Context The improvement project was done in a paediatric tertiary hospital; it was led by a junior doctor and administrative staff officer with involvement of a consultant, junior doctors and nurses.

Problem Trust strategy is to achieve zero harm, no waits, no waste and working together. In addition, the National Clinical Data Standards Assurance Program (2010) has mandated that electronic Discharge Summary (DS) should be sent out from medical teams to the appropriate GP within 24 h of the patient being discharged and the patient should be sent home with one copy of DS in their hands. In 2013, 60% of the Renal Ward discharge summaries were being sent out in time.

Assessment of problem and analysis of its causes We interviewed doctors, nurses and pharmacists to get a better understanding of the process that led to DS being posted to GPs. We identified following factors that led to delays: poor communication within the team and lack of ownership of this task. We held a stakeholder meeting for brain storming and shared ideas to improve the existing process. We developed junior doctor rota describing who is responsible for the DS completion and agreed that the patient's nurse was responsible for ensuring that patient did not leave without DS.

Intervention The new process for writing DC comprised of a number of steps. On call junior doctor for the week is in charge of getting information from the senior nurse on who will need the DS on a daily basis; the same person is in charge of completing DS, printing it and giving it to the patient's nurse who was not allowed to discharge patent without a DS. We allocated new place for the storage of GP copies of DS to trigger action from administrative staff to post DS to GPs. We ensured that all team members were aware of the new system by attending handover sessions.

Study design Observational study.

Strategy for change We attended 'away days' for all levels of nurses and junior doctors induction and informed them of the new system. We encouraged all team members to approach project leads if they identify new problems as those were to be our new PDSA cycles. We aimed to have >90% DC summaries done timely over a 16 week period. The National standard is 95%.

Measurement of improvement We kept a record of every DS completed. For those not completed a mini root cause analysis was done to investigate the cause of the delay. Data analysed weekly and results shared with all staff.

Effects of changes The effects of changes were better quality of patient care as timely DS done (one of six domains of quality) and improved communication between professionals in tertiary care and GPs. We achieved and sustained >90% target (Figure 1).

Lessons learnt This project taught me the importance of a multidisciplinary approach when planning change. We need a desire and commitment to change and on planning the improvements. It is crucial to see problem through different professionals views as this aids problem analysis. Next time, I would involve a patient or a parent to oversee our work.

Message for others Understanding problem and the process before implementing change is crucial for success. Making sure that all team members are aware of project and evaluating feedback is important for sustainability. This improvement is important for quality of care we provide as it addresses one of six quality care domains. Discuss each failure with the team and perform new PDSA for each problem identified.

G596 IMPROVING PAEDIATRIC PRESCRIBING

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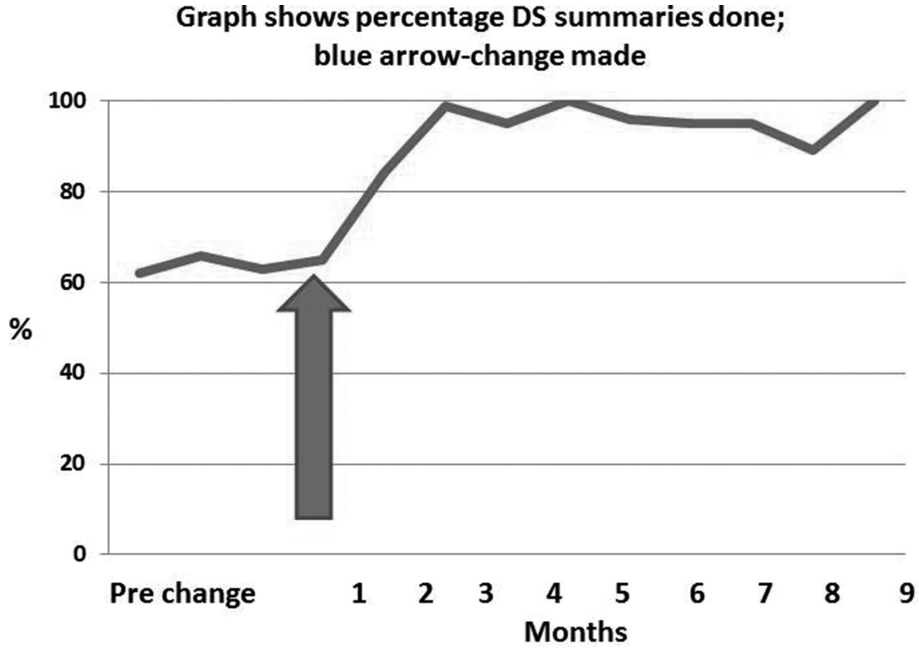
10.1136/archdischild-2015-308599.545

Context This ongoing work is being done in the busy General Paediatric Department of our Hospital. It involves doctors of all grades who prescribe medication for paediatric medical inpatients.

Problem A high incidence of errors and omissions identified in audit of prescription charts, despite paediatric prescribing being



Abstract G595 Figure 1 Results of DS completed

discussed at every junior doctor induction programme, led to initiation of this project.

