P-22 TREATMENT ESCALATION PLANS AND DNACPR DECISIONS WITHIN GENERAL SURGERY DURING COVID-19 PANDEMIC

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Background The COVID-19 pandemic has caused unprecedented pressures on hospital which has prompted early treatment escalation discussions. BMA guidance states that effective communication regarding DNACPRs should occur in a timely manner.[1] Consideration should also be given to patients' preferences and ample opportunity for discussions.[2] However, from anecdotal evidence in an acute hospital, these conversations have not happened within general surgery. Previously, the main barriers to these discussions were having unresolved feelings around death and inadequate training.[3] Many barriers to these discussions lie with doctors, we aimed to assess whether discussions were occurring, whether they were clear and accessible and to understand any barriers to discussions.
Methods Cross-sectional quantitative data collection of patients admitted to an acute general surgical ward was undertaken between Nov' 20 to March 21'. Treatment escalation and DNACPR decisions were identified from patient notes. This included time elapsed from admission, what was discussed, and by whom. A qualitative survey was sent to senior surgeons to explore ideas and any barriers to these discussions.
Results The study included 43 patients. 12/43 (28%) had treatment escalation discussions, with 8/12 (67%) being about DNACPR. Half of these decisions were made by ITU Outreach 4/8 (50%), none by senior surgeons. The average time elapsed from admission to a decision was 18.9 days. 35 senior surgeons were surveyed with a response rate of 14%. 4/5 (80%) thought treatment escalation options should only be discussed in patients who might deteriorate, with time pressures and fear of frightening patients as the main barriers cited.
Conclusion Most patients did not have a treatment escalation plan. To address one of the main barriers identified, we have created a sticker with clear prompts for treatment escalation decisions to be placed in the clerking booklet. Further work is required to understand other barriers involved.

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P-23 A COMPARISON OF PATIENTS WHO DIED IN A DISTRICT GENERAL HOSPITAL BEFORE AND DURING THE FIRST-WAVE OF THE CORONAVIRUS-19 PANDEMIC

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Background The ongoing Coronavirus-19 (CV-19) pandemic has had worldwide impact with over 240 million cases globally[1] to date. As with most the UK, The Dudley Group NHS Foundation Trust (DGFT) has cared for patients with the virus since Spring 2020 and we reviewed if the types of patients who died (all causes) changed in the pandemic on a local level.
Method Retrospective review of adult inpatients who died at DGFT – looking at November 2019 (before CV-19) and April 2020 (early in first-wave). A list of adults who were coded as dying as an inpatient in these two periods was compiled by the Informatics Team and data collected from 45 notes for each month.
Results There were 148 adult inpatient deaths in November 2019, which increased 77% to 262 in April 2020. Median ages at death were similar (77 years) but fewer females (27%). 4% were known to Specialist Palliative Care before admission. Average lengths of stay were similar (5–6 days) and approaching end of life was recognised in the majority of cases. In April 2020, there was a decreased number of patients with recent hospital admissions (24%) and a three-fold increase in those with an unimpaired functional status (29%). Fewer were admitted from home but more from care homes (18%). 25% of those with CV-19 as cause of death had no documented comorbidities (all aged over 74).
Conclusions There appears an increase of inpatient deaths at the start of the Coronavirus-19 pandemic in three main groups: care home residents, those with comorbidities and older people with no comorbidities/unimpaired functioning. Promoting advance care planning with these groups as a priority may be beneficial for future waves – especially wishes for hospital admission and preferred place of care. (Assessment of impacts of the CV-19 vaccination programme on these patient groups could be considered).

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P-24 IMPROVING DISCUSSIONS ABOUT RESUSCITATION IN COVID-19

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Aims This research aims to understand relatives' and carers' experiences of discussions about resuscitation. Findings are needed to inform policy and practice about what works well and how discussions about resuscitation need to improve.
Background Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions have been especially challenging during the pandemic. Hospital visiting restrictions and untimely deaths due to COVID-19 have disrupted usual modes of communication between staff, patients and relatives. There have been reports of blanket DNACPR decisions being applied to older people and complaints about communication are common. This is distressing for patients and families and costly for the NHS.
Methods This qualitative research uses semi-structured interviews to explore the experiences of people who discussed resuscitation on behalf of a relative during the COVID-19 pandemic. An interview topic guide was developed in collaboration with patients and public involvement partners.

