

opportunities for using emerging technologies in interventions and training. Our next project is a VR tour of our inpatient unit and grounds filmed using a 360 degree camera for patients to watch at home to try and alleviate some of the worries and anxieties they may have about staying with us or accessing our services.

**Conclusion** The use of VR in healthcare has endless possibilities. Working with our local education partners is an opportunity to explore this for our patients. Positive outcomes have provided the impetus to try new approaches that will have real impact on patient wellbeing and symptom management.

**P-138 EXPANDING THE REACH OF VIRTUAL REALITY FOR PALLIATIVE PATIENTS**

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10.1136/spcare-2021-Hospice.155

**Background** The use of virtual reality (VR) for symptom management in palliative care has grown over the last five years; most of the studies have been of its use in hospice (Popert & Riat, 2017) and hospital inpatient (Nwosu, Mills, Roughneen, 2021; Niki, Okamoto, Maeda, et al., 2019) and day therapy units (DTU). The advent of the COVID-19 pandemic resulted in the temporary closure of our DTU, so we therefore also offered patients the opportunity to use the headsets in their own homes.

**Aim** This study explores the impact of using VR on reported pain, anxiety and mood in palliative patients and the feasibility of using it in the home.

**Method** Patients are instructed how to use VR headsets on the inpatient unit or in their own home. Participants complete questionnaires on its influence on pain and anxiety scores and their experience of use. Volunteers were trained to teach patients how to use the headsets.

**Results** 30 sets of data have been collected from the inpatient unit and 10 from patients' homes, results for both groups are similar. All patients reported ease of use, a positive experience, and no adverse effects. 98% of those who reported pain before using VR reported a reduction and 93% of those who reported anxiety before using VR reported a reduction. For the majority of participants in this study using VR induced emotion with positive valence – happiness, excitement. The ability of VR to induce emotions with positive valence is deemed to influence its analgesic effect (Triberti, Repetto, Riva, 2014).

**Conclusion** The majority of palliative patients are managed in the community setting, and enabling the use of VR in their own homes means more patients can experience the benefits. There are multiple small studies on the impact of VR on symptoms in palliative patients but randomised controlled trials are needed (Austin, Lovell, Siddall, 2019). It is an intervention that puts a smile on patients' faces.

**P-139 EMERGENCY SYMPTOM CONTROL NEAR THE END-OF-LIFE: A CLINICAL AUDIT EXAMINING AMBULANCE CLINICIAN CARE**

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10.1136/spcare-2021-Hospice.156

**Background** The London Ambulance Service NHS Trust (LAS) performs a vital role in the assessment and management of symptoms in end-of-life care (EoLC) patients during times of crisis. A previous clinical audit identified symptom control as an area requiring improvement. Following funding of a Macmillan EoLC team and release of national guidance, a re-audit was conducted to assess symptom control by ambulance clinicians.

**Aim** Review ambulance clinicians' assessment and management of symptoms for patients nearing their end-of-life.

**Method** A retrospective clinical audit was conducted using data from 01/11/2019- 30/11/2019. From a total of 363 cases, 58 were excluded due to the patient having no identified EoLC needs. A resulting sample of 305 patient report forms were clinically reviewed.

**Results** Several elements of practice were encouraging but results highlighted a number of areas for improvement:

- Pain assessment: 84% of patients had an appropriate pain assessment documented.
- Pain management: 65% of patients presenting with pain/discomfort had analgesia administered by the attending ambulance clinicians.
- Pharmacological symptom control: 61% of patients received an appropriate pharmacological intervention when necessary. This included providing LAS issued medication for nausea/vomiting or anticipatory medications.
- Non-pharmacological symptom control: non-pharmacological interventions (e.g. re-positioning for breathlessness) were documented for 18% of eligible patients.

**Conclusion** End-of-life care is a novel area of pre-hospital care and whilst service improvement progresses (Murphy-Jones, Laverty, Stonehouse, 2021) it will take time to embed guidance and education into practice. Inherent actions in pre-hospital practice, such as non-pharmacological interventions may be undertaken but not documented and thus not captured by the audit process. It is clear however that EoLC symptom control requires improvement. The Macmillan EoLC team have shared findings with staff to highlight areas for improvement, created new guidance and enhanced education, covering both pharmacological and non-pharmacological symptom control. A continuous EoLC clinical audit within the Trust has been introduced to monitor and improve compliance.

**P-140 SINGLE NURSE ADMINISTRATION OF DRUGS IN A HOSPICE IPU**

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10.1136/spcare-2021-Hospice.157

**Background** St Gemma's Hospice recognises the national shortage of registered nurse (RN) recruitment with increasing dependency of patients (The Kings Fund. The NHS workforce: our position, 2021). As part of our ongoing development and cost effective use of resources, the nursing team are keen to use the existing RN resource as efficiently as possible. By moving to a workplace where it is usual practice for a single nurse to check and administer drugs (SNAD) would enable greater safety, more timely symptom management and more effective use of the workforce (Cross, Bennett, Ockerby C, 2017; Armitage, 2008).

