Abstracts

Methods Retrospective case note review of all patients who died at a university teaching hospital and local hospice in April 2018.

Results 26/34(76%) hospice patients died on an infusion in comparison to 34/86(40%) hospital patients.

Select drug dose ranges were:

Abstract 18 Table 1

	Hospice (median) mg		Hospital (median) mg	
	Start of CSCI	At Death	Start of CSCI	At Death
Morphine	5–80 (20)	10–100 (22.5)	5–30 (10)	5–30 (10)
Oxycodone	5–80 (15)	10–200 (25)	5–20 (5)	5–50 (5)
Midazolam	5–20 (10)	5–60 (20)	2.5–20 (5)	2.5–20 (7.5)
Levomepromazine	6.25–50 (12.5)	12.5–300 (50)	6.25–12.5 (6.25)	6.25–15 (6.25)
Haloperidol	1–3 (1.5)	1.5–5 (3)	1.5–3 (3)	1.5–3 (2.25)

21/26(81%) had been on a regular opioid prior to starting an infusion in hospice, in comparison to 6/30(20%) in hospital.

Median survival after starting a CSCI: 3 days in hospice, 2 days in hospital.

Although recognition and discussion of dying was often recorded, documentation around starting a CSCI was poor in hospital. In the hospice, all patients had a documented indication and 24/26(92%) had a documented rationale for starting doses. While documentation of discussion with patients, family and between doctors was good, discussion with nursing staff was poorly documented in both settings.

Conclusions Higher drug doses used in the hospice setting could be attributed to more complex symptom control needs and interestingly did not seem to have a negative effect on survival. This comparative review highlights areas for improvement: documentation of discussion with family about starting a CSCI, indication and rationale for starting doses in hospital and documentation of discussion with the wider team in both settings. These are likely to apply to other hospices and hospitals.

Poster presentations

Poster 1 | caregivers and the family

1 WHAT IS THE EXPERIENCE OF CAREGIVERS IN RELATION TO ANTICIPATORY MEDICATIONS?

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10.1136/spcare-2021-PCC.19

Background More than half of patients with a terminal diagnosis want to die at home.

NICE recommend provision of injectable anticipatory medications as a way of managing symptoms and facilitating this. However, there is little published evidence regarding the experience of caregivers in relation to anticipatory medications. The primary objective of this study was to explore these experiences and secondly ways to improve practice.

Methods We developed a questionnaire with public involvement and sent it to 100 consecutive caregivers, 3 to 9 months post bereavement. Carers were identified from hospice notes as having been issued anticipatory medicines to have in the home. Data was analysed using descriptive statistics and thematic analysis of free text comments.

Results The response rate to the survey was 38%. The majority were spouses of the deceased (61%). Most patients died at home (63%) and 82% had cancer.

87% of carers said there were benefits of having anticipatory medications available. The majority were reassured that medicine would be readily available when needed to provide symptom relief. However, some people found medicines distressing as they highlighted that death was imminent. Some expressed concern about storage of medication and potential for waste.

Several people commented that they were unable retain all the verbal information given but there were mixed views on potential usefulness of having written information.

Just over half reported that the medication was used; usually for pain or agitation with good effect.

Of those patients that did require the medications the most common problems carers experienced were: delay in a health care professional attending to administer medication (29%); knowledge of the person attending (24%) and deciding when to call for help (21%).

Conclusion Most caregivers find having these medicines is a generally positive experience but some experience challenges and there are areas for practice development.

Posters 2 – 32 | Covid-19

2 NEW COVID INITIATIVE – INTRODUCTION OF THE JUST IN TIME EMERGENCY MEDICINE PACK (JEMP)

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10.1136/spcare-2021-PCC.20

Background During the coronavirus pandemic, it was essential to ensure access to End of life (EoL) medications while protecting the medications supply chain. Traditional Just in Case prescribing could have exhausted the national supply. Consequently, a new NHS Wales Interim End of Life COVID-19 Medicines Service was implemented to provide access to a medication box a Just-In-Time Emergency Medication Pack (JEMP).

Methods The JEMP scheme ensured that end of life medications could be delivered directly to the patient within 2 hours, 24 hours a day 7 days a week, across the whole of Wales. The JEMP contained an agreed list of medications. The Health Courier Service Wales managed a Single Point of Contact, and directed the JEMP request to the most appropriate EoL Pharmacy Hub situated at one of five strategic sites around Wales. To access the service, a healthcare professional would call a 24/7 phone line and send a digital image of the prescription for EoL medications via Hospify (like an NHS Whatsapp). The JEMP then would be delivered directly to the patient's house and the prescription would be collected.

Results 17 requests were activated. 1 call was stood down. 15 out of the 16 requests had a JEMP delivered within 2 hours. This ranged from 34 minutes to 111 minutes. The mean time was 72 minutes.

