length of hypoglycaemic episodes and shorten treatment duration for babies.

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P08 TEN-FOLD MEDICATION ERRORS IN A TERTIARY PAEDIATRIC HOSPITAL

Caitlin Cubbin*. *Alder Hey Hospital, Liverpool*

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Aim To perform a retrospective analysis of tenfold medication errors between the 1st January 2017 and the 31st December 2018 and identify contributing factors.

Method Information from all tenfold medication errors reported to the Ulysses system between 1st January 2017 and 31st December 2018 which met the criteria was inputted into a data collection sheet. Information gathered included the age of the patient, the time the error occurred, the location within the hospital, the point in the medication process the error occurred, the drug involved and the NCC-MERP category of harm assigned to the error. Reports were excluded if they were repeated entries or if they did not meet the criteria for a tenfold medication error. The total number of medication errors reported per month and the total number of admissions per month was also identified. Once data collection was complete, these errors were qualitatively analysed and compared with those of a previous audit using errors reported from 1st January 2013 to 31st December 2014.

Results Tenfold errors were most likely to be reported in the Critical Care areas (34.4% of tenfold errors being reported over the two-year period). Prescribing was the most common origin of error accounting for 54.3% of tenfold errors in 2017 and 51.7% in 2018. The most common category of harm assigned was category B (no harm – error did not reach patient) with a total of 40.6% of the errors reported. The age group with the highest number of errors reported was 29–364 days with 39.3% tenfold medication errors reported over the two-year period. Morphine was the most common drug involved accounting for 13.8% of errors reported.

Conclusion The findings from this report mirror the results from the previous audit performed in 2014 in respect to error origin and patient age. Tenfold prescribing errors have more chance of being intercepted before reaching the patient due to there being more steps in the process before administration, therefore it is less likely that errors that originate at prescribing will reach the patient. Tenfold administration errors were more likely to reach the patient and therefore to cause harm. Morphine was the most reported drug in both 2017/18 and the 2013/14 audit suggesting that more work needs to be done on the safe use of opioids. Critical Care was the location with the highest number of errors reported, patients in this area often require complex medication regimes increasing the likelihood of being involved in a medication error.[1]

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P09 A SURVEY OF THE NPPG GROUP CONCERNING MEDICATION ADMINISTRATION PROBLEMS AMONG CHILDREN AND YOUNG PEOPLE AGED 0 TO 18 YEARS OLD

Dania Dahmash*, Chi Huynh, Daniel Kirby, David Terry. *Aston University, Birmingham*

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Aim To identify issues encountered by pharmacy healthcare professionals with regards to problems that they have experienced, complaints received, queries and feedback by the patients or parents or caregivers in terms of medication administration for children and young people aged 0 to18 years old.

Method An online survey using the Online Surveys tool was devised to obtain healthcare professionals' perspective regarding medication administration problems encountered by parents, caregivers or paediatric patients when administering or taking their medication at home. The survey was sent to the members of the Neonatal and Paediatric Pharmacists Group (NPPG), who represent different geographical areas within the UK and further afield. Informed consent was obtained from participants. This study was reviewed and approved by the Life and Health Sciences Ethics Committee, Aston University.

Results 37 pharmacists and 1 technician completed the survey. The majority of the respondents 23/38 were currently practicing in England, with 6/38 respondents being registered pharmacists outside the UK, 1/38 was practicing in Northern Ireland, 3/38 within Scotland and 4/38 were practicing in Wales. 71.1% of the respondents strongly agreed that parents or caregivers require further training when it comes to medication delivery to their children. In addition, when asked about their concerns regarding prescribed medication to children aged between 0 to18 years old, respondents expressed a different level of concern regarding each age group. Regarding neonates, the main concern was the suitability of the prescribed formulation and the ability of the parents to accurately measure and administered a low dose volume. In contrast, for children aged between 28 days to 12 years, the common concerns were associated with palatability, which will further reflect upon child compliance and the parent or caregiver's ability to understand medication instructions and administration. Finally, for older aged children, adherence was a common concern. Furthermore, liquid formulations (suspensions (60.5%), solutions (55.3%) and injections (44.7%)) were predominantly used among children aged 0 to 18 years old within both in and outpatients setting. Overall, the majority of the respondents expressed that counselling time between the patient and pharmacists and the need to provide further training and educational material to parents and young people is an important issue to improve understating in regards medication use.

Conclusion The findings suggest that medication administration problems occur frequently among paediatric patients, and the nature of these problems varies among each age group. Medication training for both parents and young people could be a key factor to help reduce this problem. Future research is needed to investigate and gain insight into personal experiences with medication use and administration from a parent and/or young person's perspective. This will help to highlight the current problem in the UK and further develop potential interventions to reduce medication administration errors by