was used more at Hospice 2. None of the patients received Phenobarbitone. Compliance with the audit standards was 65%–75%.

Conclusions Anxiolytic and antipsychotic medications were widely used in the last week of life, with variations in practice in terms of the drugs and doses used. Classification of the indication for use was inconsistent. Following the audit we developed a framework for use of these drugs at the end of life.

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P-13 USE OF BONE PROTECTION IN PATIENTS WITH PRIMARY INTRACRANIAL TUMOURS ON LONG TERM CORTICOSTEROIDS

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Background Long term use of corticosteroids can be associated with significant morbidity, including development of glucocorticoid-induced osteoporosis and resultant fractures, leading to increased pain and disability. There are currently no specific standards or guidelines pertaining to the use of bone protection in patients on long term corticosteroids in palliative care. However, given that a significant proportion of palliative care patients are on corticosteroids for prolonged periods, this is an area that should be explored further.

Aims

- To ascertain current use of bone protection in a palliative cohort of patients with a diagnosis of primary intracranial tumour on long term corticosteroid treatment
- To identify patients in this cohort who would likely have benefited from receiving bone protection

Standards Standards used were the American College of Rheumatology 2010 Recommendations for the Prevention and Treatment of Glucocorticoid-Induced Osteoporosis. These guidelines recommended for this cohort that patients on long term glucocorticoid treatment (dose $\geq$7.5 mg prednisolone daily for $\geq$ three months) should be on bone protection therapy (bisphosphonate).

Methodology Retrospective audit using chart review of patients with primary intracranial tumours on initial referral to Palliative Care Team.

Results Initially 39 eligible patients identified. On manual review of these charts, 32 were eligible, n=32. 37.5% were on steroids on admission, and had been on steroids for > three months on initial assessment and had greater than three months to live. 12.5% had > six months to live and were on steroids on first assessment, and 6.25% had been on >3 month course of steroids.

Conclusions 62% patients who were initially assessed by palliative care team should have been considered for bone protection therapy prior to referral. 45% of patients were not suitable for consideration for bone protection treatment. This leaves 55% which could have potentially been considered for bone protection therapy by the palliative team following initial assessment.

P-14 A RETROSPECTIVE AUDIT OF THE PRESCRIPTION AND USE OF END OF LIFE ANTICIPATORY MEDICATIONS IN A COMMUNITY SETTING

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Aims To ensure that PRN injectable medications for end of life care are prescribed safely, in a timely and appropriate manner and that the drugs are received and given in the community as required. Our intention was to ensure patient comfort and safety at the end of life; whilst providing assessment and reassurance for community teams and GPs that end of life medications are being prescribed appropriately.

Methods A retrospective snapshot audit examining 37 community deaths known to St Raphael's Hospice, between December 2015 and January 2016. Notes were accessed, results collated and analysed from online records held within the hospice.

Results Out of the 37 deaths recorded, 33 had injectable PRN medications requested. 35% of patients received medications within 24 hours of the request and 88% received them in less than two weeks. 78% of patients died within a month of PRN medications being prescribed. All patients had the correct opioids prescribed, with 43% receiving alternatives due to poor renal function. Once prescribed and received, 71% of patients used their medications within 24 hours of receiving them.

Conclusions The audit identified that the majority of patients are having their anticipatory medication prescribed appropriately prior to their death and were receiving them in a timely manner (within two weeks). However: considering that in most cases, medications were used within 24 hours, there is potential room for improvement. The process by which patients receive their PRN medication requires further investigation to identify and overcome possible problems. The audit also highlighted a number of cases of incomplete or inconsistent record keeping. This emphasised the importance of clear documentation, especially in the community, where multiple teams are involved in patients' care.

P-15 AN AUDIT OF THE STANDARD OF COMPLETION OF THE ACHIEVING PRIORITIES OF CARE (APOC) PAPERWORK – PILOT AUDIT IN THE WESSEX REGIONAL RENAL DEPARTMENT, QUEEN ALEXANDRA HOSPITAL, PORTSMOUTH

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10.1136/bmjspcare-2017-00133.15

Background In 2014, The Leadership Alliance for the Care of Dying People developed the five priorities of care for people in the last hours or days of their life. To facilitate the implementation of these priorities in Queen Alexandra Hospital, Portsmouth, a regionally created document came into use in

2015; the achieving Priorities of Care (aPoC) document. This audit focused upon the standard of the completion of this document.

