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

Victoria Phelan, Louise Tomkow, Louise Butler. *Northern Care Alliance, University of Manchester, Northern Care Alliance*

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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

Lucy Bleazard, James Coxon. *University Hospitals of Leicester NHS Trust*

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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

Eileen Sutton, Renata Medeiros Mirra, Silvia Goss, Mirella Longo, Kathy Seddon, Alison Penny, Anne-Marie Nelson, Anthony Byrne, Emily Harrop, Lucy Selman. *University of Bristol, University of Cardiff*

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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

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played a central role in supporting the bereaved. We describe the impact on and response of these services to inform service development and policy.
Methods Mixed-methods explanatory sequential design in two phases: (1) Online survey (March-May 2021) of VCS bereavement services in the UK, disseminated via national organisations, networks and social media; (2) Qualitative semi-structured telephone interviews with staff/volunteers at case study VCS bereavement services (June-December 2021). Interviews explored challenges/innovation in bereavement support during the pandemic, with transcripts analysed using thematic analysis.
Results 147 organisations participated in the survey; 53% were regional, 16% UK-wide. 36% were hospice/palliative care services, 15% national bereavement charities/Non-Governmental Organisations; 12% local bereavement charities. During this period of the pandemic referrals increased for 46% of organisations and decreased for 35%. 78.2% changed services and 51.7% introduced new services (such as online/telephone support). 24 people across 14 organisations were interviewed. Challenges encountered included: rapidly setting up online/telephone provision and consequent changes to the therapeutic encounter; developing new policies/procedures; coping with fluctuating demand and clients' complex grief responses; supporting staff/volunteers working from home; and a loss of funding. Nevertheless, innovation and positive impacts were reported including: modernisation of services; expanding access for some groups (younger people, men, rural communities); increased cohesion amongst staff; and instigation of local collaborations.
Conclusions UK bereavement services rapidly transformed during the pandemic, despite significant challenges. Important lessons have been learned and providers generally advocate a blended approach for future provision of bereavement support. To ensure positive changes are retained, the experiences and acceptability of new/adapted services among clients and staff require further investigation, while services' ability to meet demand requires sustained or additional resources.

P-28 DID THE GOLD STANDARDS FRAMEWORK (GSF) SUPPORT NIV WITHDRAWAL DURING THE COVID-19 PANDEMIC?

Natasha Freeman, Joanne Bowen, Philip Brammer. *The Dudley Group Foundation Trust*

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Introduction Despite this year's challenges with Covid-19, the data collected by Dudley Group Foundation Team has offered assurance that GSF has continued to be embedded across the hospital with improved identification of patients in the last year of life, enabling an individual plan of care and continued use of data to drive improvements. There has been local variation with the level of Specialist Palliative Care (SPC) support for COVID-19 patients and withdrawal of NIV. Local guidelines vary and these can be compared with the Association for Palliative Medicine guidance developed. This review was carried out to look at practice in Dudley Group NHS Foundation Trust.
Method Retrospective review of 20 randomly selected COVID deaths whereby NIV had been used outside of the ITU setting between November 2020 and February 2021.
Results Over a third of patients were on NIV for 1 day only. A decision to withdraw NIV was made in 65% (13/20) of cases reviewed and the remaining 35% (7/20) died with NIV in place. Good discussions were documented around NIV withdrawal with the patients where they had capacity (7/13) and 100% with family. For those that died with NIV in place there were discussions with family regarding an individual plan of care.

Seventy five percent of cases reviewed had anticipatory medication prescribed, however, none required a syringe driver. None of the cases reviewed were referred to the specialist palliative care team and 100% had a DNACPR in place.
Conclusion The results illustrate that none of the cases resulted in referral to the SPC team, however, there was evidence of good discussions and provision of anticipatory medication via the sub-cutaneous route. This suggests that the GSF has supported the respiratory team in providing individualised, good end of life care without the need for Specialist Palliative care input for all cases of NIV withdrawal.

P-29 HAS A GLOBAL PANDEMIC HELPED DOCTORS TALK ABOUT CEILINGS OF CARE, AND CAN WE KEEP IT GOING? LOOKING AT MEDICAL ADMISSIONS IN A DISTRICT GENERAL HOSPITAL AS IT RECOVERED FROM THE FIRST WAVE

Nicola Williams. *Worcestershire Acute Hospitals Trust*

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Background Admission to hospital is associated with significant mortality.[1] Admission should prompt early consideration of ceilings of care (CoC) to ensure appropriate treatment provision. Delays in these decisions can lead to care mismatched with patient wishes, inappropriate escalation, delays in palliation, less time to come to terms with prognosis for patient and loved ones, as well as difficulties for staff out of hours. The post-take ward round (PTWR) often represents the most appropriate time to discuss CoC, as comprehensive patient information and consultant support are available. During the first wave of the Covid-19 pandemic, emphasis was put on early decision making and communication of CoC.[2]
Aim To ascertain if one month after first lockdown, as the hospital was recovering and normalising, whether early decision-making regarding ceilings of care continued.
Method PTWR proformas and Respect forms for 50 medical patients admitted to Alexandra Hospital Redditch during February 2020 were audited for CoC documentation. Due to the covid-19 pandemic, the UK went into lockdown from March to July 2020. Over one month later, in August 2020, a second audit of 50 patients was completed
Results From pre-covid to one month after lockdown was lifted, CoC documentation at PTWR increased from 4% to 18%. For patients aged over 70, documentation increased from 6% to 23%.
Discussion Results were likely heavily influenced by the unprecedented covid-19 pandemic. These results are likely due to more pro-active clinical decision making as a result of the acute crisis, awareness of bed pressures and a shift in perception of the importance of CoC. Potential alternative reasons include raised public awareness prompting patient-led

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