Next time, I would survey paediatric doctors and ENPs in addition to emergency care doctors as they also complete the checklist while clerking.

Message for others Without regular measurements, we could not tell if the checklist was being used. To find out it is being used poorly through a serious case review is not acceptable. By regular measurement, we have weekly data which provides more detailed information on completion rates. Staff engagement was vital to improving the checklist and increasing compliance, as detailed above.

**G581(P)** IMPLEMENTATION OF A PAEDIATRIC PRESCRIBING POCKET GUIDE

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**Context** Neonatology department in a busy district general hospital.

**Problem** The project set out to address inpatient prescription errors which could result in illegal prescriptions and patient harm.

**Assessment of problem and analysis of its causes** I collected data from 20 random drug charts and used a checklist to identify the incidence and types of prescribing errors in in-patient drug charts for patients on Special Care Baby Unit and Neonatal Intensive care Unit. After completing the data collection, I met with paediatric pharmacists and departmental doctors and nurses to determine why certain prescribing errors were being made.

**Intervention** I wrote, designed and developed a paediatric prescribing pocket guide to clarify local and national guidance regarding paediatric prescribing. I used my own drawings to make a user-friendly guide.

**Study design** Audit.

**Strategy for change** I worked with management and senior staff to get the paediatric prescribing guide approved and authorised. It has subsequently been published on the hospital intranet and is available as hardcopies in clinical areas. I used email and departmental meetings to advertise the new prescribing guide, as well as educating new arrivals about paediatric prescribing.

**Measurement of improvement** To measure the effects of my intervention, I re-audited the incidence and types of prescribing errors on in-patient drug charts. I compared the overall mean prescribing error rate, as well as specific prescribing errors.

**Effects of changes** Re-audit showed a reduction in mean prescribing error rate, although there is still room for improvement. This has led to clearer prescriptions and fewer uncertainties surrounding delivery of medication. Subjective feedback has reported that the guide has improved communication between multi-disciplinary team members reviewing and using drug charts.

**Lessons learnt** This project has taught me the need to collect feedback from different team members (pharmacists, nurses, doctors, specialist teams) to identify the reasons behind prescribing errors. I have also learnt how to develop new guidelines and the steps that are needed to go through in order to get new guidelines approved and disseminated.

**Message for others** It is important to involve senior members of staff when developing new guidelines and to be persistent, yet realistic when it comes to implementing new guidelines e.g. printing the guidelines for all new arrivals is expensive whereas making the guidelines available on the trust intranet is cheap and accessible to all healthcare staff.