P-135 EVALUATION OF TOLERABILITY AND DEPREScribing OF ANTI-FIBROTICS IN PULMONARY FIBROSIS (IPF) PATIENTS

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Background IPF is a progressive fibrotic lung disease of unknown cause. Median survival for IPF patients is approximately three years from diagnosis. NICE guidance states that best supportive care should be offered from diagnosis to provide information, symptom relief and support withdrawal of therapies suspected to be ineffective or causing harm, and to provide end of life care (NICE, 2013). To this end, a hospice-based pulmonary fibrosis support group has been set up providing care for patients with IPF to improve access to palliative care support including consultant review. The anti-fibrotics nintedanib and pirfenidone (NICE, 2016; NICE, 2018) are recommended by NICE to slow the progression of the disease but have considerable side effects.

Aim This evaluation will collect data regarding the demographics of IPF patients seen, the source of referral and assess the proportion taking anti-fibrotics. The side effects experienced by patients will be described and obstacles in deprescribing anti-fibrotics outlined.

Methods A retrospective case note review will be performed to extract data from the narrative. This will be used to identify whether there are certain characteristics that these patients share in order to inform decisions regarding those who may be unable to tolerate anti-fibrotics in the future.

Result It is anticipated that many patients taking anti-fibrotics will experience significant side effects. There may be shared characteristics that enable us to predict which patients cannot tolerate these drugs that can have a significant and detrimental effect on quality of life of patients.

Conclusions The hospice has a highly evaluated IPF support group that provides professional and peer support to patients/families. It facilitates access to the Palliative Medicine Consultant who is able to support patients in discontinuing anti-fibrotic drugs that can adversely affect quality of life. The characteristics of patients who do not tolerate anti-fibrotics are outlined and obstacles in deprescribing described.

P-136 IMPLEMENTATION OF ELECTRONIC PRESCRIBING AND MEDICINES' ADMINISTRATION (ePMA) INTO A HOSPICE SETTING

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Background ePMA is used in many UK hospitals, but not in hospices. It can reduce prescribing errors, enable more efficient administration of medicines and free up staff to spend more time with patients (Ahmed, Garfield, Jani, Jheeta *et al.*, 2016). St Helena introduced SystmOne into clinical practice in 2012 and implemented ePMA into the inpatient unit (IPU) in November 2018.

Aims To reduce drug errors, improve patient safety, strengthen information governance, and enable staff to use their time more efficiently.

Methods A project team of IPU and SystmOne managers, senior pharmacy staff and a consultant was set up and pre-implementation research undertaken, including visits to other healthcare settings. A business plan highlighted training needs and cost implications. Specific formularies were built, mobile 'computers on wheels' (COWs) were ordered, the risk register was updated and training sessions for all clinical and pharmacy staff (group and 1-2-1) were delivered. We initially implemented ePMA incrementally as each new patient was admitted, and provided increased technical support to staff, including at evenings and weekends.

Results We identified that 40% of our recorded drug errors may not occur with ePMA, for example lost drug charts. We remained vigilant for new or unanticipated errors, and dealt with them swiftly.

Since implementation, the number of drug errors has fallen by 35% (from 28 to 18). A small increase level 2 errors (Hospice UK, 2017), from 3 to 4 has been noted, none related directly to ePMA.

Informal feedback from staff and patients has been positive, e.g. nurses have more ward time, patients do not feel the COWs detract from their interactions with staff.

Conclusion The system is now fully embedded in the inpatient setting. This year we plan to complete an audit, support other interested hospices, carry out staff and patient satisfaction surveys and implement discharge medication functionality.

P-137 IMPLEMENTING E-PRESCRIBING – THE EXPERIENCE OF ST CATHERINE'S HOSPICE PRESTON

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Background E-prescribing is understood to provide benefits to patient safety by reducing medication errors and may provide some staff efficiencies (Ammenwerth, Sschnell-Inderst, Machan, & Siebert, 2008; Franklin, O'Grady, Parasidou *et al.*, 2007). However implementing e-prescribing, requires introduction of new working processes and within a specialist health care setting an adapted e-prescribing system is recommended (Ward & Watson, 2013). Despite the perceived benefits, e-prescribing use nationally is low and a paucity in the research exists regarding implementation within a hospice setting.

