

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.

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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.

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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