A patient questionnaire gained the opinions of 38 patients on being weighed and their understanding of the reason for being weighed.

Results 97% of patients did not find being weighed distressing. However, 51% of staff members were opposed to routine weighing.

13% of patients had a weight recorded. 13% were prescribed low molecular weight heparin, 80% of these patients were weighed and 60% were on the correct dose.

Implications Routine weighing has been introduced for all patients where appropriate. Clinical staff now receive training that demonstrates the inaccuracy of estimating body weight. An alert sticker is now attached to the medicine chart, for patients prescribed weight dependant medication and a prompt on the shelves where the medication is stored acts as a reminder to check body weight.

P-78 USE OF AUDIT IN MEDICINE MANAGEMENT AT ST ANN'S HOSPICE

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Background Medication errors can lead to patient harm including death. Prescribing error rates of 7% and administration errors of 8% are recognised. Effective systems and processes can minimise the risk of preventable medicine-related problems.

Methods A four monthly audit of prescribing standards contained in the hospice medicine policy was undertaken by the hospice pharmacists. Prescribers received feedback verbally and via posters.

An annual administration of medicines audit was conducted by the practice development nurses. Nurses received feedback and an action plan was agreed.

During the period April 2015 to June 2016, the hospice introduced the Medicine Safety Thermometer (MST) to assess recording of allergy status, pharmacy medicines reconciliation, omitted medicines and safety of high risk medicines.

Results Audit results are displayed in the clinical areas to highlight the current issues. Findings were also used to inform changes in the medicine chart.

An anonymous questionnaire to doctors showed the prescribing audit was felt to be a useful educational tool.

An action from the MST included the development of a variance recording form, integrated in the medicine chart. This records details why a medication was omitted rather than just using a variance code. For example a patient may decline a medicine because they don't like the taste. The extra detail should trigger an action to resolve the issue.

Implications Prescribing and administration audits and the MST were used in the in-patient hospice environment to identify medicine-related safety incidents. Subsequent learning contributed to the safer use of medicines.

P-79 DISTRESS VERSUS HARM; HAVE WE IMPLEMENTED CHANGES TO DNACPR DOCUMENTATION FOLLOWING THE TRACEY JUDGMENT?

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Background Following the Tracey judgment in 2014, DNACPR decisions *must* now be communicated to the patient or, when this is not possible, their relatives. The *only* exceptions are if the patient has expressed a clear wish not to be involved or there is significant risk of causing physical or psychological harm to the patient by communicating the information.

Currently there is no guidance on what constitutes 'physical or psychological harm', therefore it is subject to varying interpretation.

The aim of this pilot was to investigate the communication of DNACPR decisions following the Tracey case and the interpretation of 'physical or psychological harm' by healthcare professionals.

Methods A retrospective audit of clinical notes was performed. 30 notes were analysed from 2013 (before the Tracey ruling) to determine who DNACPR decisions were communicated to and, if this information was withheld, the reasons why. 30 patient notes from 2015 (following the Tracey ruling) were analysed to obtain the same information, then a comparison was made between both years.

Results 6/30 (20%) DNACPR decisions were discussed with patients in 2013 compared to 17/30 (57%) in 2015. 4/30 (13%) decisions were discussed with families in 2013 compared to 17/30 (57%) in 2015.

Reasons for not discussing DNACPR decisions in 2013: distress (79%); patient choice (13%); no reason documented (4%); anxiety (4%).

Reasons for not discussing DNACPR discussions in 2015: psychological harm (39%); no reason documented (23%); patient choice (15%); patient confused (15%) patient unable to communicate (8%)

Psychological harm in 2015 was described as 'extreme distress', 'anxiety', 'distress', 'extreme distress' and 'upset'.

Conclusions Communication of DNACPR decisions increased following the Tracey judgment.

There was no clear consensus on what constitutes 'harm' although the term 'distress' was most commonly included in its explanation. This indicates the need for further research and guidance in this area.

P-80 PATIENTS WITH METASTATIC CANCER: HOSPICE PATIENTS DIE; HOSPITAL PATIENTS SURVIVE – TRUE OR FALSE?

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Background No evidence could be found to support the general perception that hospice patients die whereas hospital palliative care patients survive. Such a perception could make patients reluctant to accept hospice support; and lead clinicians to over treat hospital patients and deny beneficial interventions to hospice patients.