## P-64 MULTIDISCIPLINARY TEAM OPINION ON HOSPICE CARE DURING THE PANDEMIC

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**Background** Changes made by palliative care services in response to the pandemic have been reported by service leaders, describing organisation-level decisions and solutions (Bradshaw, Dunleavy, Walshe, et al., 2021; Dunleavy, Preston, Bajwah, et al., 2021; Oluyase, Hocaoglu, Cripps, et al., [preprint], 2020). The impact of the pandemic on direct care provision as experienced by multidisciplinary team members has not been explored.

**Aims** To understand hospice multidisciplinary staff's views on care provision during COVID-19 and the effect of providing care on staff wellbeing, burnout levels and spiritual health and the consequent influence on workforce sustainability.

**Methods** A survey of clinical staff in an independent hospice providing adult and paediatric inpatients and lymphoedema, bereavement and day services during the pandemic including validated wellbeing, burnout, and spirituality questions. Qualitative data from the survey was analysed using the Human Learning Systems Framework (Lowe & Plimmer, 2019).

**Results** 29% of staff completed the survey. Staff's responses demonstrated that the pandemic had a significant negative effect on their wellbeing with high levels of all domains of burnout whilst spiritual health was less affected. Qualitative analysis revealed human themes including the impact of isolation and visiting restrictions on patients and family whilst staff described their ability to maintain a sense of positivity and purpose despite anxiety and frustration. Learning themes focussed on adapting and learning through adversity. System themes described the barriers to providing holistic care and how these were overcome and the importance of accessible communication and ensuring appropriate assessment including the provision of remote, domiciliary, and ambulatory care.

**Conclusions** Hospice staff's psychological wellbeing and expertise in providing holistic care has been tested to the limit during the pandemic, however, they have responded with positivity, producing innovative solutions. Hospice staff's opinions and support for their wellbeing must be incorporated into current and new care models to ensure they can continue to be empathic carers, patient and family advocates and inspirational innovators (Marie Curie, 2021).

## P-65 CHALLENGES OF COVID-19 PANDEMIC IN KEEPING HOSPICE STAFF INFECTION CONTROL COMPLIANT

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**Background** Due to the COVID-19 pandemic Infection Control Link Nurses within the hospice environment became one of the most important factors in patient and staff safety. The Infection Control Link Nurses have a crucial role in providing training, information and instruction. In the fluctuating situation reaching everybody became a priority, and this is where the challenges began.

**Aims** Our aims were to educate and update all members of our organisation. We looked at different methods of providing bespoke training and updates - including the safe wearing of PPE and infection control precautions.

**Methods** We had to become innovative in how we approached training and delivery. Every member of the organisation has email access at work and home. Employees working remotely had electronic devices provided. This gave us the clue in how to reach out to everyone in a safe and timely manner. Our team of Link Nurses created their own videos on the safe application of donning and doffing of PPE, and the correct method of hand-washing. This was included into a PowerPoint presentation which was emailed out to all users and imported on to all hospice computer desk-tops. To ensure validity of the information we accessed government and national societies' websites.

**Results** The uptake on the on-line training was immediate and the team have received good feedback from the evaluation forms about the content and accessibility of the training package. Confirmation of completion of the training package is by emailing the certificate to the link nurses.

**Conclusions** Evaluations have proved that the training package has been successful with 98% compliance. Follow up audits have shown compliance with all Government guidance, even though social distancing is an alien concept for our hospice setting. It has proved fruitful and fulfilling for our team that relevant and essential quality training has been successfully provided.

## P-66 AN AUDIT OF DNACPR DECISIONS AND DISCUSSIONS DURING THE COVID-19 PANDEMIC

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**Background** Do not attempt cardiopulmonary resuscitation (DNACPR) discussions and decisions are an important part of person-centred care. Compassionate discussion with patients is a legal requirement when clinicians are introducing DNACPR forms. A recent Care Quality Commission report emphasised that all decisions should be individualised and part of broader advance care planning (Care Quality Commission, 2021).

**Aim** The aims of this audit were to evaluate the timing of DNACPR discussions, to explore whether conversations regarding DNACPR were documented and whether DNACPR discussions were part of wider advance care planning. The standards for the audit were based on national Resuscitation Council guidance (2021), 'Deciding Right' regional document (Northern Cancer Alliance, 2015) alongside the Trust policy on resuscitation.

**Methods** All patients with DNACPR forms initiated during an inpatient stay in November 2020 were identified from the Trust's database. A data collection tool was created to retrospectively collate information from the patient's electronic records.

**Results** We identified 62 patients who had a DNACPR initiated in November 2020. The results were overall very positive; a discussion with the patient, or where necessary with a relative, took place in all patients where electronic notes were accessible. Six (10%) DNACPR forms were initiated at the time of deterioration and 39 (63%) were as part of a conversation incorporating elements of advance care planning, with

more thorough advance care planning conversations occurring in six patients (10%). Almost 30% of patients audited were positive for COVID-19 infection. Where CPR was felt to be of no clinical benefit, COVID-19 infection was rarely (2% of patients) the named medical condition documented in the DNACPR.

