

## 8 AN EVALUATION OF END OF LIFE CARE FOR PATIENTS WITH COVID-19 RECEIVING NON-INVASIVE PULMONARY SUPPORT

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**Background** Non-invasive pulmonary support (NIPS), (CPAP or NIV), is available to patients with Covid-19 and a ward based ceiling of treatment. Evidence demonstrate a 50% survival with NIPS in this cohort. We, and our respiratory colleagues, were interested to understand the experience of dying in this context.

**Method** This was a retrospective case note review. Aims and objectives include:

- To describe the symptoms experienced, medications required and reasons for withdrawal in patients dying of covid-19 following treatment with NIPS
- To evaluate care against the five priorities (NICE guideline (NG142)).

**Results** 18 patients were included for analysis. The majority were aged over 80 (67%). All patients experienced breathlessness when dying, and seventeen had agitation or delirium. Twelve patients (66%) required a regular benzodiazepine, either alone (22%) or in combination with an opioid (45%). Two patients (11%) were treated with only an opioid. The doses of opioids and midazolam were relatively small - most commonly 10 mg. 66% of patients received <3 as required doses of opioid or midazolam in the final 24 hours. The commonest reasons for withdrawal were the patient stopping tolerating treatment (56%), and treatment failure (28%). No patients died within three hours of withdrawal, with the majority dying six hours to two days later. In 17 cases (94%) it was recognised and documented that the patient was sick enough to die. This was communicated to the patient and/or their family in all 94%. All patients had a DNACPR and Treatment Escalation Plan. 94% of families were offered to visit their dying relative, this was taken up in 44% of cases.

**Conclusions** Good end of life care is achievable in the context of patients with Covid-19, receiving NIPs. Key learning includes:

- The need to regularly review symptoms and consider increasing background sc infusions more frequently than our usual practice of every 24 hrs.

## 9 DELIVERING GOOD QUALITY END OF LIFE CARE (EOLC) DURING A PANDEMIC: THE RESPONSE OF THE TRANSFORMING END OF LIFE CARE TEAM (TEOLCT) TO COVID-19 IN AN ACUTE LONDON NHS TRUST

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**Introduction** The COVID-19 pandemic highlighted the need for high quality EOLC, unprecedented in scale and setting. We describe the initiatives led by the UCLH TEOLCT who

played a key role in preparing and supporting staff to provide EOLC, as well as providing support for inpatients and their families.

**Methods** Utilising QI methodology, the TEOLCT rapidly implemented changes in six key areas of practice between 23/03/2020 and 25/08/2020. The multidisciplinary TEOLCT collaborated with Specialist Palliative Care and Clinical Psychology teams to achieve these outcomes.

**Results** (i) Staff education: high demand for teaching, e.g. difficult conversations, EOLC and COVID-19 specific symptom control, for redeployed staff largely inexperienced in EOLC. 1037 clinical staff were trained utilising a combination of socially distanced lectures and video-conferencing/webinars. (ii) Staff support: drop-in sessions were facilitated for >200 staff members. (iii) Guidance and Standard Operating Procedures: for symptom control, non-invasive ventilation withdrawal and communicating with family were collaboratively written and disseminated with appropriate training. (iv) Clinical audit: quality of decision-making and documentation scrutinised by auditing treatment escalation plans and do not attempt cardiopulmonary resuscitation orders, identifying areas of practice improvement and training needs. (v) Clinical support: modifying the SWAN model of care for patients in last days of life, TEOLCT supported care of 107 patients during the pandemic peak (23/03 – 15/05/2020), totalling 255 inpatient visits. (vi) Bereavement support: with restricted visiting and changes to after death care, TEOLCT oversaw formal bereavement support for bereaved families of 348/392 patients who died, plus appropriate sign-posting to community services.

**Conclusions** The TEOLCT rapidly adapted to an unprecedented clinical challenge, identifying and responding to needs, working towards a common goal and leading a coordinated response to the demand for training and support. The key areas of development will inform future practice to ensure ongoing training and support in future surges.

## 10 WHAT CAN WE LEARN FROM THE COVID-19 PANDEMIC ABOUT ADMISSIONS TO A HOSPICE IPU?

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**Background** The 2020 COVID-19 pandemic has affected how hospices have functioned, with visiting restrictions and perceived public fear of healthcare environments. It was thought that hospice IPU admissions had reduced and that those admitted were further on in their disease trajectory.

**Aims** To review hospice referrals, admissions, length of stay, care and communication records and mortality during the COVID-19 pandemic and compare it to the previous year.

**Methods** A retrospective review of the case notes of all admissions to a hospice IPU over a 6-month period from 1st of April to 30th September in 2019 and 2020.

**Results** There were 97 admissions in 2019 vs 94 in 2020. 44/97 (45%) vs 45/94 (48%) died during admission. The average length of stay was 14.4 days (2019) vs 10.4 (2020)  $p=0.036$ , when excluding respite admissions (which had temporarily suspended in 2020) and day procedure admissions the average length of stay was 17.3 days vs 10.3 days,  $p=$