wards and medical & nursing staff was updated via regular teaching and educational sessions.

We completed one audit cycle by retrospectively reviewing 20 patient medical notes each time (May-June 2019 & August-September 2019).

Results Our first audit showed that only 20% (4/20) patient notes had a co-morbidity sheet whereas the re audit post educational sessions helped to improve it to 75% (15/20).

Since implementing the co-morbidity sheet and using it regularly from April 2019, our low bracket coding (between 0–1 co morbidity) reduced from 40% to 27%; mid bracket coding (2–5 comorbidities) improved from 47% to 54% and the highest bracket coding (6+ co morbidities) improved from 13% to 19%. Overall this resulted in a financial gain of £195,000 since the implementation of co-morbidity sheet.

Conclusion Comorbidities are conditions that are present in association with a current illness with which a patient is admitted. It is very important to document comorbidities in clinical notes and discharge summaries which can then be coded accurately. This in turn helps to secure appropriate funding to provide appropriate and effective patient care. Our experience shows that using a comorbidity sheet based on common health conditions helps clinical as well as coding staff to improve clinical coding. Regular updates via educational sessions about the benchmarking data and PDSA cycles are key to sustain this improvement.

G106(P) ABSTRACT WITHDRAWN

G107(P) REDUCING PARACETAMOL MEDICATION ERRORS IN CHILDREN

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Introduction Paracetamol is one of the most common medicines administered to children nationally. Accidental overdoses with intravenous (IV) paracetamol in children <10 kg have been reported, including fatalities. High numbers of medication incidents (MI) involving prescribing and administration of paracetamol on paediatric inpatient wards were reported. To reduce the level of harm the multidisciplinary team reviewed incident trends and implemented selected interventions.

Method MI were recorded and reviewed retrospectively every quarter (Q) from Q1 March-May 2018 to Q2 July-Sept 2019. Ethics approval was not required for this study. Selected measures were then used to track changes in incident numbers and trends on implementation of intervention.

Measures

- Number of paracetamol incidents
- Level of harm
- Incident type – categorised into trends.

Intervention 1 (Q3 October-December 2018) Paracetamol medication safety bulletin, highlighting risks associated prescribing paracetamol in children was circulated to staff. Standardised dosing approved in cross-site guideline. Targeted staff education around incident data, trends and top tips. Removal

of multi-route screens on the electronic prescribing system to reduce number of IV paracetamol prescriptions.

Intervention 2 (Q1 March-May 2019) Introduction of dose/volume checks for intravenous paracetamol included in the paediatric IV guide.

Results

Intervention 1

- 75% reduction in number of paracetamol errors. A 65% reduction in the total percentage MI involving paracetamol.
- 50% reduction in number of MI with a reported level of harm, the level of harm remained the same
- 100% reduction of oral dosing errors. 50% reduction in number of IV dosing errors for babies <10 kg and 40% reduction in duplication of doses.

Intervention 2

No reported IV paracetamol dosing errors for babies <10 kg in Q1-2 2019.

Conclusion A significant level of harm has been reported with paracetamol MI in children. Regular review of MI numbers and trends, with targeted education and standardisation of practice can reduce number of MI, including those causing harm. Increased risk of adverse effects of paracetamol overdose in children means the level of harm was not reduced. Future work is needed to reduce incident numbers involving dose duplication.

G108(P) IMPLEMENTATION OF A PROLONGED JAUNDICE PATHWAY: A QUALITY IMPROVEMENT INITIATIVE. TIME FOR NICE TO HAVE A RETHINK!

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Introduction Prolonged neonatal jaundice (PNJ) is mostly benign and self-limiting; however, it could represent a serious pathology such as biliary atresia; timely identification of which is vital. NICE guidance is available on PNJ, however, hospital referrals of all such infants can lead to over-investigation, unnecessary pressure on hospital resources and undue parental anxiety. Hence, there needs to be a fine balance between over-investigating well infants and timely detection of serious pathology.

Background Previously, all cases of community diagnosed PNJ were referred to consultant clinic in our tertiary neonatal unit. An audit in 2013 (Jan-Dec) revealed a high number (222) of such referrals. Of these, 38% were not even clinically jaundiced at the time of clinic attendance. The rest had unnecessary investigations-91% and 61% had liver and thyroid function tests respectively; not recommended by NICE.

Aim The above audit prompted a quality improvement initiative of implementing an alternative pathway to streamline PNJ referrals in Sep'15. As per the pathway, community midwives perform direct and indirect bilirubin on infants and refer only if any of the following criteria are met- not thriving, pale stools, total bilirubin >200 ummol/L, direct bilirubin >20 ummol/L or worsening jaundice despite blood test.

Method A re-audit was performed in May'19 to evaluate the efficacy of the pathway over 3 years (Mar'16-Feb'19) and to assess any delay in diagnosing serious pathology.

Results Table 1 compares results before and after implementation of PNJ pathway.