Methods Documentation was audited, to review standard of completion, for patients in whom the aPoC document was used between 1/7/15 and 30/9/15. During this time there were seven deaths where the aPoC document was used. Staff questionnaires regarding the priorities of care and the aPoC document were also carried out.

Results The desired standard of 100% completion was used. 43% of documents were signed by the Consultant deciding to use the aPoC with 29% of cases having clear documentation that aPoC was to be used in the medical notes. On average, the standard of completion of the front page was 60%, the recognition of dying section was 61%, previous wishes of the patient 49%, individualised care plan 86%, ongoing medical review 84% and psychological review 42%. Staff questionnaires showed that 40% of staff were not aware of the five priorities of care and 28% were not aware of the aPoC document.

Conclusions Overall, the standard of completion of the document was variable. Some sections were carried out well but others showed significant areas for improvement. Staff questionnaire data suggests that across different staff groups, there is limited knowledge and awareness of the priorities of care. Staff education will therefore be the main implementation strategy prior to a re-audit of the standard of completion of the apoc document.

P-16 AUDIT OF ADHERENCE TO PRESCRIBING STANDARDS AS A MEANS OF IMPROVING PRESCRIBING PRACTICE ON DRUG CHARTS IN A HOSPICE IN-PATIENT UNIT

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10.1136/bmjspcare-2017-00133.16

Background The safe and effective function of any in-patient unit depends on drug charts being clearly and correctly completed.

Aims To assess the adherence of the medical team to good prescribing practices regarding completion of drug charts. To explore whether audit of this area as part of the junior doctor induction programme provides a means to improve prescribing documentation habits.

Methods The audit tool analysed compliance with standards established by the Sue Ryder Management of Medicines Policy for Care Centres and Hospices (July 2014). Junior doctors analysed the notes and drug charts of 10 in-patients sampled at random. Performance of the entire medical team was audited at the beginning and end of 2 successive junior doctor placements.

Standards Audited fields were

- *Patient Identifiers*.
- *Chart completion*: eg, capitals; generic names.
- *Rewriting*
- *Technical information*: eg, correct use of units, decimals etc.
- *Prescriptions written correctly*: eg, signed, dated, PRN indications etc.

The standard set for all criteria was 100%.

Results Each audit fell significantly short of the desired standard of 100% in the 26 possible criteria. Both audit cycles demonstrated improvement in prescribing performance. Between December 2014 and February 2015, 100% concordance rose from 32% (8/25) to 50% (11/22) of assessed criteria, with betterment seen in another 73% (8/11). Comparison of April 2015 and July 2015 saw 100% concordance increase from 28% (5/23) to 69% (18/26) with progression in a further 40% (2/5) of criteria.

Discussion and conclusion Reflecting on the data, it was clear that those who had been auditors became better prescribers. Most of the remaining errors were made by consultants and registrars! This project suggests that involving junior doctors in prescribing audits is effective at educating them in good prescribing practice. Perhaps senior doctors would also benefit from engaging in such an exercise?

P-17 IMPROVING PSYCHOLOGICAL ASSESSMENT OF HOSPICE IN-PATIENTS USING OACC

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Background Anxiety and depression are under-diagnosed and under-treated in palliative care with prevalence thought to be 20%–49%. The Palliative Adult Network Guidelines state that psychological assessment is imperative to guide management. The Outcome Assessment and Complexity Collaborative (OACC) is seeking to implement outcome measures into routine palliative care that may improve practice.

Aim To review whether psychological symptoms including mood state and anxiety were being assessed and reviewed in patients admitted to St John's Hospice, Moggerhanger, UK.

Method Data were collected from 28 patients admitted to St John's Hospice during August 2015. Psychological assessment recorded in their medical notes were systematically reviewed using a checklist devised from OACC.

The medical clerking was then changed in line with OACC so the psychological assessment included two questions taken from Integrated Palliative care Outcome Scale:

- Over the past 3 days, have you been feeling anxious or worried about your illness or treatment?
- Have you been feeling depressed?

A separate assessment of Information and Insight was also introduced.

All case notes were re-audited in November 2015.

Results 80% of patients had a psychological assessment completed by a doctor but only 35% mentioned mood or anxiety. Most common non-mood or anxiety related comments related to physical symptoms, prognosis or insight.

At re-audit, 100% of patients had a medical psychological assessment and there was a significant decrease in recording of non-mood symptoms.

Conclusions Without clear prompts, doctors often made poor assessments focusing on non-mood symptoms like insight or prognosis. Implementing OACC caused significant improvements in psychological assessment of patients by doctors. The change required minimal training. OACC can be a powerful and measurable tool for improving patient assessment.