

completed in the hospice (19) followed by those completed in hospital (13) and then GP settings (4).

Conclusions The piece of work identified the majority of ReSPECT forms completed were of high quality and had high completion rate for clinical recommendations and resuscitation decisions. Interestingly, forms completed within a hospice setting were assessed to be of higher quality. This quality improvement process used standard reporting and benchmarking quality standards to compare across the health economy. This emphasises the need for services to use co-created tools both in terms of assessment and governance.

65

THE USE OF OPTIFLOW THERAPY IN A SPECIALIST CANCER HOSPITAL AND IT'S IMPLICATION FOR PATIENTS RECEIVING PALLIATIVE CARE

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10.1136/spcare-2021-PCC.83

Background Optiflow therapy (OF) is nasal high flow Oxygen that is hospital based. Its aims are to reduce work of breathing and symptomatic breathlessness. Its use is generally initiated by critical care outreach in order to prevent admissions to critical care for ventilatory support. The concern was that OF was mainly commenced acutely without considering ramifications on achieving Preferred place of care or death (PPC/PPD). Local and National guidance is lacking for patients who are receiving palliative care. We aimed to develop a guideline for initiating OF within the hospital.

Methods A baseline retrospective notes review was conducted. 60 adult medical in-patients who started OF on the wards between October 2018 and October 2019 were included.

Results The most common reason for commencing OF was infection (61%), Pulmonary oedema (13.4%), Pneumonitis (4.9%) and Pleural effusions (4.9%). Most patients remained on OF for less than 4 days (43 patients, 71.7%). OF was initiated in 65% patients out of hours. Most often an MDT was used to make the decision. In 43% patients a 'ceiling of treatment' decision was documented prior to starting OF: of these 35% were for full escalation, 35% for inotropes but not intubation and 30% for ward-based treatment only. Prior to starting OF 3% had a PPD documented. The majority of patients 65% improved on OF and were weaned off. However, 82% patients died within 8 (most of those within the first 4) months of initiation of OF; either whilst on OF, later in the admission when stopped OF, or following discharge.

Conclusions The results suggest that although the vast majority of patients are weaned off OF, it does signal a deteriorating patient and referral to palliative care should be initiated. A guideline is being developed to support clinical decision making around the use of OF.

66

ASSESSING THE QUALITY OF END OF LIFE CARE IN PATIENTS DYING IN AN ACUTE HOSPITAL IN LONDON AND THE IMPACT OF THE COVID-19 PANDEMIC

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10.1136/spcare-2021-PCC.84

Background This audit measures the extent to which in hospital end of life care is meeting the Five Priorities of Care for the Dying Person. 1) Recognise 2) Communicate 3) Involve 4) Support 5) Plan & Do.

Aims

1. To assess the impact of the Covid-19 pandemic on end of life care.
2. To provide trust wide feedback in preparation for increasing rates of Covid-19.

Methods Cases were audited retrospectively using quality measures based on the 2016 National End of Life Care Audit. Thirty deaths from November/December 2019 were compared with forty deaths from April 2020 (first peak of Covid-19)

Results Median age was similar pre and during pandemic (81.5 vs 80.3). During the pandemic 70% of patients audited tested positive for covid 19. Pre pandemic 13% of patients died without a Treatment Escalation Plan (TEP) compared to 2% during the pandemic. Pre pandemic 27% of patients received active treatment in the last days of life compared 48% during the pandemic. Involvement of the patient and next of (NOK) in decisions remained >90% pre and during pandemic. During the pandemic spiritual/cultural needs assessments fell by 25% and discussions around place of death fell by 36%.

Conclusions The increased likelihood of active treatment in the last days of life during the pandemic may reflect the rapid disease trajectory of covid-19. The consistent high level of communication with patients and NOKs reflects efforts to communicate via telephone due to visiting restrictions. TEP completion improved during the pandemic in keeping with national drives to establish ceilings of care and the transfer to electronic TEPs in the Trust during the pandemic. Prioritisation of communication and medical intervention during the pandemic may have adversely impacted holistic needs assessment. Learning points from this audit have been publicised in the Trust in preparation for the second wave of the pandemic.

67

GOLD STANDARDS FRAMEWORK IMPLEMENTATION DUDLEY GROUP NHS FOUNDATION TRUST

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10.1136/spcare-2021-PCC.85

Gold Standards Framework (GSF) is a systematic, evidence based approach to optimise care for all patients approaching the end of life, delivered by generalist frontline care providers. There is evidence that 30% of adult hospital inpatients are in the last year of life (Clarke et al. 2014). The specialist palliative care team have completed a yearly audit to establish the percentage of adult inpatients on a particular date in June, who died during the following 12 months. The overall percentage is 33 percent of adult inpatients on the 3rd June 2018 had died within 1 year. Therefore, this data supported the published evidence and also supported the wards with the GSF implementation programme.

