Programme implementation phases

- IPU managers undertook programme
- Self-selecting Band 5 RNs undertook programme
- Joint working with another local hospice which has offered a peer review and ensured sustainability of the education programme.

Evaluation phase

- Claims, concerns and issues (Guba & Lincoln, 1989) exercise around prescribed medication with all RNs.
- Patient and family experience with pain and symptom medication sought through direct engagement and review of general hospice feedback
- Focus groups with RNs
- Review of CD administrations procedure pre- and post-implementation
- Mapping against the Person-centred Practice Framework (McCance & McCormack, 2017).

Results RNs described moving through a period of anxiety to feeling overall confidence, autonomy, safety, trust and eventual sense of liberation and empowerment through the process. They reported reduced waiting and quicker response times for patients requiring controlled drugs since the commencement of the SNCDA programme. In a 24 hour period 14 hours of nursing time was released for other activities.

Conclusion SNCDA has a positive impact for patients and RNs in supporting pain and symptom management. A PD approach supported staff to embrace SNCDA and enhanced person-centred practice.

P-116 'AS REQUIRED' MEDICATION ADMINISTERED WITHIN THE HOSPICE IN-PATIENT UNIT

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Background The use of 'as required' (PRN) medication provides relief from symptoms and guides adjustment of regular medication. Previous studies have looked at PRN medication *prescribed* for hospice patients (Russell, Rowett & Currow, 2014; Sera, McPherson & Holmes, 2014) but not PRN medication *administered*. The time taken to administer PRN medication on an orthopaedic post-operative unit has been studied (Pizzi, Chelly & Marlin, 2014) but there is no data for a hospice setting.

Aim To establish how many and which PRN medications are administered in a hospice in-patient unit and identify factors correlating with the number of PRNs given. To look at the feasibility of measuring time taken to give PRNs in a hospice.

Method We collected prospective data from all the patients' prescription charts on the in-patient unit over a 28 day period (September 2017). We recorded:

- Patient demographic details
- The number and type of PRN medication administered, route of administration and time of day
- Length of time to administer PRN medication and suggestions from staff on improving the process.

We scrutinised staffing levels, number of admissions, discharges and deaths over this period.

Results

Abstract P-116 Table 1 'As required' Medication Administered within the Hospice In-patient unit

Average number of PRNs administered in 24 hours	2.85/patient
Most common PRN administered	Oral opiates
Average time taken to administer	8.6 min (up to 20 hours nursing time/day)
	4.7 min with designated key-holder
Correlating factors (only 1 identified)	Increase use of PRNs in last 2 days of life

Conclusions The number of PRNs given may reflect the complexity and variability of patient symptoms and their active management within the hospice. It may also highlight that the management of the background medications needs more proactively reviewing. The baseline data is allowing us to learn and look at approaches to improve patient symptom outcomes as well as maximising nursing and medical time. Further benchmarking data would be helpful.

P-117 INVESTIGATING THE PRESCRIBING PRACTICE OF A COMMUNITY SPECIALIST PALLIATIVE CARE NURSE

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Background Therapeutic interventions, including prescribing medication, was a nationally agreed element of the advanced role (Department of Health, 2010), a view supported by Help the Hospices (2013). Palliative care patients often present with multiple complex symptoms and the benefits of Nurse Independent Prescribers (NIP) include faster access to medicines and rapid symptom control (Quinn & Lawrie, 2010; Dawson, 2013). However, increasing demands on Community Palliative Care Teams providing timely access to medicines and embracing seven-day working, highlight a need to evaluate the role of the NIP within this service, to determine their benefits and enhance planning.

Aims This report's objective was to examine the prescribing practice of a NIP within the Community Specialist Palliative Care Team, examining the scope, appropriateness of prescribing and reviewing benefits to patients and carers.

Methods Quantitative data was collected for one year from one NIP, collated according to the drug monographs in Palliative Care Formulary 6 (Twycross, Wilcock & Howard, 2017) and evaluated according to the range of drugs and frequency of prescribing.

Patient and carers' experience of NIP was gathered qualitatively via semi-structured interviews and written feedback. Thematic analysis was undertaken on these accounts to identify findings.

Results Data analysis showed the range and frequency of prescribing were appropriate and within the NIP's scope of practice. Over one third of prescriptions involved analgesics. Patient and carer responses were overwhelmingly positive and related to the nurse/patient relationship and expertise in prescribing for complex symptoms.