111 HEART FAILURE – THE EXPERIENCE OF LIVING WITH END-STAGE HEART FAILURE AND ACCESSING CARE ACROSS SETTINGS

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Aims Heart failure is a complex clinical syndrome affecting an increasing number of the ageing population. Patients and carers require increasing input from specialist palliative care services to both manage symptoms and access support in the last year of life. An integrated clinical service between the local cardiology team at Princess Royal University Hospital and the palliative care team at St. Christopher's Hospice was piloted for patients with end-stage heart failure in Bromley in Kent, UK. This study explored views of patients and carers who participated in the integrated pilot service.

Methods and Results A qualitative study was conducted in which a convenience sample of patients and carers were invited to participate in focus groups: two bereaved carer groups (n=2,n=2); one patient group (n=4), held between 14th December 2018 and 18th January 2019. Participants were asked to describe their experiences of care received facilitated by a topic guide. Interviews were recorded, transcribed and coded using thematic analysis to identify common themes.

Four patients (2:2 M:F) aged between 70 to 87 years and four female carers whom had cared for patients aged between 70 to 96 years who were since deceased, participated in this study. Overall, the service was positively received, and responses were mapped into four key areas; being diagnosed and living with heart failure, referral to palliative care, key helpful components of the care received and finally, unhelpful components of the new service in terms of care. Common themes emerged including understanding of heart failure and its trajectory, communication around palliative care, having a 'broker' for the system, recognition of carer's needs, service responsiveness, and feeling 'in control'.

Conclusions This qualitative study highlighted important considerations when developing an integrated heart failure and palliative care service. Education about heart failure for patients and carers, but also the integrated multidisciplinary team is crucial to improving detection of deterioration and facilitating communication around Advance Care Planning. The value of the 'expert-carer' should also be promoted and supported in chronic conditions. We recommend a focus on development of integrated services that enable joined-up care or single point of contact for patients and carers.

112 SPECIALIST PALLIATIVE AND END OF LIFE TIMELY INTERVENTION PROJECT (SPELITIP) ON THE EMERGENCY FLOOR – OUTCOMES FROM THE FIRST 20 WEEKS

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Background The majority of deaths occur in hospital. Most hospitals have access to Specialist Palliative Care with a variable amount of provision. Most are designed to be reactive and responsive.

A local audit in 2018 demonstrated that 89% of hospital deaths occurred following emergency admission. Clinical decision-making at admission did not always reflect the fact that the patient was at risk of dying. Opportunities to plan and involve patients in escalation decisions were missed and individualised planning was inconsistent. The aim was to improve the experience and outcomes for patients admitted with palliative and end of life care needs through role modelling, clinical support and education.

Methods A successful bid to Macmillan Cancer Support funded 2-year project for a proactive model of care with two Palliative Clinical Nurse Specialists (PCNS) based on the Emergency Floor. The Emergency Floor includes the Emergency Department and a variety of Acute Medical and Frailty wards. We wanted to evaluate the effectiveness of the PCNS service on staff and patients.

Results We report the first 20 weeks of the project, November 2019 to March 2020. The team had 336 contacts with 202 patients. 85% achieved their preference for place of care. The average length of stay was 3.75 days as opposed to 14 days for similar patients. Over 50% of patients did not need admission into the hospital from the Emergency Floor. Feedback has been extremely positive.

Conclusion Proactive specialist palliative care located at the point of admission improves the experience and outcomes for patients admitted with palliative and end of life care needs in an emergency. This work should influence how specialist services are provided in the future at a local and national level.

113 IMPLEMENTING VIDEO CONSULTATIONS IN A UK HOSPICE DURING THE COVID-19 PANDEMIC: LEARNING FROM HEALTHCARE PROFESSIONALS' FEEDBACK

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Introduction Providing care for our patients, carers and families during the coronavirus pandemic required a rapid shift to remote consultations, using videoconferencing technology. A service evaluation was performed to capture hospice professionals' experience.

Methods An online survey exploring experience and satisfaction was sent to a convenience sample of hospice professionals who had participated in video consultations between March and June 2020.

Results 35 hospice professionals responded, and both quantitative and qualitative data was analysed. 62.5% rated their video consultations as good, despite 94.1% having no prior video consultation experience. A third of respondents had undertaken potentially sensitive consultations, including advance care planning and resuscitation. Although 50% of respondents had undertaken first assessments remotely, they consistently found this more challenging when the patient was not known to them previously. The results helpfully captured specific scenarios, when video consultations were less appropriate. 75% of respondents had undertaken a video

consultation with a family member participating and 52.9% had included an external health professional. Wellbeing staff had also successfully provided multiple group support sessions via video for both patients and carers. The respondents thought video consultations were efficient and convenient for hospice professionals (80.6%) and patients (67.7%). As a consequence of the rapid shift to video consultations, our results highlighted that 78% of respondents had received no formal training, and in addition, 39% reported some technical difficulties. Overall 80.7% wanted to offer video consultations as an option in the future.

