

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.