16 DO SYMPTOM CONTROL NEEDS DIFFER IN PATIENTS DYING FROM COVID-19? A SPECIALIST PALLIATIVE CARE EXPERIENCE FROM AN ACUTE TRUST

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Introduction Data around end of life care in COVID-19 patients remains lacking. We present a study of 89 COVID-19 hospital patients who received specialist palliative care (SPC) input, which provides a novel understanding of the symptom needs of those dying from COVID-19.

Methods Retrospective review of health-records of 89 COVID-19 patients with SPC involvement between 20/3/20 - 21/4/20. 54 pre-pandemic control patients referred to SPC between 20/11/19 - 20/12/19 were included as comparison.

Results and discussion 84% (n=75) of COVID-19 patients had died at follow-up compared to 44% (n=24) of controls. Average time from SPC involvement to death was 3.4 days for COVID-19 patients and 8.3 days for controls.

COVID-19 patients were more breathlessness (92%, n=69 vs 75%, n=18) and pyrexial (44%, n=33 vs 4%, n=1) than controls. Control patients were more likely to experience pain (58%, n=14 vs 17%, n=13). Agitation rates were similar in COVID-19 patients (45%, n=34) and controls (58%, n=14).

High symptom burden and rapidity of deterioration in COVID-19 patients necessitated an increased use of continuous subcutaneous infusions (CSCI's), (69%, n=52 vs 46%, n=11).

Median doses of opioids and benzodiazepines required in CSCI's to control symptoms were similar across both groups. Median 24 hr CSCI morphine equivalent dose of 15 mg (n=51) in COVID-19 patients vs 10 mg (n=10) in controls. Median CSCI midazolam dose of 10 mg in both groups (n=40 vs n=10 in controls). Few COVID-19 patients required glycopyrronium (n=15) and antiemetics (n=5) via a CSCI.

Conclusion and recommendations COVID-19 patients have a rapid deterioration and symptomatic dying phase with different symptom profile to control patients. Symptom control in COVID-19 can be achieved with traditional drugs often at low doses, though with earlier use of CSCI's. Education and reassurance for generalists in the early use of opioids and benzodiazepines is essential to managing symptoms of dying COVID-19 patients.

17 IS ROUTINE INPATIENT COVID-19 TESTING APPROPRIATE IN THE HOSPICE SETTING? AN AUDIT OF CLINICAL PRACTICE DURING THE COVID-19 PANDEMIC

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Introduction Nasopharyngeal swabbing for COVID-19 is now standard for hospital admissions. At Martlets Hospice, a paucity of swabs, and reservations about the invasiveness of swabs in patients approaching the end of life, meant that routine inpatient testing was not implemented until June, when a standard operating procedure (SOP) was written. Post-SOP, patients should have been swabbed as soon as possible after admission, unless they were known COVID-19 positive, were actively dying, or were unable to consent. Our audit aimed to

ascertain how manageable routine testing is in a palliative care setting.

Methods 142 patients were admitted to Martlets between 1/4/2020 and 1/10/2020. N =71 both pre and post SOP implementation. All inpatients' notes were checked for documentation of swab results or why swabbing was inappropriate, and this was checked against the online pathology reporting system ICE.

Results Pre-SOP, 48/71 patients were deemed appropriate to swab. Of the remainder, 16 were known COVID-19 positive, and 7 were actively dying on admission. 44% of patients deemed appropriate were swabbed, of whom 19% tested positive for COVID-19. 50% of those with positive swab results had been asymptomatic, but were swabbed because they had been admitted from high risk hospital wards. Post-SOP, 60/71 patients were deemed appropriate. There were no COVID-19 positive admissions. 70% of patients deemed appropriate were swabbed, of whom 0% were COVID-19 positive.

Discussion Our results indicate that routine inpatient testing is feasible and appropriate in hospice settings. Clear guidelines increase the frequency of swabbing and ensure that only appropriate patients are swabbed. Positive swabs in some asymptomatic patients indicate that particularly in the context of a second wave, routine inpatient testing will be necessary, despite the unpleasantness of the procedure. To reach 100% of appropriate patients tested, integration of our SOP into admission proformas and documentation is being trialled.

18 RETROSPECTIVE AUDIT TO ASSESS FOR DIFFERENCES BETWEEN PATIENTS DYING OF COVID-19 VS PATIENTS DYING OF OTHER CAUSES

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Background Specialist palliative care is essential in caring for patients dying of Covid-19. Facing this new disease, it is essential we develop an understanding of this patient population and how best to manage their end of life. We wanted to assess if there are any significant differences between patients dying of Covid-19 versus those dying of other causes.

Methods We compared the patients who died of Covid-19 in April 2020, with patients who died in April 2020 and April 2019 without Covid-19 who were known to the specialist palliative care team at a district general hospital. We collected the data by retrospective case note review.

Results Total of 39 patients; 12 patients in the Covid-positive group, 15 in the Non-Covid-2020 group and 12 in the Non-Covid-2019 group. There were 25 males distributed across the groups, with a comparable median age across the groups. Malignancy was less common in the Covid-positive group but co-morbidities including cardio-vascular disease and type two diabetes were more common. Patients who were Covid-positive; had a shorter window of palliative care team involvement, a lower AKPS at point of referral and were more likely to be in the dying phase of illness. Symptoms of breathlessness were more likely in the Covid-positive group, but they were less likely to have pain. Agitation was present across all groups. The median doses of morphine and midazolam were very similar across all groups and for all groups these treatments were recorded as being effective.

