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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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

Conclusions The checklist is in its pilot phase. Evaluation is planned for February 2021. Adaptations, if required, shall be made when this data is available. Discharge home from critical care for patients who are dying is possible. To ensure fair and equitable care for all, PPOD should be discussed and explored for patients in ITU, and although a complex process, it is achievable and highly rewarding for all involved.

70 A REVIEW OF END OF LIFE CARE OF PATIENTS ON HIGH FLOW NASAL CANNULA AT THE ROYAL VICTORIA INFIRMARY, NEWCASTLE UPON TYNE

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10.1136/spcare-2021-PCC.88

Background High flow nasal cannula (HFNC) has a role in managing chronic and acute respiratory failure. Many published reports suggest that HFNC decreases breathing frequency and work of breathing and reduces needs of escalation of respiratory support in patients with diverse underlying diseases. These properties may provide beneficial symptom control where reversibility of the condition is not possible.

Method Our aim was to evaluate end of life care delivered in patients who received HFNC in their terminal admission. These patients were identified via database kept by Critical Care Outreach Nurses from December 2019 - February 2020. Data was collected retrospectively from electronic notes.

Results 33 patient notes were reviewed (mean age= 77.2 years (15 female, 18 Male)). A majority (24) were admitted from home, with the remainder from nursing or residential care. Initiation of HFNC happened throughout the hospital (Emergency Department and admission unit= 14, Respiratory unit= 8, other medical wards= 6, Non-medical wards= 5). The primary indication for commencing HFNC was pneumonias (15), with an average duration of 7.24 days. 15 patients weaned off HFNC, 11 died with HFNC in situ, 4 did not tolerate treatment, 2 were discharged to community for end of life care and 1 was intubated. Regarding the recognition and management of the dying patient: 31 were recognised to be dying by medical teams and of these, 29 had documented discussions regarding end of life care with patient or relatives. 27 patients were referred to Palliative Care for specialist advice and 27 were prescribed anticipatory medications for symptom management.

Conclusion There was clear evidence of good symptom management and onward referral to Specialist Palliative Care for patients who were treated with HFNC during their final admission. However, we are limited by reviewing retrospective documentation and the likely change in practice given the Covid-19 pandemic.

71 HOW AND WHEN TO ASK CANCER PATIENTS WITH A PALLIATIVE DIAGNOSIS ABOUT CORNEAL DONATION. A QUESTIONNAIRE BASED STUDY

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10.1136/spcare-2021-PCC.89

Background Fewer than half of families agree to donation if unaware of their loved one's decision to be a donor. This rises to over 9 in 10 when the decision is known (organdonation.nhs.uk). All previous research on this topic bar one recent qualitative study has focused on views of health professionals, or relatives.

Aims The aim of this study was to determine the best way to ask about corneal donation; by asking patients directly. Secondary aims were to establish whether patients knew they could donate corneas despite having cancer, if they would donate and if they had registered their wishes.

Methods Twenty patients with a palliative cancer diagnosis, were given a questionnaire to complete anonymously. Questions asked about current understanding and views on organ donation, whether any wishes were registered, and how they felt we should ask about donation.

Results 18 completed questionnaires were returned. Only 2 patients were aware that cancer patients can donate corneas. Despite 11 patients stating they had previously considered donation, and 17 stating they would wish to donate, only 4 had registered their wishes online. The same 4 also carried a donor card. The majority felt it didn't matter who asked (10), or where (16). 11 felt face to face was best although 6 felt it would be acceptable to ask via questionnaire. Patients were divided on when the best timing would be. 15 patients felt we should discuss donation routinely at the time of hospice admission, and the same 15 felt we should routinely ask all patients under hospice care.

Conclusion The majority of patients would consider donating but don't realise they are eligible to do so. Most patients feel we should routinely ask about donation; even if they did not wish to donate themselves. Education is required to empower health professionals to start conversations.

72 THE BUTTERFLY PROJECT – IMPROVING TREATMENT ESCALATION PLANNING IN THE EMERGENCY DEPARTMENT

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Background The 2017 End of Life Care Hospital Improvement Programme (ELCHIP) audit of deaths at the Leicester Royal Infirmary (LRI) an Emergency Department (ED) attendance may be an opportunity to proactively identify and plan for deterioration. The clinical frailty scale (CFS) can identify older people at increased risk of deterioration or dying and local data suggests a 1 year mortality rate of 50% in the cohort of patients with CFS 7–9.

Methods The Butterfly Project is a multidisciplinary quality improvement project aiming to increase the percentage of older people CFS 7–9 dying in their preferred place of care, with additional outcomes based on early identification of uncertain recovery and treatment escalation planning.

ED notes were reviewed for all CFS 7–9 patients dying within 30 days of an ED attendance between February 2019 and May 2020. Interventions were broadly within two streams. The first focused on improving treatment escalation planning including verbal and visual prompts and the introduction of the ReSPECT process. The second was based on improving the skillset of ED staff via educational interventions.