- Forced function: All paracetamol prescriptions for patients under 1 year of age were capped at 180 mg (change from 1000 mg). The prescriber could not enter a number greater than 180 mg.
- Automation: All oral paracetamol prescriptions were changed to automatically prescribe 15 mg/kg 6 hourly regardless of age (previously 2 different options requiring the prescriber to input dose and frequency according to formulary directions).
- Standardisation/simplification: All oral paracetamol prescriptions were rationalised to a single option with automatic dose and frequency as above (previously 2 different options unnecessarily).
- Reminder/rule: A rule of 'Consultant Approval' was added to all intravenous paracetamol prescriptions. The intention of this was for a review of the prescription before use to ensure appropriate use and dose/frequency. This could not be forced, so an education package was launched across the unit by the quality improvement group.

Prescription details were downloaded from the EP system for 3 month periods pre and post changes. he data was audited by pharmacy undergraduate students for prescribing accuracy.

Results The forced function, automation and standardisation options were implemented with 100% compliance. The 'consultant approval' rule was followed in 23% of cases. Consultant review led to a 58.6% reduction of IV paracetamol prescriptions on the unit and zero prescriptions for the first 2 months post implementation. The usage of oral paracetamol increased accordingly. This change corresponded to an overall reduction rate of 41.7% for intravenous paracetamol prescriptions.

Conclusions This project demonstrates how changes that increase automation within prescribing can reduce error and that implementation is more successful than education. A limitation of our data analysis was that we did not measure the effect on pain relief or pain scores in the patients who did not receive IV paracetamol compared to those who did.

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P16 CEASE: DEPRESCRIBING ON DISCHARGE FROM PICU

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Aim To develop a screening tool for prescribers to aid deprescribing on discharge from paediatric intensive care (PICU). Deprescribing is defined as 'the process of withdrawal of an inappropriate medication supervised by a healthcare professional with the goal of managing polypharmacy and improving outcomes'.[1] On the subject of deprescribing in paediatrics there is currently a lack of published literature however it is thought that we will be able to rationalise medicine use by being able to identify and document their indications.[2]

Method An audit was completed of twenty-five paediatric patients following discharge from PICU. Data was collected on which medicines were not appropriately stopped by PICU prescribers when patients were stepped down to the ward. These medicines were categorised by their indication and this information was used to create a deprescribing screening tool. Prescribers on PICU were educated on this new tool and a further audit is currently underway to assess the impact of this.

Results Twenty-five children were discharged from PICU to wards within the hospital over a four week period. Of these all twenty-five had two medicines or more that should have been deprescribed or a plan documented for before stepping down. A total of 110 medicines could have been deprescribed (median 4 per patient, range 2–8). These medicines were categorised by their indication: sedation 38.2% (n=42), electrolytes 33.6% (n=37), additional charts 18.2% (n=20), gastroprotection 4.5% (n=5), antibiotics 2.7% (n=3), other 2.7% (n=3).

We found that these medicines included high risk critical care only medicines that were unsafe to be administered on a ward such as high strength potassium infusions or inotropes, oral and IV sedative agents and antibiotics with no documented plan. Based on this information the following 'CEASE' screening tool was created:

Charts - are additional charts still in use and appropriate?

Electrolytes - have all PICU only electrolytes been stopped?

Antibiotics - do all antibiotics have a documented plan?

Sedation - has all sedation been stopped or if not is there a documented plan of when and how to stop?

Enteral - if enteral feeds have started has all gastro-protection been stopped?

A further audit is currently underway to assess the impact of the 'CEASE' tool.

Conclusion The audit has shown that a range of different medicines were inappropriately continued outside of PICU, this includes high risk medicines not suitable for use on the ward. The development of the 'CEASE' tool has been created to aid prescribers in the identification of medicines which should be deprescribed. This should help to provide better treatment, improve patient safety and promote antimicrobial stewardship.

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P17 INTRODUCING CONCENTRATED PRETERM STOCK PARENTERAL NUTRITION AND THE IMPACT ON BESPOKE COMPOUNDING

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Background It is widely recommended that stock parenteral nutrition (PN) bags are used where possible to reduce the risks associated with bespoke PN compounding.[1] A review was undertaken within a level three neonatal unit which identified that a large proportion of compounded bags were made due to the need to provide full nutrition in a smaller volume. A preterm concentrated aqueous PN bag was developed which, when run with stock lipid syringes, meets the nutritional requirements of preterm babies in a total volume of 100 ml/kg/day.[2]