INCIDENTS INVOLVING PAEDIATRIC PARENTERAL NUTRITION

Between 2014 and 2017, 100% of patient PN was reported to be involved in medication errors. This increased again to 76% (n=14) in 2017. The majority of incidents of PN. Omitted medicine/dose is the most common 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. The majority of all incidents did not cause harm to patients.

REFERENCES

P25 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. PN is a class of high alert medications listed by The Institute for Safe Medication Practices. Medication errors involving PN may have potentially serious consequences especially in infants. 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.

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.

REFERENCES

P26 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 transccribing 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).
**Method** The pharmacist would attend the consultant-led morning handover or would liaise with the nurse in charge on the ward to establish discharges and transfers for that day or over the weekend if on a Friday. The most urgent discharges and any complex patients were prioritised. The EPR system would be used to generate the EDLs, transcribe the medicines for discharge and add any relevant written information. Any medication related issues would be clarified with the medical team. The prescription would be handed over to the medical team to be reviewed and signed. This would then be dispensed and checked by the pharmacy team. The patient/parent or carer would be counselled on their medications. Data was collected from November 2018 – March 2019, this included time informed about discharge, time EDL started, time EDL printed and time EDL completed. Other data collected included if any additional written information was provided to the GP and if any amendments were required after the doctor had reviewed the prescription. The data was inputted into an Excel spreadsheet and was compared against August – October 2018.

**Results** 152 discharge prescriptions were included in the service. The data was compared to the data from August – October 2018 which showed more than double of the prescriptions were completed in the morning between 9am-12noon (compared to 12noon-5.30pm) since the service started. Less prescription needed amendments at the point of screening and more prescriptions included additional medication related information. The quality of the prescriptions had improved and completing prescriptions earlier meant timely discharges, improved bed utilisation and improved patient quality. Positive feedback was given by patients, doctors and nurses as well as the rest of the ward teams.

**Conclusion** Communication has improved between the hospital and community care, as well as patient satisfaction and bed availability. A future development would be to introduce prescribing pharmacists within medical teams to streamline the discharge prescription process further, freeing up medical time and increasing the focus on medicines optimisation for all patients.

**REFERENCE**


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**P27 IMPACT OF HAVING A PAEDIATRIC MEDICINES MANAGEMENT PHARMACY TECHNICIAN IN A DISTRICT GENERAL HOSPITAL**

Rebecca Le Maistre*. Northampton General Hospital

10.1136/archdischild-2020-NPPG.36

**Aim** Patients are more likely to experience a ‘medicines-related safety incident’ when medicines reconciliation happens more than 24 hours after admission to an acute setting,1 according to the National Institute for Health and Care Excellence (NICE). The study aimed to assess the impact on medicine reconciliations following the introduction of a dedicated Paediatric Medicines Management Pharmacy Technician to the paediatric wards at a District General Hospital (DGH).

**Methods** Data has been routinely collected by the pharmacy department over a number of years showing the time of medicines reconciliations compared with the time of hospital admission. This data shows the number of medicine reconciliations that were completed within 24 hours of hospital admission and the number that were not completed within 24 hours. The data is routinely collected on the Thursday of the first full week of every month. All patients that were admitted to the paediatric wards were included in this data. The service is only funded Monday to Friday through the Child Health Department of the DGH. This data excludes neonates admitted to the Neonatal Intensive Care Unit. Data was collected from 83 paediatric patients in March/April/May 2017 and 78 paediatric patients in March/April/May 2019.

**Results** Data collected for the paediatric patients over March/April/May 2017 showed that around 21.7% of all paediatric patients admitted to the wards had a completed medicines reconciliation within 24 hours. The data collected over the same period in 2019 showed that 85% paediatric patients admitted to the wards had a completed medicines reconciliation within 24 hours.

**Conclusion** This study was useful in demonstrating the effectiveness of introducing a dedicated Paediatric Medicine Management Pharmacy Technician to the paediatric wards in a DGH. It showed that the proportion of medicine reconciliations within 24 hours prior to the change was very low, but after the change it was very high with nearly all patients having a completed medicines reconciliation within 24 hours. Prior to the introduction of a dedicated Paediatric Medicines Management Pharmacy Technician, the paediatric wards at this DGH were not meeting the standards set by NICE regarding medicines reconciliations within 24 hours of being admitted to an acute setting. After the introduction the paediatric wards were meeting these standards. By meeting NICE guideline QS120 Medicines Optimisation, the DGH has reduced the likelihood of medicines-related safety incidents. With the introduction of a dedicated Paediatric Medicines Management Pharmacy Technician there have been many other benefits. These include counselling to parents/children on the use of their medicines; checking of patients’ own medicines to see if they are still fit for purpose; advice to parents about unlicensed medicines and why they are used; where to obtain further supplies when new medicines have been started; and assisting parents and GP surgeries with any supply issues.

**REFERENCE**


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**P28 GENTAMICIN-RELATED INCIDENTS IN NEONATES BEFORE AND AFTER THE INTRODUCTION OF ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION (EPMA)**

Kimberly Mak*. Leeds Teaching Hospitals NHS Trust

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**Aim** Gentamicin is widely used to treat early neonatal sepsis as part of a regimen recommended by NICE.1 However, it is frequently implicated in clinical incidents relating to errors in prescribing and administration. This project aimed to evaluate whether the introduction of ePMA had an effect on the frequency and type of incidents that occur relating to the use of gentamicin in neonates.

**Method** A paper gentamicin prescription chart was used from July 2013 until the implementation of ePMA on 28th January 2019. Using ePMA, prescribers were encouraged to use a pre-set template for ‘neonatal early onset sepsis’,