obtaining supplies, likely cost and the risk of confusion between propranolol base and hydrochloride when prescribing and dispensing. Preparations B and C are suitable for use in children over 1 month of age. Preparation C is recommended because it contains less propylene glycol and no alcohol. Preparation A should only be used in children under 28 days. Using Preparation C instead of Preparation A gives the benefits that a licensed preparation is used, dispensing delays are reduced and costs are reduced.

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A BASELINE REVIEW OF THE ACTIVITY OF THE PICU PHARMACISTS USING ELECTRONICALLY CAPTURED DATA

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Aim To date there are no metrics for the clinical pharmacist service to PICU. It is accepted that use of a Clinical Information Management System (CIMS) has a role in medication safety,¹ however there are few studies that review the information potential of a CIMS for collecting pharmacist activity.²

Method Additional fields and custom reports were configured in the CIMS to enable PICU pharmacists to record their activity in the following areas:

- Medicines reconciliation within 72 hours of admission to PICU
- Discharge kardex review
- Analgesia and sedation (A&S) review
- Clinical pharmacy review

Other interventions & medication error reporting continued as per normal practice. Data was analysed using Microsoft Excel®.

Results Complete data was available from July 2017 to end of 2018.

There were 1274 medicines reconciliations by a pharmacist within 72 hours of admission (78% admissions). 14% of discharge kardexes had been reviewed prior to discharge to the ward. There was an average of 190 pharmacy reviews per 100 bed days. A total of 780 Pharmacist A&S Plans were documented by the clinical pharmacists – an average of 2 per working day, and 48% of admissions.

Comparisons between each six month period showed a significant increase in the number of pharmacists medicines reconciliations ($p < 0.001$). No other differences were found.

Conclusion This study has shown that electronic tracking of pharmacist ward activity is possible. It has the potential to demonstrate compliance with external or internal standards

and audits. This data continues to be collected, and therefore these results will be used as a baseline to compare future activity. The findings of this study may encourage other units to replicate, providing data that can be used for comparison. Further configuration of the CIMS to capture other metrics such as TDM, and document discrepancies in medicines reconciliation is planned.

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A REVIEW OF THE USE OF INTRAVENOUS IMMUNOGLOBULIN (IVIG) IN PAEDIATRIC NEUROLOGY PATIENTS AT A CHILDREN'S HOSPITAL FROM APRIL 2017 TO APRIL 2019

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Aim To determine if the use of IVIG in neurology patients at a children's hospital was appropriate according to local¹ and national guidance^{2,3}.

Method All paediatric neurology patients supplied with IVIG from the hospital pharmacy from April 2017 to April 2019 were identified retrospectively using the pharmacy dispensing system. The standards were based on local and national guidelines from the Department of Health (DoH). Patients' details, for example indication and dose, were recorded and analysed on Microsoft Excel.

Standards

1. 100% of patients will have an IVIG request form completed.
2. 100% of patients will have IVIG prescribed for indications approved by the DoH.
3. 100% of patients will have panel approval before being supplied with IVIG.
4. 100% of patients will have the appropriate dose and duration of IVIG for the corresponding indication according to guidelines.

Results A total of 20 patients were identified for this audit with 4 patients from 2017/18 and 16 from 2018/19. Standard 1 was met by 100% of patients. 8 patients (40%) were given IVIG for indications that do not have automatic approval from the DoH guidelines, i.e. for indications under 'grey' or 'black' categories. 2 patients (10%) did not have panel approval and both of these patients had acute flaccid myelitis, which is a 'black' indication. 16 (80%) patients were prescribed IVIG at a dose or duration advised by local and DoH guidelines.

Conclusion and Discussion During the study period the method for completing the IVIG request forms changed to a new electronic system. The two patients with acute flaccid myelitis were incorrectly approved by the IVIG panel due to an error in the new electronic request form. The approval system was updated to prevent this error from reoccurring. All other patients that did not have automatic approval from the DoH guideline were approved by the local IVIG panel before use. Overall cost and usage increased significantly from