Aims

- To share the lived experience of implementing e-prescribing within a hospice In-Patient Unit, Community team and Lymphoedema service;
- To monitor staff attitudes and perceptions of e-prescribing pre- and post- implementation;
- To review medication error rates pre – and post – implementation.

Method Implementation commenced on 29 May 2019. The hospice has an established electronic patient record system and the e-prescribing software is an add-on to the existing system. The e-prescribing software has been specifically written for a hospice service. Implementation was supported by a contracted IT team and a designated project manager. A pre-implementation questionnaire was completed by all hospice staff. The questionnaire focused on perceived benefits and barriers of e-prescribing, compared to the previous paper-

based system and staff attitudes about the change in clinical practice.

Results Nine days post implementation, e-prescribing was fully implemented on the In-Patient Unit as all patients had a prescription in place as part of their electronic patient record. At the time of writing, staff continue to gain experience of using the system in clinical practice being supported by the IT team.

Future plans Pre-implementation questionnaires require analysis. The questionnaire will be repeated at three and six months post-implementation, to monitor staff experience and attitudes over time. Medication error rates will be monitored via an electronic clinical incident reporting system.

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THE EVOLVING ROLE OF A COMMUNITY SPECIALIST NURSE PRESCRIBER, THEIR IMPACT AND SUPPORT PROCESSES

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Background Palliative care patients of Community Specialist Nurse Independent Prescribers (CSNIPs) often have multiple complex symptoms requiring specialist management (Ziegler, Bennett, Blenkinsopp & Coppock, 2015). CSNIPs are key to delivering this care with a timely response. Perceived benefits include faster access to medicines (Tatterton, 2018) and rapid symptom control (Dawson, 2013), supporting end of life patients to remain at home. The challenge for CSNIPs is to maintain specialist knowledge with processes that support their prescribing practice.

Aims Exploring the range of medicines prescribed by a CSNIP in the Community Specialist Palliative Care Team, establishing impact on practice and examining support processes.

Methods An audit was undertaken of CSNIP yearly activity with data collated according to drug monographs in Palliative Care Formulary 6 (Twycross, Wilcock & Howard, 2017). Appropriateness of prescribing was evaluated, including anticipatory and syringe driver prescribing and medicines reconciliation activity.

Qualitative data was gathered regarding patient and carers experience of CSNIP via interviews and written feedback, followed by thematic analyses.

Investigative methods identified processes supporting annual CSNIP prescribing reviews and supervision.

Results Prescriptions demonstrated an appropriate range of medications prescribed and within the CSNIP scope of practice. Analgesics were prescribed in 32% and central nervous system medications in 22% of cases, with increasing anticipatory and syringe driver prescriptions on previous years.

Feedback from patients and carers showed continued positive benefits, especially in managing complex end of life symptoms.

Support for CSNIPs is via partnership working with the local Community Health Care Trust and Medicines Management Team, involving annual mandatory CSNIP 'Prescribing Reviews' and supervision.

Conclusions The range of medications prescribed demonstrated appropriate CSNIP practice. Patients and carers valued the CSNIP clinical expertise and prompt receipt of medications. This evidences the value of CSNIP training. Annual reviews of CSNIP prescribing and support is via partnership working.

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ABSTRACT WITHDRAWN

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CHANGING THE CULTURE OF ANTIMICROBIAL PRESCRIBING IN A HOSPICE IN-PATIENT UNIT

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Palliative care patients are susceptible to infection due to their underlying condition and treatment. Studies have shown a prevalence of infection at the time of death in 47–63% of patients with advanced cancer, and large proportions of patients in specialist palliative care units receive antibiotics in the last week of life.

Antibiotics may be considered non-aggressive therapy and appropriate, even when other treatments such as intravenous fluids or chemotherapy are not. However, they carry significant risks including treatment related side effects, adverse