**Conclusions** Documentation regarding the timing of DNACPR decisions and DNACPR discussions was of a high standard, despite increased pressures during the COVID-19 pandemic. Advance care planning discussions occurred, however, further analysis would be necessary to fully evaluate the quality of these discussions.

## P-67 COMMUNITY PALLIATIVE CARE RESPONSE TO SUPPORT CARE HOME RESIDENTS AND STAFF DURING THE COVID-19 PANDEMIC

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**Aim** To review our response to support residents and staff in Bromley Care Homes during the COVID-19 pandemic (April 2020–March 2021), reflect on our learning, joint working with colleagues and identify good practice to inform future models of care.

**Methods** We collated clinical activity data and key case reviews of care home patients referred to our service over the year. Contemporaneous notes from formal/informal reflections and debriefs (internal and joint with GPs/CCG/other professionals) were reviewed. Themes from feedback of care home staff and managers (ad hoc and formal focus groups) were included with personal reflections.

**Results** 345 patients were referred from 32 care homes. The majority (45%) in Quarter 1 (first wave), 14% in both Q2/Q3 and 27% in Q4 (second wave). Median age 89(53-110) with 69% >85 years; two-thirds female. 80% had a non-malignant primary diagnosis. Just over half died within the year; median time referral-to-death 17(0-229) days, 81(23%) remained on the caseload April 2021.

Key themes in Q1 included: limited effectiveness of virtual assessments, atypical patient presentations, significant impact of social isolation on mental health/function, with families unable to advocate and inconsistent messaging about visiting rights. Care home staff were distressed, burnt out, feeling unsupported. In Q2/Q3 regular GSF meetings with care home-GPs, virtual teaching (webinars/ECHO) and staff 'cascade project' study days helped consolidate learning. The second wave was heralded by an outbreak in extra-care housing; care home-GPs were self-isolating. We led urgent senior clinical review and response.

In Q4, daily COVID-19 monitoring meetings were key (representation from CCG, Public Health, Pharmacy, CH-GPs and St Christopher's). Over a month, successive outbreaks were identified and resources coordinated to ensure clear advance care plans, timely review, targeted multiprofessional support to care home staff. Learning from each setting informed changes to approach in the next, including: understanding culture, correcting/enhancing infection control procedures, improved shared decision making and addressing hydration.

**Conclusion** Senior clinical leadership, cross-boundary flexible working and willingness to learn together were vital.

## 68 INTRODUCING A CARE HOME PROJECT TO SUPPORT END-OF-LIFE CARE DURING A PANDEMIC

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Seventy per cent of care home residents die in a care home (Public Health England, 2017) therefore a large part of what care homes provide is end-of-life care (Social Care Institute for Excellence, 2017). Since April 2020 there were 173,974 deaths of care home residents which was an increase of 19.5%, meaning care homes were dealing with more resident deaths than ever before (Office for National Statistics, 2021). The care home project was introduced to sixteen care homes across a geographical area in April 2020 in response to the COVID-19 pandemic.

The aim of this project was to enable care homes to identify residents who were in the last year of life. This was achieved through weekly support either by phone or video conferencing platforms using an empowerment approach. Once residents were identified the facilitators prompted care home staff to consider the following; Do Not Attempt Cardiopulmonary Resuscitation orders, emergency care plans, anticipatory medications and any communications which may be needed with the GP, resident or resident's family.

To support learning, a root cause analysis was completed following a resident's admission to hospital to determine if the admission was avoidable or unavoidable. A reflective debrief was also conducted following each death. All of these were subjected to thematic analysis. The analysis identified several findings including having rescue packs of antibiotics and clear, concise completed ReSPECT forms could make hospital admissions avoidable. The care home staff were also able to clearly reflect on the impact of the COVID-19 pandemic on the end-of-life care residents received, with the visiting restrictions causing a great deal of distress to both loved ones and care home staff.

Overall, the care home project supported a number of care homes and their staff to provide good quality end-of-life care during unprecedented times using learning from across the project to inform all homes.

## P-69 CARE HOME DESIGNATED TO TAKE COVID-19 PATIENTS – PALLIATIVE CARE SUPPORT

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**Background** Three Acute NHS Trusts were reaching maximum bed capacity by January 2021 due to the COVID-19 Pandemic. A local recently refurbished care home was identified as a suitable COVID-19 discharge facility for COVID-19 positive and COVID-19 contact patients whose ceiling of care could be managed in this setting (including oxygen therapy) to help ease bed pressures.

**Aims**

- To support primary care and care home staff with symptom control and decision making for those patients who were end-of-life.
- To help avoid readmission back into the Acute NHS Trusts who were already at capacity.
- To support the relatives of these patients.