ABSTRACTS FROM THE NEONATAL AND PAEDIATRIC PHARMACISTS CONFERENCE 2021

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Oral presentations

SP1 USING KOTTER'S CHANGE MODEL TO REDUCE PAEDIATRIC PRESCRIBING ERRORS

Ashifa Trivedi*, Richa Ajitsaria, Tristan The Bate. *Hillingdon Hospitals NHS Foundation Trust*

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Aim We describe a quality improvement project to reduce the paediatric prescribing error rate on a paediatric ward in a district general hospital. The project is called STAMP (Safe Treatment and Administration of Medicine in Paediatrics) and was started in 2016. In 2017 the local error rate was 5.2% (average monthly error rate) and decreased to 3.8% in 2019. Despite these earlier interventions the error rate has since not improved and in 2020 the error rate increased to 4.4%. Using Kotter's Change Management model[1] our aim was to decrease the prescribing error rate by 20% (from 4.4% to a target of 3.5%) by August 2021.

Method The paediatric pharmacy team collected weekly error data from December 2016 to August 2021. Reynolds et al[2] report that hospital doctors are often unaware of their errors. As a result of this Reynolds et al developed a questionnaire to better understand the attitudes and perceptions of prescribers with regards to prescribing errors. Permission was asked if we could use the questionnaire locally and this was given to us.

The questionnaire was emailed to all paediatric prescribers, including non-medical prescribers, in September 2020. 97% (30/31) of respondents felt that the number of prescribing errors can be reduced. However, 65% (20/31) of prescribers said that they feel they do not make a significant number of prescribing errors. The results of the questionnaire helped us to better understand why prescribing errors happen and changed the way errors were fedback to prescribers. Interventions included paediatric pharmacy teaching at induction, reporting of weekly error rate, 'spot the error' quizzes and individual feedback given to prescribers. Prescribers were asked if they were happy to receive feedback via email if we were not able to give face to face feedback.

Results The project has been able to achieve a reduction in error rate to an average of 2.1% (from September 2020 – July 2021) compared to an average error rate of 4.4% the previous year. The aim was to reduce the error rate to 3.5% or below and we have been able to achieve this constantly since October 2020. There have been four weeks where there have been no errors on the ward.

Conclusion This project demonstrates that Kotter's model can successfully be used in healthcare to reduce prescribing errors. Our most successful interventions have been paediatric pharmacy teaching at induction and emailing individual feedback to prescribers.

REFERENCES

1. Kotter JP. Leading change. Boston, MA: Harvard Business Review Press; 2012.
2. Reynolds M, Jheeta S, Benn J, *et al*. Improving feedback on junior doctors' prescribing errors: mixed-methods evaluation of a quality improvement project. *BMJ Quality & Safety* 2017;**26**:240-247.

SP2 NPPG/RCPCH POSITION STATEMENT: USING STANDARDISED CONCENTRATIONS OF UNLICENSED LIQUID MEDICINES IN CHILDREN. HOW WELL HAS IT BEEN ADOPTED NATIONALLY?

[1]Andrew Wignell*, [2]Helen Cooper, [3]Jennifer Duncan, [3]Andrea Gill. [1]*Nottingham Children's Hospital*; [2]*Evelina London Children's Hospital*; [3]*Alder Hey Children's NHS FT*

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Aim In 2018, the Neonatal and Paediatric Pharmacists Group (NPPG) and Royal College of Paediatrics and Child Health (RCPCH) published a Position Statement recommending use of standard concentrations for 20 unlicensed medicines. The current version of this document contains recommendations for 12 of the original 20; the remainder having been removed due to introduction of licensed products.[1] This project aimed to assess the extent to which the current list has been adopted nationally, and to identify any barriers to its implementation.

Method A survey was developed using *Microsoft Forms* before email circulation to all NPPG members, asking them to share the survey with non-member colleagues who had been involved with local discussions and/or implementation of the recommendations. The survey was open for two weeks.

Participants were asked if they were aware of the recommendations. Those who answered 'no' were asked no further questions; those answering 'yes' were asked to indicate if each of the 12 recommended concentrations was in use locally, and whether or not this was as a result of the publication. If a conscious decision had been taken not to adopt the concentration for a particular drug, respondents were asked to indicate if this was in favour of an alternative concentration, a non-liquid formulation or because the drug is not used locally. Multiple options could be selected for each drug.

Respondents were then asked to detail any difficulties experienced in adopting the recommended concentration for particular drugs, or the list as a whole; and to suggest ideas which would support implementation if the list were to be extended in future.

Results 108 responses were received. 73 respondents (67.6%) were aware of the publication and provided feedback for the 12 recommended concentrations. Responses for a selected 4 of the 12 medicines were as follows:

Spironolactone: 88.3% were using the recommended concentration; of those 24.4% reported adding it to a local formulary as a result of the list; 11.6% were unsure when it was added.

Phenobarbital: 86.7% were using the recommended concentration; of those 19.3% reported adding it to a local formulary as a result of the list; 8.4% were unsure when it was added.

Chloral Hydrate: 94.4% were using the recommended concentration; of those 11.1% reported adding it to a local formulary as a result of the list; 13.6% were unsure when it was added.

Sodium Chloride: 72.8% were using the recommended concentration; of those 11.1% reported adding it to a local formulary as a result of the list; 11.1% were unsure when it was added.

Common reasons given for not adopting a recommended concentration were a licensed product existing of a different