

*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**

Alison Phippen, David Waterman, Jan Codling, Jessica Blandford. *St Ann's Hospice, Manchester, UK*

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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**

Helen Cooper. *Ashgate Hospicecare, Chesterfield, UK*

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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.

**Conclusions** The NIP demonstrated appropriate prescribing practice. Patients and carers reported receiving medications more promptly and having doses adjusted when Out of Hours services were reluctant to do so. This provides evidence of the value of NIP training within the team.

**P-118 THE IMPACT AND DEVELOPMENT NEEDS OF INDEPENDENT NON-MEDICAL PRESCRIBERS IN CHILDREN'S HOSPICES**

Michael J Tatterton. *Martin House Children's Hospice, Wetherby, UK*

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**Background** Non-medical prescribing (NMP) is well established within the British health service (Smith, Latter & Blenkinsopp, 2014); NMPs in the UK have the most extensive prescribing rights of non-medical prescribers worldwide (Paterson, Redman, Unwin *et al.*, 2016). Increasing numbers of NMPs are practicing within children's hospices (Tatterton, 2017) particularly in the community setting (Tatterton, 2018). Whilst writing the medicines management toolkit (Armitage, 2014), interest in prescribing from clinical and managerial perspectives increased.

**Aim** To explore the current context of non-medical prescribing in children's hospices in the UK, from the perspectives of prescribers and those who manage them; focusing on the challenges and benefits to children and families, practitioners themselves, their colleagues, and the employing organisation.

**Method** Internet-based questionnaires were sent to all 55 UK children's hospices, exploring the practice and context of prescribing of qualified and trainee prescribers, and service managers.

**Results** 20 children's hospices responded. Fourteen hospices employed a total of 39 NMPs. 50% of NMPs prescribed to enable the continuation of existing medicines, 37.5% prescribed independently surrounding symptom management and control and 31.3% in end of life care. Perceived benefits of prescribing included timely access to medicines, increased efficiency and accuracy in the admissions process and medicines reconciliation and the increased ability to offer choice in the place of palliative and hospice care. Perceived barriers to prescribing surrounded opportunities to develop confidence, defining the scope of practice and the time required to assess, diagnose and treat.

**Conclusion** NMPs make a significant contribution to the prescribing workforce within children's hospices. The benefits of NMP are wide ranging, enhancing the experience of children, young people and their families, organisations and practitioners. To realise the benefits, the structures and processes that underpin prescribing need to be developed in order for practitioners to feel fully supported. This includes opportunities for peer support, specialist CPD opportunities that focus on the needs of paediatric life-limiting conditions, and better governance frameworks.

**P-119 ANTIBIOTIC STEWARDSHIP IN A HOSPICE ENVIRONMENT: AN AUDIT OF START SMART THEN FOCUS**

<sup>1,2</sup>Annelise Matthews, <sup>1</sup>Aharani Kirupanadan, <sup>1</sup>Roisin O'Dea, <sup>1</sup>Tina Duttgupta, <sup>1</sup>James Ferguson, <sup>1</sup>Sumeru Kayani. <sup>1</sup>*Sue Ryder St John's Hospice, Moggerhanger, UK;* <sup>2</sup>*North West Anglia NHS Trust, Huntingdon, UK*

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**Background** Antimicrobial stewardship is an important element of improving the safety and quality of patient care and reducing the emergence and spread of antimicrobial resistance. The Start Smart then Focus Toolkit was introduced to help NHS Trusts improve antibiotic stewardship (Public Health England, 2018). Previous work has shown hospice patients are at high risk of infections due to frailty and immunocompromise. Furthermore there may be poor documentation of antibiotic prescribing (Donald & Lindsay, 2014).

**Aims** To promote antibiotic stewardship by changing prescribing practice and introducing a sticker for antibiotic prescriptions.

**Methods** Two matched retrospective audits of hospice inpatients over one-month periods in July 2017 and February 2018. Notes were analysed for patients prescribed antibiotics and drug charts checked for review dates, stop dates, indications and signatures (Public Health England, 2018). The February 2018 notes were also checked to see if antibiotic stickers were used on the drug charts.

**Results** In February 2018, of the 30 inpatients, 16 were prescribed antibiotics, compared to 12 of 38 in July 2017. The original audit showed poor compliance with standards, with 50% (6/12) review dates, 75% (9/12) stop dates and 41% (5/12) indications.

Correct prescribing increased with sticker use, with 100% (4/4) review dates, 50% (2/4) stop dates and 100% (4/4) indications compared to 17% (2/12) review dates, 0% (0/12) stop dates, and 75% (9/12) indications in the February 2018 re-audit. However, there was poor sticker use with only four of 16 prescriptions on stickers.

**Conclusions** The stickers were an effective intervention for improving antibiotic stewardship, but one dependent on individual prescribers remembering to use them. In a hospice with continually changing junior staff, the best option may be to change the drug chart to have an antibiotic page to meet the Start Smart then Focus criteria. Further auditing could examine whether the hospice completes the Toolkit's Secondary Care Prescriber's Checklist (Public Health England, 2018).

**P-120 ANTICIPATORY PRESCRIBING IN LINCOLNSHIRE – A 21ST CENTURY APPROACH TO PATIENT-CENTRED CARE**

<sup>1,2</sup>Katharine Collett, <sup>2</sup>Anna Chippendale, <sup>3</sup>Jacqueline Rizan. <sup>1</sup>*St Barnabas Hospice, Lincolnshire, UK;* <sup>2</sup>*United Lincolnshire Hospitals NHS Trust, Lincoln, UK;* <sup>3</sup>*Lincolnshire Community Health Services NHS Trust, Lincoln, UK*

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**Background** For most people the greatest fear about dying is being in pain (ComRes, 2011; Parliamentary and Health Service Ombudsman, 2015). Anticipatory prescribing to aid prompt symptom management is well-established in end of life care (NICE, 2015). Lincolnshire has an established process for administering injectable medication in the community through a direction to administer (CD1) form completed by hand. Stakeholder feedback reported challenges with the existing system that limit pro-active, safe planning of symptom management for dying people. Lincolnshire's rural infra-structure means that arranging medication once a person develops symptoms is time consuming and causes delays in providing symptom relief.

**Aims** To redesign the CD1 form and associated processes to remove barriers for completion by prescribers, to provide clear guidance, and to facilitate safe administration of medications. Ultimately we want people in Lincolnshire to receive the right care at the right time.