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 antiemetic. 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

prescribers working remotely or on call can now complete Drug Instruction Charts in a timely way, improving experience for patients, families and staff.

P-143 DEVELOPMENT OF PALLIATIVE CARE SAFE PRESCRIBING RESOURCES FOR PRIMARY CARE

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10.1136/spcare-2021-Hospice.160

Background Anecdotal evidence from community pharmacies (CPs) and care homes indicate palliative care medicines are often incorrectly prescribed due to lack of knowledge of CD (controlled drugs) regulations and of doses/formulations used. These incidents did not lead to patient harm but changes to prescriptions cause unnecessary delays to symptom management for patients and additional stress for carers collecting medicines.

Aims The aims of the project were to produce resources for primary care teams to help support safe prescribing and supply of these medicines and to raise awareness of the Community Pharmacy Palliative Care Network. The network pharmacies keep an agreed stock list of palliative medicines and receive annual generalist palliative care training. We also wanted to challenge CPs' awareness of the issues families face when trying to access palliative medicines and support them to improve their service.

Methods

- Baseline surveys to gain feedback from community pharmacy staff, GP practice staff and district nurses (DN) on issues with prescribing and supply of palliative care medicines.
- Developed resources with key safe prescribing messages and distributed to all CPs and GP clinical pharmacists, GP practices, district nurses and care homes, with copies of the Scottish Palliative Care Guideline handbooks and Palliative Care Network leaflet.
- Presented to local conferences and team meetings about project and distributed resources.
- Improve awareness of 40 Palliative Care Network Pharmacies and how they can help support palliative patients.

Outcomes

- The baseline survey showed 78% of survey respondents were aware of the Palliative Care Network Pharmacies, repeated survey showed this had increased to 92%.
- 'What influences your choice of community pharmacy?'- the response, '*Good relationship with community pharmacy*' increased from 18% to 52%.
- Repeated requests for more resources.

P-144 THE ROLE OF NON-MEDICAL PRESCRIBERS

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10.1136/spcare-2021-Hospice.161

Within our hospice we have a team of four senior nurses working as Non-Medical Prescribers (NMP). The role was being developed prior to the pandemic, however, was initiated during lockdown when some of the medical team were shielding. With the doctors now fully available the aim is still to bridge the gaps in medical cover such as extended hours over the weekends and to facilitate annual leave/training or cover sickness.

We also work to support the nursing team for training, medication queries and as a mediator for discussions with the medical team, where needed. We work to assist with discharge planning, external referrals, gathering information and equipment loans. We work to support all areas of the hospice as part of the multi-disciplinary team including adult inpatient unit, wellbeing centre, out-of-hours advice line, accepting referrals at weekends and palliative care support workers.

Moving forward the hope is to expand the nurse-led clinics that are supported by the NMP role. We currently run a 'Looking forward' clinic for patients with liver disease and plan to offer similar clinics for cardiac and respiratory diseases. As we are able to open up our services further we plan to reinstate access to the Wellbeing Centre for patient assessments such as complex symptom management and discharge follow ups.

As advanced practitioners we have an awareness of our own limitations, and each of us has our own experience and expertise from previous roles, which brings value to the team as a whole. It is still a developing role and we are one of the few hospices to have a NMP team in post. With good communication, a broad skill mix, regular sharing of opinions and ongoing education this helps us to be an effective service for supporting all areas of the hospice.

P-145 POST FALLS MANAGEMENT

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10.1136/spcare-2021-Hospice.162

Background We became aware, following an audit, that there were a number of patient falls in which the post falls assessment would have benefited from being more comprehensive. There is a risk that if someone is moved without being fully assessed for potential fractures or neurological damage, they may sustain further injury. Therefore, we embarked on a quality improvement project, with the aim of improving our post falls assessment.

Aim(s)

- For all staff to be aware of the correct procedure to follow after a patient falls.
- To increase staff knowledge around their role in post fall management.
- Reduce the risk of any harm.

Methods

- The post falls assessment process was laid out using NICE guidelines.
- Baseline measures were taken:
  - Doctors and nurses were given three scenarios and asked a set of questions
  - Documentation of previous falls was audited.
- Post Falls Pathway was developed, introduced and placed in each room.
- Bite size education was delivered.
- Baseline measure was repeated, with the documentation of falls following the introduction of the pathway being audited.