	Trust Incident Reporting	Paediatric Medication Errors	Serious Errors (amber)
2011–2012	11.7%	5.5%	36%
2013–2014	12.6%	2.2%	3%

Conclusions A significant reduction ($p < 0.05$) in paediatric medication errors was seen after the multidisciplinary action plan was implemented, although the overall Trust incident reporting increased. Serious errors were significantly reduced ($p < 0.001$) and there were no lethal paediatric medication errors during this period. The Root cause analysis and prescribing audit identified a number of interventions, including re-designing the Paediatric drug charts to include antibiotic indication and duration and the launch of the specials project to procure secondary care prescriptions in-house. We conclude that it is possible to reduce medication errors by implementing a multidisciplinary approach.

G308(P) PARENTS THINK THAT 'MEDICINES FOR CHILDREN' REACHES NICE PLACES

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Background Whilst only 20% of content discussed in a consultation is retained, it's improved by giving additional written information. Patients are able to use written leaflets to consolidate their knowledge away from the stressful environment of a patient-doctor discussion. Such written information may increase treatment compliance and concordance. The 'Medicines for Children' website is designed to provide practical and reliable advice for families about giving medicine to their children. It has a variety of leaflets, videos and web-based information on over 200 children's medications. It's a partnership between the Royal College of Paediatrics and Child Health, the Neonatal and Paediatric Pharmacists Group and WellChild; a charity for parents and carers.
Objective To evaluate the 'Medicines for Children' website and information sheets, against the NICE quality standard 15; Understanding Treatment Options and NICE Medicines adherence guideline 76; involving patients in decision about prescribed medicines.
Methods A questionnaire was designed against the specific criteria set out in NICE quality standard 15 and clinical guideline 76. Questions focused on the layout, language and content of the leaflet, particularly information regarding the treatment risks and benefits. Data was collected from a convenience sample of parents attending children's outpatient clinics. Qualitative feedback was also sought.

Parents were asked to read the leaflet on 'Beclametasone inhaler for asthma prophylaxis' and answer the questionnaire as though their child were starting on this medication.
Results 106 parents participated. 16 declined.

Question	Percentage who agreed
Good Leaflet Layout	91%
Lay terminology used	92%
Suitable content	89%
Appropriate Information on medicine's benefits	93%
Appropriate Information on medicine's risks	93%
Would they use the Website in future?	92%

Parents comments included: 'clearly laid-out with simple sub-headings', 'written in a way that everyone can understand'. They suggested future developments should include: 'pictures for adults with lower literacy levels' and 'having the leaflets in both English and Welsh.'
Conclusion Medicines for Children information leaflets fulfil NICE standards and provide high quality information about children's medications which is highly valued by families.

G309(P) "SAFETY HUDDLES": MULTIDISCIPLINARY VIEWS REGARDING THE PURPOSE AND EFFECTIVENESS OF A NOVEL PAEDIATRIC SITUATIONAL AWARENESS TOOL

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Aim Following an audit in 2012, which identified variability in the recognition and escalation of deteriorating patients, Safety Huddles were introduced, utilising a Childrens' Early Warning Score (CEWS), to enhance situation awareness.

Huddles are scheduled, regular multi-professional meetings, no longer than ten minutes, held in the clinical environment alongside an interactive electronic patient board. The sickest and most at risk patients (CEWs >2) are identified, prompting immediate and appropriate escalation. Four additional risk factors (family concerns, high risk therapies, clinicians' gut feeling and communication concerns) further identify patients as 'watchers.'

Huddles provide:

- Optimum safety through elimination of avoidable harm
- Greater empowerment and accountability of all staff through shared decision making

Our aim was to evaluate the attitudes and understanding of front-line staff regarding the purpose and effectiveness of Huddles, 18 months on.
Methods A voluntary, anonymous online survey was disseminated to staff across 3 clinical areas (2 wards, 1 outpatients).
Results 41 responses were returned. Respondents included 2 consultants, 4 registrars, 24 nurses, 1 nursing student, 1 healthcare assistant, 2 pharmacists and 5 interpreters.

The majority rated their understanding regarding the purpose of the Huddle as "good" (51%) or "excellent" (41%). 88% described the Huddle as an "important aspect" of their work, 98% no longer requiring reminders to attend. Subjectively, the Huddle led to improvements in: Team Communication (95%), Patient/carer involvement (63%), Staff support (80%), identification of deteriorating patients (93%) and timely escalation (90%). 83% felt better informed about patients not specifically allocated to their care. 50% felt Huddles should occur with increased frequency.

Crucially, 93% felt enabled to have their concerns heard.

Problems identified included punctuality of start times and occasional non-attendance of doctors, which subjectively lessened the value of the Huddle.
Conclusion Huddles are regarded as useful by the vast majority of staff and are an inclusive, empowering, non-hierarchical method of information sharing regarding patient safety. Our findings have been shared with all staff and suggested modifications are being considered.

Huddles are now being introduced across UK 12 sites as part of the SAFE collaborative of RCPCH.

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