

engagement with stakeholders, including the CCG. The focus of improved patient experience, safety, and clinical effectiveness was maintained. The innovation allowed a greater focus on enabling patients' to maintain their independence in managing their medicines.

### P-129 THE ESSENCE OF TIME – CAN AUTOMATED DISPENSING RELEASE HOSPICE NURSING TIME FOR PATIENT CARE?

Tracy Livingstone, Nan Jones. *Nightingale House Hospice, Wrexham, UK*

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While there is research supporting the benefit of automated dispensing for the prevention of medication errors in emergency departments Fanning *et al.* (2015) this has not previously been looked at in a hospice setting neither has the impact of automated dispensing and top-up on releasing nurses time to spend with patients in this area.

With the likelihood of increasing demand for hospice services and increasing complexity of patient needs there is a drive to provide more care from the same or even less resource, technology ranging from telemedicine and remote monitoring to automated systems may provide an opportunity to increase our ability to meet these challenges and free up nurses to focus on the provision of patient contact and care that hospices are historically associated with.

This presentation follows the journey within a 12-bedded inpatient hospice of installation of automated dispensing medication system in a hospice in-patient unit, from the point of pre installation time and motion studies of medication dispensing through installation and beyond investigating the impact on:-

- System acceptability to staff
- Nurse time taken to dispense
- Nurse time taken to complete stock checks and weekly top-up
- Nurse satisfaction with system following installation
- pre and post installation medication error rates.

In addition the presentation reflects the benefit of considering change proactively rather than as a response to critical incidents with medication and the significant impact this can have on staff confidence and morale within a small team.

### P-130 "JUST IN CASE" BAGS – WHAT IS THE VALUE OF ANTICIPATORY PRESCRIBING ON DISCHARGE FROM AN ACUTE TRUST?

<sup>1,2</sup>Helen Lock, <sup>2</sup>Simon Haslam, <sup>2</sup>Alice King, <sup>2</sup>Caroline Pinckney, <sup>2</sup>Rameshwor Sunar, <sup>2</sup>Jennifer Barry, <sup>1,2</sup>Becky Baines. <sup>1</sup>Hospiscare, Exeter, UK; <sup>2</sup>Royal Devon and Exeter NHS Foundation Trust

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The concept of "Just in Case" bags to support anticipatory prescribing in end of life care is not new, but there is little research evidence to support their use – anecdote and small audit level evidence at best. The recent 2015 NICE guidance on care of the dying patient highlighted the lack of evidence and specifically suggested more research into this topic.

In our rural community (population 380,000), "Just in Case" bags have been used in practice for many years. Over the last two

years, it has been usual practice to dispense small supplies of "Just in Case" medication on discharge from our large, 75-bedded acute trust.

The usefulness of Just in Case bags is being reviewed in a number of ways:

1. Retrospective review of hospital and specialist palliative care records of a cohort of patients discharged over a six-month period with "Just in Case" medication
2. Attempts are being made to determine appropriateness, usage and effectiveness of symptom control
3. Estimation of costs
4. Preferred and actual place of death
5. Detailed review of patients prescribed "renal friendly" drugs - checking for appropriateness and effectiveness.

An analysis of problems associated with Just in Case bags will be undertaken and attempts to improve the process will be undertaken using quality improvement methodology.

The work is being developed by a team of junior doctors in the Trust, with the support of the specialist palliative care lead consultant and registrar. We also aim to show that by working closely with the lead prescribers of these medications (junior doctors) we can highlight the appropriate use and potential benefits of "Just in Case" bags in a more systematic way. At the same time we hope that this project will enhance more general awareness of end of life care beyond the acute hospital in this key group of staff.

### P-131 ENHANCING MEDICINES SAFETY – SMALL CHANGES LEAD TO BIG IMPROVEMENTS!

<sup>1</sup>Kate Marley, <sup>1</sup>Carole Slocombe, <sup>1</sup>Clare Doyle, <sup>2</sup>Graham Holland. <sup>1</sup>Woodlands Hospice, Liverpool, UK; <sup>2</sup>Liverpool Heart and Chest Hospital

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**Introduction** Woodlands Hospice has a transparent approach to incident reporting and staff are encouraged to report near misses. In 2014/15, 76 medicines administration errors were reported, many relating to incomplete documentation. 'Enhancing medicines safety and reducing documentation errors' was chosen as an organisational priority for 2015/16.

**Actions** Improvements were led by the hospice's Medicines Management Group. A revised medicines management policy was implemented and the annual medicines training programme revised.

Inpatient nurses were consulted for their ideas about improvements in medicines safety and 'fact-finding' visits were made to local hospices. All practical ideas were considered and the following were implemented:

- A 'Woody' sign (based on the hospice rabbit mascot) was designed as an aide-memoire to be placed on bedroom doors to indicate that a medicines-related action needs to be completed e.g. return to administer heparin
- An additional medicine trolley was purchased to reduce the number of patients on each medicine round
- A Controlled Drug checklist was devised to ensure daily completion of documentation.

**Results** Medicines administration incidents for the year 2015/16 reduced from 76 to 25.

Additional benefits included: