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 the 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

Annelise Matthews, Nick Green, Sunil Hathi, Hamna Jaffar, Arjun Kingdon, Sayyada Mawji.
Sue Ryder St John’s Hospice, Moggerhanger, UK

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**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?