Assessment of problem and analysis of its causes The problem had already been quantified by previous audits. Doing a weekly prescribing review by randomly selecting 2 drug charts from each of the 3 wards and discussing them as a team helped identify key issues. This led to all staff being actively involved from the early stages. Various interventions were introduced as follows.

Intervention Interventions were escalated to achieve the desired outcome, with weekly performance monitoring by review of randomly selected drug charts.

Cycle 1: Review of drug charts to identify problems

Cycle 2: "Prescribing lesson of the week" posters in the doctors' office

Cycle 3: Personal emails with recommendations to individuals who had made errors or omissions

Cycle 4: Combining personal emails with a themed, eye-catching poster

Cycle 5: Introducing star chart to positively motivate good performance, continuing personal emails

Cycle 6 (December 2014): Increasing sample size- all charts from one ward

Cycle 7 (January 2015): increasing sample size- all Paediatric Wards

Cycle 8 (March 2015): Re-audit

Study design This project is designed as per the Plan-Do-Study-Act Cycle suggested by the Institute for Healthcare Improvement's Model for Improvement: small sample cycles were performed to identify the main prescribing problems, implement changes and test the effect of each intervention.

When improvement has been maintained in the small sample cycle we plan to expand the study sample (December 2014) and demonstrate the overall impact and change (if any) in the Department.

The goal is 100% BNFC general guidance compliant drug charts by the end of January 2015 for all medical paediatric patients.

At the final stage of the project (January 2015) measures aiming to preserve the improvement overtime will be introduced and will be tested after the trainees rotate (March 2015).

Strategy for change Interventions were escalated and implemented as described. All staff were active participants at every stage and consequently were aware of planned interventions.

Measurement of improvement The percentage of BNFC general guidance compliant drug charts out of the total number of drug charts reviewed per cycle has been set as a quantitative outcome measure to compare results and quantify progress.

Effects of changes Fewer prescription errors and omissions were noted following the implementation of intervention with inferred improvement in patient care.

Lessons learnt Sustained team focus and escalating interventions tested in rapid cycles led to the desired outcome becoming achievable. Staff involvement early in the choice of intervention may have shortened the time to achievement of goal and reduced resistance.

Message for others A clinical improvement project with short, small sample PDSA cycles and early staff involvement leads to quicker and possibly more sustained benefit. Positive identification of individual good practice motivates improvement.

G597 AUDIT AND RE-AUDIT OF DISTRACTIONS DURING PRESCRIBING IN A PAEDIATRIC CRITICAL CARE UNIT

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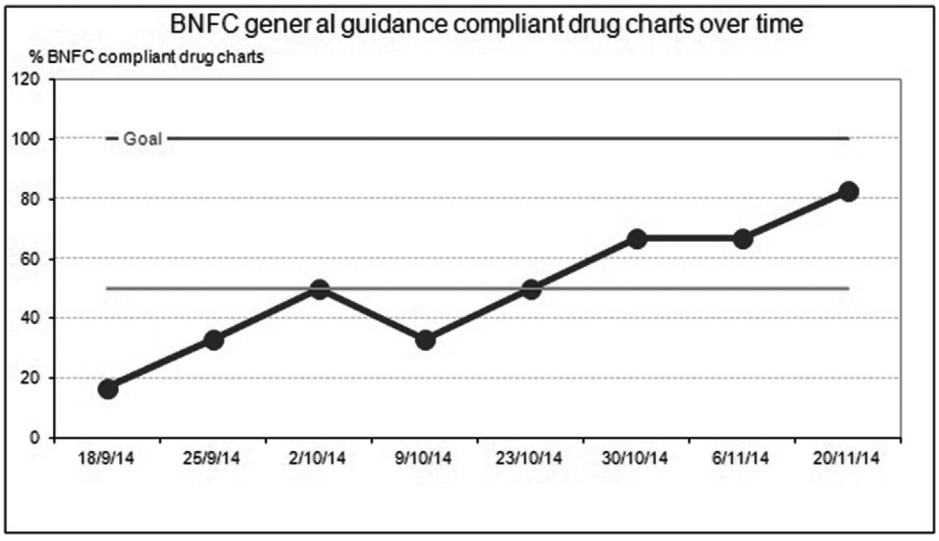
Context A 6-beded Paediatric Critical Care Unit (PCCU) at Royal London Hospital (UK) with the involvement of consultants, registrars and pharmacists at PCCU.

Problem A previous audit at PCCU showed that prescribing errors occurred at a frequency of 0.02 per PCCU bed days in 2013, with 3 cases of serious drug dose error, incorrect adjustment for renal impairment and electrolyte replacement error. A dedicated prescribing area was introduced in 2013 but the effectiveness was undetermined. Upon observation of prescribing practice at PCCU, it was noticed that prescribers were distracted frequently, which might be contributory to the increase in prescribing errors.



Abstract G596 Figure 1