through use of a standard template to decrease identified deficiencies.

Aims

- Increase use of a standardized template for DS to >90% in 6 months
- Improve quality of DS to >85% in 6 months
- Achieve the state of no deficiencies in the DS to >80% in 6 months.

Methods

Study Design: Prospective PDSA (Plan, Do, Study, Act) cycle-based Quality Improvement Project.

Study Setting: 54 bedded quaternary level NICU, Doha, Qatar.

Study Period: January 1, 2019 to December 31, 2019.

Phase 1: January to May 2019: Pre-intervention phase: Conducted an anonymous DS survey and audit and provided education on improving DS qualities in several team group meetings

Phase 2: June to August 2019: Intervention phase: Designed new DS template and implemented in daily care along with other interventions bundle

Phase 3: September to December 2019: Post-intervention phase: Regular monthly audit or quality check and feedback

Definitions Template: A structured DS processes and framework.

Quality: The standard of the DS measured with apriori outcome measures.

Deficiencies: Missing or inaccurate required information on DS documentation.

Results

Abstract G86 Table 1

Outcome measures (mean%)	Pre-Intervention	Intervention	Post Intervention
	Jan to May 2019	June to Aug 2019	Sep to Dec 2019
Use of standard DS template	10	85	90
Quality of DS	40	75	85
No deficiencies in DS	50	85	95

Conclusion The NICU DS quality improvement project initiative achieved the goals of improved DS quality, increased use of a standardized template for DS, and decreased the deficiencies in DS. Going forward, we plan to continue with regular audits to maintain DS quality.

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IT'S A 'DRUGGLE': REDUCING DRUG ERRORS AND DISSEMINATING LEARNING

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Aims Our aim was to improve team awareness of medication errors on the general paediatric ward by June 2019. We hoped that this would:

- Improve safe prescribing;
- Reduce medication errors.

Methods An audit revealed frequent and serious administration and prescribing errors on the general paediatric ward. Over a

half were administration errors and a third were prescribing errors.

Other trusts have implemented discussions around drug errors known as a 'Druggle'. We have replicated the idea but adapted it to make it relevant to our trust.

A multipronged, multidisciplinary intervention was planned using a PDSA approach which included:

- implementing a weekly Druggle, to be attended by the multidisciplinary team (MDT). The purpose of our Druggle is to review all the drug errors and near misses from the previous week with discussion and action points on how to reduce the likelihood of the errors recurring;
- dissemination of learning points from the Druggle;
- restructuring the paediatric prescribing induction.

Outcome measures:

- weekly attendance at the druggle;
- dissemination of learning;
- restructure of the paediatric prescribing induction;
- total number of drug errors (as recorded on Datix).

Results Our run chart demonstrates that a steady increase in attendance at the Druggle, now maintained at 100% for a number of months. There was a temporary fall in attendance when there was a change in the staff leading the project, which resolved with new leadership.

Learning is disseminated at nursing huddles and highlights in the monthly governance letter.

The paediatric prescribing induction has been restructured to test basic paediatric prescribing skills and prescriptions to be successfully completed on the electronic prescribing system.

There has been a sustained reduction in drug errors over time with an overall 24% reduction in administration and prescribing drug errors comparing the 8 weeks pre and post-intervention.

Conclusions Drug errors are trending downwards with nearly a quarter reduction in errors. This project is particularly valuable as the education is ongoing and weekly action taken.

There were several challenges and areas for learning: finding a convenient location and time; MDT involvement in planning and implementation; encouraging pharmacy to take ownership and the need for a project lead to ensure sustainability.

G88(P)

ADVANCING ACCESS TO ADVANCE CARE PLANS

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Introduction The Paediatric Advance Care Plan (PAC-Plan) supports families in exploring understanding of the multi-agency response to death. This record of conversations helps support families and clinicians to make decisions during often fraught and difficult circumstances at the end of life. In practice its effectiveness is often restricted because in times of crisis it cannot be found.

The aim of this quality improvement (QI) project was to improve access to PAC-Plans a) for out-of-hours medical staff in our local district general hospital, where such crises might occur, and b) by the Paediatric Palliative Care team from across the region.