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

[1,2]Annelise Matthews, [1]Aharani Kirupanadan, [1]Roisin O'Dea, [1]Tina Duttagupta, [1]James Ferguson, [1]Sumera Kayani. *[1]Sue Ryder St John's Hospice, Moggerhanger, UK; [2]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

[1,2]Katharine Collett, [2]Anna Chippendale, [3]Jacqueline Rizan. *[1]St Barnabas Hospice, Lincolnshire, UK; [2]United Lincolnshire Hospitals NHS Trust, Lincoln, UK; [3]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.

Methods A multi-stakeholder team updated the form and processes with user feedback. Improvements included:

- rewriting and expanding symptom management guidance
- providing a starting 'recipe' of anticipatory medicines that can be adjusted to individualise care
- an electronic version of the CD1 form including options to integrate into SystmOne and EMIS
- the ability to tailor the CD1 form for local prescriber preference
- additional resources including formularies for SystmOne and EMIS
- making all resources openly available on www.eolc.co.uk

Evaluation The updated CD1 form and resources were published in May 2018. Its use is being promoted alongside encouraging associated behavioural change within Lincolnshire around anticipatory prescribing. Initial feedback around clarity and ease of use is positive suggesting the revised CD1 form has addressed previous barriers around its use.

Next steps Formal user feedback survey. Data is to be collected from out of hours providers pre- and post- implementation to evaluate if the new process results in a reduction in calls to these services for symptom management in dying patients.

P-121 A NEW ANTI-EMETIC: OLANZAPINE FOR THE PREVENTION AND TREATMENT OF CANCER-RELATED NAUSEA AND VOMITING

[1,2]Anna Sutherland, [1]Katrien Naessens, [2]Emma Plugge, [2]Martin Burton, [2]Lynda Ware, [2]Karen Head, [3]Bee Wee. *[1]Sue Ryder Nettlebed, Oxfordshire, UK; [2]Cochrane UK, Oxford, UK; [3]Sir Michael Sobell House, Oxford, UK*

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We undertook a new Cochrane Systematic Review to assess the efficacy and safety of oral olanzapine when used as an anti-emetic in the prevention and treatment of nausea and vomiting related to cancer in adults. We searched published and unpublished trials up to the 8th September 2017. We included randomised controlled trials (RCTs) of olanzapine with or without adjunct therapies for the prevention and/or treatment of nausea or vomiting in patients with cancer aged 18 or over, in any setting, with $\geq$10 participants per treatment arm. Standard Cochrane methodology was used.

We included 14 RCTs (1917 participants) from high, middle and low income countries in which olanzapine was administered orally, in people with over 24 different cancers, none of which were funded by pharmaceutical companies. Participants received: highly emetogenic (HEC) or moderately emetogenic (MEC) chemotherapy (12 studies); chemoradiotherapy (one study); or no active treatment (one study). Eight studies await classification and 13 are ongoing. The majority of studies were at low or unclear risk of bias across most domains. A high risk of bias, related to issues of blinding, was present in 10 RCTs.

Oral olanzapine probably almost doubles the likelihood of freedom from nausea and vomiting during chemotherapy from 25% to 50% (RR 1.98, 95% CI 1.59 to 2.47; 561 participants; solid tumours; HEC or MEC therapy; moderate quality evidence) when added to standard therapy. Number Needed to Treat for additional benefit (NNTB) was 5 (95% CI 3.3–6.6). Serious concerns have been raised regarding the efficacy and safety of injectable olanzapine (intravenous, intramuscular or subcutaneous). Olanzapine probably increases somnolence and fatigue compared to no treatment or placebo (RR 2.33, 95% CI 1.30 to 4.18; anticipated absolute risk 8.2% more). It is unclear if anti-emetic efficacy differs between 5 mg and 10 mg doses.

P-122 EMBRACING INFORMAL CARERS AS PART OF THE HEALTHCARE TEAM

[1]Vanessa Gibson, [1]Sophie Edmonds, [2]Carole Roberson. *[1]St Richard's Hospice, Worcester, Worcestershire; [2]Worcestershire Health and Care Trust, Worcester, Worcestershire*

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The aim of this project is to empower patients and families to take an active role in symptom control at end of life. A multiprofessional team has been working together to develop a policy which will enable informal carers to administer as required subcutaneous medication at end of life. This project has been informed and guided by patients and carers. The rationale for this project is to:

- Enhance symptom control by more rapid administration of as required injectable medication, potentially enabling patients to remain at home
- To support and empower family members who want to provide this type of support to the patient, ensuring underpinning training and education is in place
- To complement rather than replace existing services, district nursing support will continue to be required
- To have a positive impact upon bereavement, enabling families to feel that they have done all that they can do for their loved one.

We have faced multiple challenges in developing this policy not least professional concerns relating to prescribing medication which will be administered by an informal carer and the professional implications of supporting informal carers to administer the prescribed medication. Initially it was hoped that this project would include the acute sector but this has been too difficult to achieve. Careful multiprofessional working has been critical.

We now have support to proceed from Worcestershire Clinical Commissioning Group, St Richard's Hospice and a General Practitioner (GP) locality team. An outline paper, inclusion/exclusion criteria and process has been agreed. Supporting documentation and underpinning training is being developed. We aim to pilot the policy commencing August 2018. Our approach will be on a patient by patient basis. Patients will be highlighted to the GP by St Richard's Hospice Clinical Nurse Specialists. There will be ongoing review of this policy's use.

P-123 THE OPIOID CONVERSION WORKBOOK: A NOVEL EDUCATIONAL INTERVENTION TO ENHANCE PATIENT SAFETY

Robert Brodrick, Sylvia Reid. *Sue Ryder Thorpe Hall Hospice, Peterborough, UK*

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Background Proficiency in safely converting between opioids is an important skill for doctors and nurses working in palliative care. Rigorous opioid conversion training is rare (Webster, Bremner, Oosenbrug *et al*., 2017; Spitz, Moore, Papaleontiou