P 08 CLINICAL PHARMACY IN PAEDIATRICS—A PILOT TO DESIGN AND DEVELOP AN EFFECTIVE SERVICE

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Aim To identify and develop an effective clinical pharmacy service to the paediatric and neonatal wards and subsequently improve the prescribing and care given to these patients.

Method There are numerous national and international documents which highlight the benefits of a clinical pharmacy service in an acute hospital environment, however very few have been written with paediatric or neonatal settings in mind. A National Patient Safety Agency (NPSA) document indicated that serious medication errors may be up to three times more common among children than in adults[1] and a recent UK study showed an overall prescribing error rate of 13.2% in paediatrics.[2] At a multi-site District General Hospital with no pharmacy input into paediatrics (90 beds), funding was obtained to pilot a clinical service to the department of Child Health. Background research of literature reviews, staff opinions and baseline audits gave an overall assessment of the current service and suggestions for improvement. A senior pharmacist piloted a service for a year, covering clinical, safety and operational aspects to identify the potential role of the pharmacy team.

Results A variety of clinical activities were performed with the scope widening as the year progressed. A ward service, implementation of a paediatric HDU service, involvement in junior doctor induction, departmental education sessions, electronic prescribing systems, community paediatrics and a wide range of medicine information queries are examples of activities undertaken. A ward based service was piloted at one site for 14 weeks, where 85 clinical interventions were made and which demonstrated an increase in adherence to prescribing standards from 53% to 100%. The potential cost savings of these clinical contributions were calculated using a model commissioned by the National Institute for healthcare excellence[3] and found to be £11,062. Extrapolated for a year, a potential saving of in excess of £84,000 could be made (single site). Clinical governance played a key role in the pilot, with the production of more than twenty clinical guidelines and protocols, and significant input into incident reporting and root cause analysis meetings. Despite having relatively low drug expenditure, a drop of 9.4% was observed during the pilot year with the potential for further savings in the future. Consultant perception of the service increased from 3.1 (out of 10) to 8.6 with nursing staff also seeing a rise (5.5 to 8.5). An appreciation and appropriate utilisation of the pharmacist was observed throughout the pilot, with a noted shift from stock and supply concerns to those revolving around safety and clinical issues as understanding of the pharmacist role grew. Qualitative feedback from leads within the Pharmacy department confirmed a more cohesive service with standardisation of practice cross-site.

Conclusion The role of the clinical pharmacist within paediatrics is varied but vital. Involvement in clinical governance issues within the acute and community setting played a key part to the pilot year, aiding to increase awareness of paediatric medicine within the Trust and reminding practitioners that children are not just 'little adults'.

REFERENCES

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