Conclusion This is a pioneering service that developed during the coronavirus pandemic, it went from concept to a national pilot in 6 days. The uptake of services was less than originally predicted. However, it has been successful in its primary aims to maintain the supply chain and deliver vital EoL medications directly to the patient anywhere in Wales (24 hours 7 days a week) within 2 hours from the initial request. Further work needs to be done on collecting feedback and assessing sustainability.

3 THE USE OF ONLINE VIDEOCONFERENCING FOR FOCUS GROUPS IN PALLIATIVE CARE RESEARCH

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10.1136/spcare-2021-PCC.21

Background Qualitative focus group research traditionally involves participants meeting face-to-face in small groups to allow for participant interaction. The Covid-19 pandemic has prevented such meetings. Consequently, research has moved to holding online meetings using videoconferencing software. We discuss the advantages and challenges of running such groups.

Method We ran two focus groups on early palliative care in haemato-oncology using the videoconferencing platform Zoom. Recruitment was conducted online using pre-existing mailing lists and in person within the hospital outpatient department. Potential participants were emailed information about the focus of the discussion, before signing a consent form returned by post or email. Groups were audio recorded with the consent of participants and transcribed for analysis.

Results One person declined to participate due to the group's online setting. Four and eight participants respectively attended the groups, each led by a lead facilitator and two PPI co-facilitators. Participants conversed openly, using hand raising to indicate when they wanted to speak. Conversation did not appear hindered by the online setting. Participants commented that they felt able to interact easily on the virtual platform even when discussing highly emotive issues; in-depth discussion of the chosen topic was achieved. Participants thought that some participants may be deterred from participation in online videoconferencing; one person declined to participate due to the group's online setting. The virtual platform enabled participants from a wide age range and geographical location to participate. There were no significant technical challenges. One person declined to participate due to the group's online setting.

Conclusion Online videoconferencing is increasingly common in professional and social settings due to the Covid-19 pandemic. It can be used effectively in qualitative research. Choice of platform, recruitment methods, obtaining valid consent, and recording the meeting need to be carefully considered. Researchers and participants should be supported to engage with technology to support robust research but consideration must be given to several factors to ensure success.

4 RESTRICTED VISITING DURING COVID-19 PANDEMIC : AN UNCOMFORTABLE OXYMORON FOR HOSPICE STAFF

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10.1136/spcare-2021-PCC.22

Background Visiting in a hospice setting during COVID-19 has been incredibly emotive and challenging, not only for patients and relatives, but also for staff. Restricting visiting conflicts with holistic patient-centred care, and the complexity of discussions and decision-making cannot be underestimated, impacting on the emotional burden for staff morale and resilience.

Method A three-pronged approach was taken. 1. A hospice visiting task and finish group was set up. 2. A new role was developed, using government COVID-19 funding- a 'Visitor Co-ordinator' for an initial three-month period. This role supported decision making, communication with families and screening/practical support in the use of PPE as well as facilitating virtual visiting. 3. A 3-tiered Visitors Traffic Light Guideline (green, amber, red) providing some clarity for staff around 'essential visiting' and adapting to fluctuating local government restrictions was developed, and implemented. Feedback was collated for the visitor coordinator role, and a survey is underway to evaluate the Visitor Traffic light guideline.

Results Feedback from staff members following the introduction of the Visitor co-ordinator role was extremely positive and demonstrated an improvement in wellbeing at work. Staff reported the role of the co-ordinator relieved a 'huge burden and source of stress' and as a consequence allowed them to 'dedicate more time to patients'. The hospice visiting tiered guideline has aligned with the 'Visiting healthcare inpatient settings during the COVID-19 pandemic: principles' NHS guidelines however, some staff still report that the application of guidelines remains extremely challenging.

Conclusions A Visitor Co-ordinator role was extremely beneficial during the first weeks of the pandemic. Although helpful, a guideline alone does not alleviate all the challenges associated with restricted visiting; it remains an uncomfortable oxymoron for hospice staff and a flexible individualised risk approach is still needed to ensure compassionate visiting at the end of life.

5 RESTRICTED VISITING AND GENDER INFLUENCE PERCEPTIONS ABOUT END-OF-LIFE CARE SUPPORT: A NATIONAL UK SURVEY OF BEREAVED RELATIVES' VIEWS

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10.1136/spcare-2021-PCC.23

Background The COVID-19 pandemic significantly affected experiences of death and dying for patients and families. Our focus was on bereaved relatives' perceptions about experiences of care in the last days of life during the pandemic to help inform practice and policy.

Methods A national online survey, informed by patient and public involvement, was developed and disseminated via social media, public and professional networks between June and October 2020. Validated instruments (e.g. abbreviated 'Care