

P20 COVID SUPPORTED DISCHARGE: A LIVERPOOL EXPERIENCE

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Introduction The Liverpool Community Respiratory team (CRT) is a multi-professional team supporting patients with COPD exacerbations to reduce hospital admissions and length of stay. During the first wave of the Covid 19 pandemic, CRT piloted a service to support and monitor patients hospitalised with covid 19 pneumonia on discharge. Patients were provided with telehealth equipment for remote physiological monitoring, and were called daily by a member of the team.

Results 157 patients (87 male, mean age 59.7, range 21–88) were supported by the CRT covid discharge service between May 2020 and May 2021. 11 (7%) were readmitted, 4 withdrew and 1 died at home. 141 completed 10–14 days of support.

Mean hospital stay was 13.7 days (range 11–112). 8 were current smokers, 52 were ex smokers and 87 had never smoked. Mean BMI was 31.4 (range 18.5–54.5).

Chair based exercises were introduced early and 141 were offered pulmonary rehabilitation, of whom 135 (95.7%) agreed to a referral; only 6 declined.

Feedback from all patients supported by CRT was positive.

We noted that anxiety levels improved subjectively during the period of CRT support so introduced GAD7 to further assess this. Although 28 patients achieved the minimal clinically significant difference, this was not seen consistently across the group.

Conclusions Supported discharge after hospitalisation with covid pneumonia is safe and well-liked by patients. Readmissions were rare and pulmonary rehabilitation uptake was high. There may be some benefit in term of anxiety management, but numbers were too low for this to be proven.

P21 DEVELOPMENT OF A COVID-19 VIRTUAL WARD TO FACILITATE EARLY DISCHARGE FROM HOSPITAL FOR PATIENTS WITH AN ON-GOING OXYGEN REQUIREMENT

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Introduction and Objectives The COVID-19 pandemic required rapid service changes in order to meet the emerging needs of our patients and to reduce pressures on hospital beds. In March 2020 we established one of the first virtual wards with the aim of supporting patients with a continuing oxygen requirement safely at home during their COVID-19 illness.

Methods The virtual ward was delivered by the integrated care ImpACT+ service. This multi-disciplinary service comprises respiratory consultants, respiratory specialist nurses, physiotherapists, occupational therapists and fitness instructors. Our local criteria for on-boarding included: 10 days post onset of symptoms, oxygen requirement 4L or less and the ability to manage with home monitoring equipment. A mix of telephone and home contacts were offered and daily consultant MDTs undertaken. Therapy team members were up-skilled to support oxygen assessments and weaning regimes to maximise service capacity. A direct electronic referral icon was

created on the hospital whiteboard system accompanied by a nurse-led telephone referral service. The scheme was advertised through posters and in-reach work into COVID-19 areas.

Results 107 patients were managed on our virtual ward since March 2020. This included 99 COVID-19 patients and 8 with other acute respiratory exacerbations. The mean continuous oxygen prescription on discharge was 1.5 L (range 0.5–4L) and for ambulatory purposes 2.4L (1–6L). 55 patients with COVID-19 were discharged on anticoagulation, 33 on steroids and 21 on antibiotics. 8 30-day readmissions, 3 deaths (2 expected). The total number of bed days on the virtual ward was 2010 (mean 21 days) and in total the activity that service delivered included 904 telephone calls and 274 home visits. Service feedback demonstrated a high level of satisfaction with patients commenting that they valued being at home with support during their recovery.

Conclusions This service has shown a supported discharge Covid-19 oxygen weaning service is a valuable initiative to relieve pressures on the acute hospital service and provide high quality care to facilitate early discharge from hospital. This virtual ward highlighted the value of having an integrated respiratory team and extension of this model to other respiratory conditions should be possible with considered adaptations.

P22 EARLY SUPPORTED DISCHARGE WITH DOMICILIARY OXYGEN AND INTEGRATED RESPIRATORY TEAM (DO-IRT) CARE FOR HOSPITALISED SARS-COV2 PATIENTS

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Introduction The SARS-CoV2 pandemic has placed unprecedented pressures on inpatient capacity nationally. An early discharge pathway with domiciliary oxygen and integrated respiratory team support (DO-IRT) was implemented for patients admitted with SARS-CoV2 pneumonia at a large inner London teaching hospital. We report the outcomes and patients' experiences of the DO-IRT pathway.

Methods Inpatient referrals to the 7-day DO-IRT pathway were assessed for clinical suitability between 15-January and 13-April in 2021. Inclusion criteria were patients in South East London boroughs, non-pregnant, able to use pulse oximeter, have a phone, ongoing oxygen requirement ($\leq 2L/min$ or $\leq 24\%$ Venturi), $PaCO_2 \leq 6.5kPa$, bicarbonate $< 28mmol/L$, non-smoker, medically stable ≥ 48 hours with improving clinical trajectory (including $CRP < 50$), $NEWS \leq 4$, $> day 10$ from symptom onset, stable SARS-CoV2-related complications (including VTE), dexamethasone completed or weaning plan and blood glucose management plan in situ, and rehabilitation needs addressed. Patients were provided with an information leaflet, monitoring diary and pulse oximeter, and were categorised into supported oxygen weaning at home or a long-term home oxygen (LTOT) pathway. DO-IRT provided home visits on day 1 and day of discharge, with daily telephone review and multi-disciplinary team discussions. Patients reported their experience in a satisfaction survey.

Results 24(22%) of 109 referred inpatients were accepted onto DO-IRT; 22/24(92%) for oxygen weaning and 2/24(8%) for LTOT. Clinical characteristics are shown in table 1.