A MODEL FOR REDUCING PAEDIATRIC PRESCRIBING ERRORS IN SECONDARY CARE

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**Background** A prescribing error is a preventable error that may lead to inappropriate medication use and patient harm (1). Prescribing errors are particularly important in paediatrics where dose calculations are complicated and small errors can result in significant morbidity and mortality. In 2017 pharmacy data showed that paediatric prescribing errors were an issue at our Hospital regarding the severity and high numbers of errors, especially for antibiotics and analgesia.

**Objectives** To achieve a zero prescribing error rate for paediatric within the hospital.

**Method**

1. Form the Paediatric Medication Errors Prevention (PMEP) group consisting of the Paediatric Consultant, Paediatric Pharmacist, Children’s Assessment Unit Sister and Practice Education Senior Nurse.
2. Paediatric Pharmacist to record and feedback all paediatric prescribing errors weekly at Doctors’ handover.
3. Paediatric Pharmacist/Nurses to DATIX report all significant medication prescribing errors.
4. Paediatric Pharmacist to produce monthly pharmacy prescribing newsletter.
5. Paediatric Pharmacist to produce quick reference charts for the drugs with the most common prescribing errors e.g. antibiotics and analgesia.
6. Paediatric Doctors to request a second check from another Doctor or Ward Sister when prescribing any medication on the drug chart of take home prescription.
7. Paediatric Pharmacist to target Doctors’ induction to improve prescribing and implement a prescribing test.
8. Doctors to complete reflections for errors with their educational supervisors.

This study did not require ethics approval.

**Results** Following implementation of the above strategies, there was a 33% reduction in the number of prescribing errors recorded by the Paediatric Pharmacist daily intervention log from 2017/2018 to 2018/2019. There were 163 prescribing errors for 2017/2018 compared to 110 for 2018/2019.

**Conclusion** The formation of the PMEP group and implementation of strategies to reduce paediatric prescribing errors has positively impacted on reducing the error rate at the hospital. It has also raised awareness of the necessity to report all errors and actively find ways to prevent these from re-occurring. Further work is required to reduce these errors to zero including targeting non paediatric teams prescribing on paediatrics and implementing Pharmacists prescribing on consultant ward rounds. Future work would also include replicating this model in other specialties e.g. neonatal intensive care to achieve the same success rate in reducing medication errors.

**REFERENCES**