nutrition and weight loss are predictors of survival (Leigh *et al*, 2003) and often relate to progressive dysphagia (Heffernan *et al*, 2004).

Gastrostomy can be used to administer nutrition with studies suggesting this can both prolong survival and improve quality of life (Mazzini *et al*, 1995; Ganzini, 2006). It is important that the option to have gastrostomy is discussed at an *early* stage taking the patient's personal preferences into account (MND association, 2019). Patients with MND often have other interventions to try and optimise QOL such as Non-Invasive Ventilation (NIV). Recent literature describes the withdrawal of NIV at the request of patients with MND (LeBon & Fisher, 2011; Messer *et al*, 2019) and the APM (2016) has issued guidance which considers the legal and ethical implications of this. However, a