Over the last 2 years the wards have engaged with six workshops and developed care plans based on national documentation for Gold Standards Framework Green, Amber and Red.

The front runner wards “ elderly care, stroke and CCU have completed the requirements for accreditation and have been awarded GSF accreditation in August 2020. CCU is the first in the country to be GSF accredited. The improvements across these wards include the following which we were able to demonstrate through a GSF log data collection system:

1. Increasing recognition of patients in the last year of life
2. Increasing number of these patients offered advance care planning
3. Increasing number of dying patients supported with Priorities for care of the dying person communication document
4. Reduced length of stay for fast track patients

The wards requested that the recording of GSF was available via the EPR system which has been achieved thanks to support from IT and allows staff to view patients that have been identified as GSF and if they have had an advance care plan offer or priorities for care communication document commenced. Furthermore, when a patient is re-admitted their previous GSF status will be visible on the tracking board. We are also able to record preferred place of death with documents on the EPR and are currently working with IT to enable reporting of achievement of preferred place on discharge and death.

March - April 2020 as we all know have been unprecedented times with COVID-19. Our data offers assurance that the GSF has continued to be embedded across the hospital and patients are being identified as GSF which will include the use of appropriate care plans and enable the development of an individual plan of care. We have also demonstrated increasing number of patients identified for GSF and died on the wards with a reduction in the number of MET calls.

68

IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR DEACTIVATION IN THE COMMUNITY: THE PERSPECTIVE OF PALLIATIVE CARE PROFESSIONALS

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10.1136/spcare-2021-PCC.86

Background Implantable cardioverter defibrillators (ICDs) are increasingly used for prevention of sudden death in people with heart failure (HF). Palliative Care health care professionals (PC-HCP) are increasingly caring for patients approaching end-of-life due to progressive HF or comorbidities. Conversations with patients, families and professionals to facilitate ICD deactivation can be challenging, particularly in community versus hospital settings.

Method A survey of PC-HCP was undertaken. Invitations to participate were emailed to hospital and community palliative care teams across the UK. We examined ease of access to appropriate services/personnel from different settings, clarification of whether policies and lines of responsibility were in place, clinical triggers to prompt ICD deactivation and availability of training for staff.

Results 97 HCP responded, of whom 46% were in post >10 years. 59% had cared for <5 patients, 16% 5–10 patients and 3 >30 patients with ICDs in the previous 12 mths. Similar numbers worked in NHS or independent

sectors (38% each), 24% working across both. 27% were based in primary/community care, 36% secondary care and 37% across both settings. 26% participated in multidisciplinary HF meetings and 72% of these had presented cases for consideration of ICD deactivation. 60% were aware of a site-specific ICD deactivation protocol in their workplace, with less knowledge about linking to a regional or DNACPR protocols or ReSPECT process. Where protocols were in place, 42% contained specific guidance for community-based deactivation. Delays in deactivation were limited by staff resource/availability in both community and hospital settings, particularly out of hours, with only 36% feeling that appropriately trained staff and equipment were available out of hours. Prompt access to a magnet for emergency deactivation differed across settings: hospital (62%), hospice (72%), home (33%) and Care Home (22%). Less than half (43%) agreed that PC-HCP had adequate training to facilitate use of the magnet.

Conclusion PC-HCP report significant barriers to ICD deactivation, particularly in the community. Local and regional policy still needs to be standardised across the UK, and education and training provided to enable timely conversations and integrated pathways in place. Further analysis of case vignettes will be presented.

69

LEARNING FROM A CASE REPORT: DEVELOPING A CHECKLIST TO FACILITATE DISCHARGE HOME FROM CRITICAL CARE AT THE END OF LIFE

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10.1136/spcare-2021-PCC.87

Background Achieving patient wishes, including preferred place of death (PPOD), is integral to excellent end of life care. Rapid discharge at end of life has been identified to be a core part of this care in the acute hospital setting. However, what consideration do we give PPOD, when caring for patients in the critical care (CC) setting? We outline a case report and evolution of a checklist to help streamline this process, ensuring patient safety and improved patient care.

Methods We describe a patient with Guillain Barré Syndrome who was ventilated via a tracheostomy on critical care. After a lengthy admission with no improvement, his discharge home for withdrawal of invasive ventilation and end of life care was jointly supported by the critical care and palliative care teams. Following reflection and learning from this and other cases, the complexities involved with a discharge of this type were identified. To achieve safe and effective care and provide direction to a process unfamiliar to many, a joint checklist was developed.

Results Our checklist has been well received by the wider critical care and specialist palliative care teams (SPCT). It aims to co-ordinate and clearly identify task responsibility.

Key learning incorporated into the checklist includes:

- Early involvement of the SPCT
- Joint CC & SPCT discussions with family are crucial
- Regular communication between primary and secondary care services
- Avoiding same day or weekend discharge