their medicines. Display boards were created advertising the option of tablets for different medicines and highlighting the different swallowing techniques. The play specialists became 'Medicine Champions' using novel approaches to provide children with the tools, confidence and ability to take tablets. Children who successfully mastered swallowing tablets were presented a 'star award' certificate for their achievement. Photographs of children with their certificates were displayed in the outpatient clinic.

Method Paediatric patients diagnosed with ALL between 2012 and 2017 were retrospectively identified using chemotherapy prescriptions, patient's medical notes and electronic patient medical records. Data collected included age at diagnosis, formulation choice initiated on and whether patients switched formulations during the course of their treatment. Children were excluded for the following reasons: if they had a history of swallowing difficulties/choking, if the child had learning difficulties or if the child was deceased.

Results 172 patients were diagnosed with ALL between 1st January 2012 and 31st December 2017; 14 patients were excluded (13 deceased, 1 learning difficulties). The percentage of children aged 3–12 years taking tablets in 2012 and 2013 was 41% (n=7) and 20% (n=2) respectively. This increased to 69% (n=11) in 2014, remained consistently above 60% in 2015/2016 and increased again to 76% (n=14) in 2017. Between 2014 and 2017, 100% of patient's ≥ 6 years took their oral chemotherapy as tablets. Over 65% of all patients 0–18 years were taking liquids in 2012/2013. From 2014 to 2017 less than 50% of all patients each year were taking liquids. No patients were identified as switching back from tablets to liquid.

Conclusion This study supports an interdisciplinary approach to tablet taking. By bringing together different members of staff with the necessary knowledge, skills and experiences, we were able to provide families with the tools and confidence to support their child in mastering the technique of swallowing tablets, increasing the number of patients initiating on or transitioning to solid oral dosage forms by approximately 50%.

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INCIDENTS INVOLVING PAEDIATRIC PARENTERAL NUTRITION

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Aim Parenteral nutrition (PN) is one of the medications most frequently reported to be involved in medication errors in hospital.¹ PN is a class of high alert medications listed by The Institute for Safe Medication Practices.² Medication errors involving PN may have potentially serious consequences especially in infants.³ The purpose of this study was to determine the type of incidents reported, who reported it, severity of incidents and the part of the process involved in the error with the aim of ensuring quality and safety in PN processes.

Method The incidents involving PN reported on the Ulysses system in a specialist children's hospital were surveyed

between April 2018 and March 2019. Incidents were assigned to different error-type categories. We focused on the whole process of prescribing, transcription, preparation, and administration of PN. Severity classification was based on the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) index.⁴

Results There were 34 incidents involving PN ranging from 1 to 8 per month. Job titles who reported these incidents were nurses (16 incidents), pharmacists (14 incidents), dieticians (2 incidents) and unknown (2 incidents). The most common types of incidents were omitted medicine/dose (7 incidents), labelling error (6 incidents), wrong quantity supplied (4 incidents) and wrong/unclear dose (4 incidents). The processes during which the incident had occurred were administration/supply of a medicine (14 incidents), preparation of medicines/dispensing in a pharmacy (13 incidents) and prescribing (7 incidents). The majority of incidents (82.4%, 28/34) were assigned category C (no harmful consequences), while 14.7% (5/34) and 2.9% (1/34) were assigned to category B (an error occurred but the error did not reach the patient) and category D (an error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm) respectively. The following actions have been taken to try to prevent error with PN: training, providing information, introduction of new labels, changes to the profiles on infusion pumps, reinforcing independent checking and the increased use of standard PN solutions.

Conclusion Nurses and pharmacists are the main reporters of incidents of PN. Omitted medicine/dose is the most common incident reported. The majority of errors involved administration of PN. The majority of all incidents did not cause harm to patients.

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PHARMACY DISCHARGE SERVICE TO FACILITATE EARLY DISCHARGES AND TO IMPROVE THE QUALITY OF ELECTRONIC DISCHARGE LETTERS (EDL'S)

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Aim The current discharge process on the paediatric wards involves transcribing medications from one electronic system to another, this has led to errors and compromises patient safety. Discharges are also sometimes delayed due to patients waiting for their medications. The newly implemented discharge service involves pharmacists working closely with the medical team to identify patients for discharge as early as possible and to accurately transcribe medications onto the electronic patient record (EPR).