

P-124 A REVIEW ON HOW PATIENTS MANAGE WITH THEIR MEDICATION POST DISCHARGE FROM SAINT FRANCIS HOSPICE

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Background Research suggests that approximately 5% of hospital admissions are medicines-related. There is an increased risk from errors or unintentional changes to a patient's medicines when their care is transferred. This includes when the patient is discharged from a hospice.

Aim(s) To identify whether patients are complying with their medicines and the types of medications related problems patients have post-discharge. To reconcile the medicines the patient is taking post-discharge against what had been prescribed on the inpatient unit.

Methods Patients deemed as medically fit by the medical team were approached by the hospice pharmacist and audit was explained to them. Those that wished to participate were contacted using their preferred method approximately two weeks post-discharge from the hospice. The data were collected using an adapted version of the medicines use review form used by community pharmacists.

Results

- A total of 20 patients were contacted
- 15% of patients had difficulties obtaining at least one of their prescribed medicines
- 5% of patients experienced at least one side effect from their medicines resulting in non-compliance
- 15% of patients chose to stop taking at least one of the prescribed medicine
- 10% of patients had medication changes made by the GP within two weeks post-discharge.

Conclusions This audit highlights some of the difficulties experienced by patients with their medication. Medicines prescribed by the team on the inpatient unit can often be quite specialised and not kept as stock in the community pharmacy causing patients to miss doses of critical medicines such as analgesics. Patients should receive counselling about their medicines before they are discharged to include information on who they should contact if they have problems with their medicines. A drug review post discharge from the hospice could also be beneficial,

P-125 AUDITING FOR SUCCESS – DRIVING FORWARD QUALITY – ACHIEVING COMPLIANCE

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Using Hospice UK's audit tools Thames Hospice have been supporting our evidence gathering for CQC.

General Medicines Audit

Aim To use the template audit tool to assess the hospice's procedures, purchasing, storage and destruction, prescribing, administration of medicines. At Thames Hospice good clinical audit looks at an aspect of care from the patients' point of view, involves the patient wherever possible, and is multi-disciplinary, looking across all relevant professions and organisations. We asked:

- What should we be doing?
 - Are we doing it?
 - If not, how can we improve?
- The Hospice UK audit tool helped us to think about our audit goals:
- Do we know and agree on what the best practice is?
 - Will we be able to make any changes, if we find we need to?
 - Will the changes make a difference to patients?
- Methods** Using the Hospice UK General Medicines Audit tool our small Audit team were easily able to review the hospice's procedures and practices regarding general medicines.

The audit:

- Looked at own practice
- Followed a systematic process
- Included standards to measure our practice against
- Involved everyone in the team and our patients
- Cross referenced standards against legislative and statutory requirements

Results The organisation completed a day-to-day general medicines audit on every patient across the medicines spectrum.

Conclusions Audit is an integral part of our hospice's ethos. Quality and assurance is intended, monitored and embraced throughout the organisation and supported us in improving training, practice and patient care.

P-126 INTRODUCTION OF ELECTRONIC PRESCRIBING IN AN INDEPENDENT HOSPICE

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Aims To introduce successfully electronic prescribing in a hospice.

Background The hospice previously used paper drug cards to prescribe and record administration of medication. Our drugs for inpatient administration and for discharge prescriptions were supplied by a hospital four miles away. We had weekly inpatient support from a pharmacist one session a week and a pharmacy technician to reconcile medication against the patients' previous GP prescription and to check there were no prescribing errors. All requests for drugs had to be faxed along with the prescription card.

Method In February 2016 we introduced electronic prescribing to increase patient safety, reduce administration errors, increase efficiency in obtaining discharge prescriptions and reduce the time spent by nursing staff in ordering drugs. The nursing and medical staff received e-learning in order to become familiar with the prescribing and administration of medications. Four electronic carts were purchased at a cost of £4000 each. The pharmacist supported the implementation of the system undertaking drug rounds with nursing staff for two weeks. Nursing and medical staff who had previously worked in the hospital were already familiar with its use. The system is networked to the hospital so has the additional benefit of all prescriptions being visibly accessible by the hospital pharmacists.

Some challenges have been encountered particularly with regards to internet connectivity and the recent cyber attack but the system is backed up daily and we can resort to paper printouts of the electronic prescription.