Conclusion The palliative care team were referred patients with Covid-19 at a later stage in their illness. The symptom burden and medication requirements at the end of life were however similar across all groups. It is helpful to be aware of these findings so that we can care for patients dying of Covid-19 effectively.

19 DO PATIENTS WITH COVID-19 REQUIRE DIFFERENT END OF LIFE MEDICATIONS? – THE EXPERIENCES OF A DUAL SITE HOSPITAL PALLIATIVE CARE TEAM

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Introduction University Hospitals of Derby and Burton (UHDB) report our Hospital Palliative Care Team's (HPCT) experience in supporting patients with COVID-19 during the pandemic's first surge.

Methods Inclusion criteria: patients supported by HPCT at two acute hospital sites, with a positive RT-PCR nasopharyngeal swab for SARS-CoV-2 between 16th March and 1st May 2020. Exclusion criteria: Patients intubated on ITU. Data was extracted from medical and nursing notes retrospectively and prescriptions in the last 3 days of life were reviewed. We sought to describe the cohort of COVID-19 patients supported by HPCT and to evaluate their medication requirements at end of life.

Results 223 patients were referred to HPCT: 155 (70%) with a positive swab for SARS-CoV-2. 95% had never been seen by HPCT previously. On average they had had one hospital admission in the preceding 12 months (range 1–8). The proportion of non-white patients was higher than our usual cohort (7 vs 4.6%). Whilst receiving input from HPCT 112 (72%) patients died in hospital and only 4% were discharged from hospital. All patients had anticipatory medications prescribed during their last 3 days of life; 41% required at least one dose in the 2 days before death, and 62% on the day of death. On the day of death, 59% required a dose of an opiate, 60% midazolam and 20% an antipsychotic; 72% had a syringe driver in place. However 23% required no anticipatory medications or a syringe driver. Doses of drugs given did not exceed those typically used in non-COVID patients.

Conclusions The vast majority of patients during this period of time were new referrals to HPCT. In line with other published work, most patients dying with COVID-19 had symptoms which were managed with usual doses of medications. An opiate and midazolam were the drugs most frequently required.

20 DEVELOPING SYMPTOM CONTROL GUIDANCE FOR COVID-19 PATIENTS WHO ARE DETERIORATING DESPITE NON-INVASIVE VENTILATION (NIV) AS THEIR CEILING OF TREATMENT

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Background COVID-19 positive patients often develop Type 1 respiratory failure requiring CPAP, meaning deteriorating

patients are often alert, leading to a challenging end of life situation at the time of NIV discontinuation. The Palliative Care team were asked to help better manage symptoms for COVID-19 positive patients approaching the end of life, and specifically those patients having NIV support as their ceiling of treatment, who were deteriorating very rapidly despite this.

Methods A case note review was performed. Guidance was developed following rapid review of existing published guidance for NIV withdrawal and sedation for other comparable clinical situations, with adaptation using the experiential knowledge of the palliative care and respiratory teams in managing COVID-19 positive patients. Finally, to evaluate the guideline an online survey was distributed to respiratory ward staff following the 'first wave'.

Results A symptom control flowchart was developed and agreed for use in the health board specifically for managing the rapidly deteriorating patient with COVID-19 on NIV as their ceiling of treatment. This later formed part of the All Wales COVID-19 National Secondary Care Guidance website. The online survey drew 12 respondents. Following introduction of the guideline the proportion of respondents who felt symptoms were adequately controlled rose from 17% to 58%. Qualitative feedback demonstrated that despite the difficult circumstances, patients were treated with compassion and overall better symptom control was achieved. 91% of relevant staff felt comfortable with the medication doses recommended for symptom control.

Conclusions Key to the appropriate implementation of this guidance has been the support of the local palliative care team and a good working relationship with the respiratory teams. A collaborative approach facilitated the rapid development of guidance in response to a direct patient need. This flowchart has given the respiratory team guidance to support better end of life care and reduce distress for patients, families and staff.

21 THE EFFECT OF THE COVID 19 PANDEMIC ON REFERRALS AND DEATHS AT MEADOW HOUSE HOSPICE (MHH)

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Background COVID 19 has caused untold levels of suffering throughout the world. Palliative care is essential, however access may be limited due to demand (Radbruch, et al., 2020). Services have had to respond with flexibility and rapid changes to systems and policies (Etkind, et al., 2020). In light of this we looked at data on referrals to see the impact that COVID 19 has had at MHH.

Methods We compared data on referrals and deaths from January to June 2020 with data from previous years.

Results Referrals to Meadow House hospice were steady during the first half of 2020 compared to previous years, with 1095 referrals from January - June 2020 compared to 1934 from January - December 2019. There were more community referrals with 970 referrals from January - June compared to 1618 in the whole of 2019. Lymphoedema referrals in contrast were reduced with 57 referrals from January - June 2020 compared to 170 from January - December 2019. There was a peak of referrals in April with 186 referrals in 2020 compared to 119 referrals in April 2019.