**Aim** Inpatient unit (IPU) moves to single nurse administration of most drugs by June 2021.

1. Improve symptom management.
2. Reduce medicine administration errors.
3. Release RN time to care.

#### Method

- Literature review and pre- training questionnaire.
- SNAD group formed.
- Networking with other hospices.
- Create teaching package, provide study day including competency assessment.
- Devised competency tool and Standard Operating Procedure (SOP).

**Results** Pre-SNAD training timings were recorded with an average administration of medicine taking 15 minutes. The study day was evaluated well with RNs feeling empowered and confident. Evaluation of the project hasn't taken place yet, as competency is ongoing, however, preliminary findings show more efficient symptom management, less interruptions and increased autonomy. We are hopeful that we will see a reduction in medication errors because of this. We have trained 75% of the RNs, those not trained do not meet the inclusion criteria but will be trained later in the year.

**Conclusion** Already we are finding that RN work has been interrupted less during the SNAD process. Medications have been administered more promptly therefore patients' symptoms managed more efficiently. By utilising SNAD, time is used more efficiently in an environment that has a small number of staff and so limited workforce resilience.

#### P-141 ANTICIPATORY PRESCRIBING AT END-OF-LIFE: DO WE NEED TO CHANGE PRACTICE?

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10.1136/spcare-2021-Hospice.158

**Background/Aims** Anticipatory prescribing (AP) of injectable medications at the end-of-life for community patients is good practice to achieve timely symptom control (National Institute for Health and Care Excellence. Care of dying adults in the last days of life, 2015). However robust evidence to support current practice is lacking. We evaluated baseline AP practices at a South London hospice against current local guidelines.

**Methods** This retrospective audit looked at patient case notes and anticipatory charts (June-August 2020) using a standardised proforma including: drug choice, dose, indication and subsequent patient clinical trajectory. Anticipatory drug use, drug wastage and themes from case vignettes are presented.

**Results** 76 patients were reviewed, median age 80 (41-107), 66% male. 52% had a cancer diagnosis. All patients were prescribed and dispensed four medications for: pain, agitation, secretions and nausea/vomiting. There was close adherence to local guidelines (choice of drug, dose). Most commonly used drugs were: morphine 61%, midazolam 99%, glycopyrronium 97% and haloperidol 88%. 94% of patients died within three months (median 9 days). Eleven patients required admission to hospital or hospice.

64% had stats given at end-of-life, 53% for pain, 41% for agitation, 24% for secretions; only 16% needed an anti-emetic. We saw wide variation in prescribing practices for seizures at end-of-life (11 patients). Multiple health care professionals (Clinical Nurse Specialists, District Nurses and the

London Ambulance Service) administered stats in and out of hours. Further training is required to ensure appropriate dose escalation and titration. Dispensing all four medications costs approximately £50 per patient; haloperidol alone accounts for 3/5ths of that cost and is not often used.

**Conclusions** Few patients required all four medications, where anti-emetics are needed the choice of drug warrants further review with likely cost savings. At least 50% of our medications could be dispensed by GPs rather than hospice pharmacy. Further education/training will improve individualised AP and tailored administration of medications at end-of-life, including improved confidence around seizure management. We are currently updating our guidelines to reflect this.

#### 142 DRUG INSTRUCTION CHART COMPLETION – IMPROVING OUR SERVICE DURING COVID-19

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10.1136/spcare-2021-Hospice.159

**Introduction** As part of discussions at the Nurse Independent Prescriber Group, we agreed to focus on the team's use of Drug Instruction Charts because:

- They are widely used for end of life care prescribing.
- They are used in an anticipatory way.
- They are used by staff outside of our service to initiate treatment.
- There were particular challenges during COVID-19 due to some prescribers working remotely; historically, our charts have been completed by hand.

**Method** We developed an audit tool with two parts:

Part 1 – Completion of form – all patient details complete; legibility; additional information documented (e.g. estimated glomerular filtration rate [eGFR], transdermal medication also in use).

Part 2 – Appropriateness of prescribing – drugs prescribed were appropriate in line with diagnosis, prognosis, risk, renal function.

The audit was carried out by the head of community services and an associate specialist/consultant in palliative medicine.

We also created a process to enable remote completion of the Drug Instruction Charts. This was far from simple, involving many staff with IT skills and access to additional software (and a determined Medical Director!). A Standard Operating Procedure for electronic completion of Drug Instruction Charts was developed to ensure robust governance.

**Results** Results were input into a spreadsheet developed by the hospice data analyst. Each prescriber submitted Drug Instruction Charts they had completed. Results were shared with each individual prescriber for their learning. Overall results were shared with all prescribers.

**Conclusions** Compliance with the form and appropriateness of prescribing were overwhelmingly positive but there are improvements that can be made to practice. The process of developing the electronic chart was in itself helpful as it opened up discussions about electronic completion of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form, as well as governance. The implementation of electronic completion of the charts means that