Conclusion Hospice professionals have quickly adapted to video consultations and are keen to continue to offer this service in the future but need appropriate training and reliable videoconferencing technology in order to do this effectively. Videoconferencing can be used in creative ways to expand access for patients and family caregivers to a range of palliative care services and enhance multi-professional team-working.

114 A SERVICE EVALUATION OF VIDEO CONSULTATIONS IN A UK HOSPICE DURING THE COVID-19 PANDEMIC: LEARNING FROM PATIENTS' AND CARERS' FEEDBACK

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Introduction During the Covid-19 pandemic, our hospice services had to rapidly move to consulting using video-conferencing technology. A service evaluation captured our patients' experiences of video consultations provided by a range of hospice professionals.

Methods An online or postal survey was sent to a convenience sample of patients, who had participated in video consultations between March and June 2020, focussing on their experience and overall satisfaction with the service.

Results We received 26 responses from patients (23) and family members/carers (3), 12 of whom were over the age of 70. Patients had consulted with our doctors (2), nurses (14), physiotherapists (5), occupational therapist (1), social worker (1), complementary therapist (4) and Well-being team (17). 25 respondents stated that they used the internet daily, 22 had access to a smartphone, and 23 used videoconferencing for reasons other than healthcare. However, 22 had never used this technology for healthcare prior to the pandemic. 32% included a family member in their consultation and this was viewed as beneficial. 88.4% experienced being able to talk in the same way as if they were face-to-face. All respondents reported overall satisfaction with consulting via video, although 41.7% still stated a preference for face-to-face consultations where possible. 91.7% said they would be happy to use video to consult with hospice professionals in the future, and 87.5% stated that they would recommend this service video to others.

Conclusions Patients and carers reported video consultations to be an acceptable way to receive support from a range of hospice professionals. The majority had access to, and familiarity with their own technology. Video consultations should be offered as an alternative to face-to-face consultations with the potential to improve access for more patients and carers to a range of hospice services in the future.

115 TIME FOR A CHANGE? TRANSFORMING THE INVESTIGATION AND MANAGEMENT OF ANAEMIA IN THE PALLIATIVE CARE POPULATION

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Background Severe anaemia is common in the hospice setting. Causes include anaemia of chronic disease (ACD) and associated functional iron deficiency (FID), with or without absolute iron deficiency anaemia (IDA). National guidance advises anaemia is investigated and treated to reduce need for blood transfusion.¹ However, this is infrequently done.² Blood transfusion is used to treat symptomatic anaemia but there is limited evidence on effectiveness and duration of response.^{3,4} Harm of transfusion is well documented; even a single unit risks transfusion associated circulatory overload (TACO).⁵ Consequently, guidelines were introduced to an inpatient palliative care unit to ensure anaemia was investigated, IV iron prescribed appropriately, and a restrictive transfusion strategy based on weight adopted.

Method Retrospective data collection from patients admitted for blood transfusion over one year: investigations (iron studies, haematinics, CRP); IV iron prescriptions. Risk factors for TACO were collated.

Results 37 units were administered to 15 patients. 58% had one unit; the remaining had two. Mean pre-transfusion haemoglobin 67g/L (44g/L–84g/L). Mean post-transfusion haemoglobin 78g/L (43g/L–125g/L); checked in 54% patients. 50% patients had <5g/L improvement in haemoglobin. Iron studies and haematinics were requested in 73% patients; at least one requested in 92%. IDA was identified in one patient, FID identified in four, and a combination IDA/FID in two. Five had no deficiency. Of the seven with IDA or FID, five received blood and iron infusions. 100% patients had one risk factor for TACO; 47% had two and 27% had three. 50% had a weight recorded within 2 months of transfusion.

Conclusion Guideline introduction increased investigation into causes of anaemia. Identification of FID/IDA enabled treatment with IV iron and blood transfusion. Prior to guideline introduction, IV iron had not been prescribed. High risk of TACO mandates a cautious approach to blood transfusion and supports a restrictive transfusion strategy.

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116 PALLIATIVE CARE PROVISION ON THE INTENSIVE CARE UNIT: A SERVICE EVALUATION OF IDENTIFICATION OF NEED, METHOD OF DELIVERY, AND QUALITY OF CARE

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