Interviews were transcribed verbatim, and analysed using framework analysis.
Results 18 semi-structured interviews have been undertaken to date. Analysis has identified the following themes:

The importance of communication. This includes the timing of communication about DNACPR and examples of good practice and the lack of information about DNACPR for patients and families.
The multiple dimensions of resuscitation and DNACPR, with misunderstanding about what resuscitation involves, how the decision about DNACPR is made, and by whom.
Wide-ranging impacts of the DNACPR decision, feeling overlooked and disregarded by the medical team, guilt at not contesting a DNACPR decision, and consequent mistrust of the healthcare system.

We aim to complete over 30 interviews by March 2022. Recruitment will continue until inductive thematic saturation.
Conclusion Urgent action is needed to improve communication and ensure appropriate DNACPR discussions. Current practice results in frequent misunderstandings and lasting negative effects which may have detrimental consequences for bereavement reactions and future relationships with healthcare professionals.

P-25 REMOTE DECISION-MAKING AND COMMUNICATION AROUND DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) ORDERS IN CARE HOMES DURING COVID-19

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Background DNACPR decisions must be discussed with patients and, where patients lack capacity to be involved in DNACPR decision-making, with a legal proxy or next of kin. COVID-19 posed several challenges to DNACPR decision-making and communication including rapid, untimely clinical deteriorations and the prohibition of visitation in care homes. Simultaneously, there were concerning reports of blanket DNACPR orders being placed on care home residents. The Department of Health and Social Care (DHSC) issued guidance during the pandemic around remote capacity assessments.
Aims This project reviewed practice around remote capacity assessments and communication around DNACPR decisions in care home residents in 2020.
Methods Secondary analysis of data from a trust-wide audit was performed. 30 DNACPR forms from 2020 were randomly selected from Salford Care Homes Medical Practice.
Results Capacity assessments were undertaken in line with DHSC guidance in all notes reviewed. Clinicians considered previous capacity assessments, remote assessments via iPad or telephone, and the views of care home staff, patients' relatives, legal proxy and IMCAs. 2 of 30 patients were deemed to have mental capacity. All DNACPR decisions were discussed with the patient, or where the patient lacked capacity, with the next of kin or legal proxy.
Conclusion We identified good uptake of DHSC guidance around remote capacity assessments during 2020, however since undertaking this analysis, the MCA guidelines have been revoked. There is now no guidance to support clinicians should capacity assessments need to be undertaken remotely. There is an urgent need for policy makers to address this, due to the possibility of further outbreaks and the clinically vulnerable nature of the care home population.

P-26 JUNIOR DOCTORS' EXPERIENCES OF RESPECT CONVERSATIONS DURING COVID-19: RESULTS OF A SERVICE EVALUATION PROJECT

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Background During the COVID-19 pandemic, with limited intensive care resources and an unprecedented number of acutely unwell patients in hospital, conversations about resuscitation and treatment escalation plans became more important than ever. Locally, these decisions are documented using a ReSPECT form. We aimed to explore junior doctors' experiences of having these conversations with patients and their relatives during the COVID-19 pandemic, in order to identify areas for further training.
Methods An anonymous mixed-methods questionnaire was distributed to junior doctors across a teaching hospital in the East Midlands. The free-text responses were manually coded and underwent thematic analysis. As this was an internally approved service evaluation project, no ethics committee approval was required.
Results 14 junior doctors' responses were included in the final analysis. 93% of respondents had discussed resuscitation or treatment escalation with a patient or relative during the COVID-19 pandemic. Compared to prior to the pandemic, 62% of these respondents felt more confident in their ability to discuss resuscitation, and 77% felt more able to identify a patient who should have a ReSPECT form in place. However, 62% would like more training on how to discuss resuscitation or treatment escalation, and only 52% felt adequately supervised when having these conversations. Thematic analysis revealed the following major themes: challenges of virtual conversations, emotional burden on junior doctors, and unmet training needs.
Conclusion The findings reveal that junior doctors' confidence in their own ability to have conversations about resuscitation and treatment escalation has improved since the start of the COVID-19 pandemic. However, there are still significant unmet training needs in this area. The results of this work are informing the development of local educational interventions to address these requirements.

P-27 THE IMPACT OF THE COVID-19 PANDEMIC ON BEREAVEMENT SUPPORT SERVICES IN THE UK: FINDINGS FROM A CROSS-SECTIONAL ONLINE SURVEY AND QUALITATIVE CASE STUDIES

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Background The Covid-19 pandemic has caused c.131,000 excess deaths in the UK to date. During the pandemic, voluntary and community sector (VCS) bereavement services have