

		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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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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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

systematic literature search has found no such evidence or guidance on the withdrawal of gastrostomy feeding in patients with MND. We present the challenges faced when a patient with MND was transferred to hospice IPU requesting withdrawal of PEG feeding and the need for further research; as hospices may increasingly play a role in withdrawal of treatment in MND in future.

46 DIETETIC INTERVENTION FOR PATIENTS WITH ADVANCED CHRONIC KIDNEY DISEASE – A CONSERVATIVE MANAGEMENT APPROACH

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Conservative management (supportive care) is defined as individuals with advanced chronic kidney disease (CKD) who choose not to undergo dialysis (supported by their kidney team).

A renal supportive care (SC) outpatient service has existed for over 10 years at this large renal unit.

Dietetic management in this population is complex, with the aim being to alleviate and/or reduce the risk of symptoms associated with advanced CKD and support quality of life. This may involve dietetic interventions such as: management of blood biochemistry (potassium, phosphate and mineral bone disease), fluid status (no added salt), low protein and nutritional support.

The aim is to evaluate current dietetic practice using a snapshot of the SC population

The method used was a random sample of selected patients. Data collected included demographics, prevalence of abnormal blood results, low protein diet advice and nutritional support.

The results for twenty patients (11% of the SC population) were used. Median age 80.5, range: 70 – 99years). Median duration under SC service: 23.5 (range: <1–56) months

Eighteen patients (90%) had received dietetic input. Half of these patients (n=9) required a low protein diet and 33% (n=6) were given nutritional supplementation. Three patients (15%) had either a recent elevated blood potassium or phosphate level.

In conclusion, the complexity of dietetic management in this SC patient population highlights the importance of a renal dietitian's involvement to help alleviate symptoms of advanced CKD and support quality of life. Further research into outcomes including patient/carer experience surveys is warranted.

47 DEVELOPING A GUIDELINE TO IMPROVE AND STANDARDISE PRACTICE IN WITHDRAWING NON-INVASIVE VENTILATION IN THE END OF LIFE SETTING

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Many patients who are reliant on NIV have chronic and incurable diseases. These include progressive neuromuscular diseases and irreversible airways disease. Hand in hand with

these diagnoses goes significant frailty. It is important when caring for these patients that we listen to their wishes at every stage. It's especially important when they may be coming towards the end of their lives. Often at this stage people have become dependent on their ventilators and withdrawing this support must be a sensitive and pre planned procedure. There are complex ethical and emotional dynamics at play for both patients and medical professionals. This only heightens the need for meticulous planning and frank discussion.

Our survey of junior doctors in the hospital setting revealed although 85% of people had been involved with managing NIV in end of life situations, 58% did not feel confident in doing so. This has a significant effect on both the patient and the junior doctor. Patients are having unacceptable deaths due to junior doctor lack of knowledge and disempowerment.

Following review of these results we undertook the development of a guideline to allow better care during this these end of life situations. This was written with multidisciplinary team input and was subsequently reviewed by a junior doctor panel.

Once globally approved it will be introduced trust-wide and junior doctors will be re-surveyed to measure impact on practice.

48 THE NATURE OF COMPLEX NEED IN SPECIALIST PALLIATIVE CARE REFERRALS

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Background Understanding complex need as the defining characteristic of episodes requiring specialist palliative care (SPC) is key to hospice service development. A single definition of complex need is lacking, however markers of complex need include: presence of multiple needs, needs across different domains, interactions between different needs and fluctuating needs. We examined which markers of complex need are present in referrals to a hospice service.

Methods Mixed-method service evaluation consisting of a case-note review and staff focus groups.

Results Physical needs were most frequently described in referral documents (91%) though needs were present across all domains. Markers of complexity across more than one domain were present in 95% of referrals. Psychological, social or spiritual needs were described in 68% of referrals; fluctuating needs in 67%; carer needs were documented in 52%. Referral forms were viewed as limited for capturing complexity. The quality of a referral was perceived as influenced by the experience and confidence of the referrer, their knowledge of the services available, the resources available to the referrer to meet the patients needs and the patient's diagnosis.

Conclusions Complex needs were documented in most referrals to hospice services. However, clarity on what service was being sought to meet a person's needs was lacking. There is scope for hospices to improve referral quality by defining