there may be a lack of uniformity in drop volume delivered which could lead to dose variability.

Conclusion Despite the increasing availability of licensed preparations with assured quality, use of unlicensed preparations to fulfill VDO prescriptions has continued in primary care in England. Unlicensed VDO preparations marketed showed wide variations between measured and declared vitamin D contents. Younger children who are more vulnerable to harm are thus exposed to unnecessary risks of under- and over-supplementation.

REFERENCES

P14

IDENTIFICATION OF PRESCRIBING ERRORS IN A PAEDIATRIC INTENSIVE CARE UNIT (PICU): AN AUDIT
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Aim To identify the nature, frequency and incidence of prescribing errors on a PICU.

Method Electronic intervention data was collected over a two-week period for all patients admitted to or currently on the PICU. A purposefully designed electronic data collection form was developed using Microsoft Excel and piloted by the researchers in advance of commencing the audit to ensure fitness for use. Data was collected in the moment and retrospectively as outlined below. A daily patient list was generated, and the following information extracted from the patient’s medication chart: total number of items prescribed each day and the proportion of those that were new. Only patients present in the unit were included in the data collection. Pharmacist interventions are recorded electronically each day. The numbers of interventions reported daily for the study were collected retrospectively from the pharmacy intervention system. The route of administration, type of error, drug, category of harm and prescriber identity to ascertain which shift the error occurred on were also extracted.

Results PICU did not operate at full capacity (24 beds) during the audit period, overall data for 39 patients was captured. Patients ranged from 0 to 15 years of age and had been admitted to the unit for a variety of surgical, medical and trauma-related reasons. A total of 36 interventions were reported giving an intervention rate of 9.2% per patient and 2.3% per number of prescriptions reviewed. The number of interventions appeared to correlate with the number of items prescribed (none of the prescriptions with 15 or less items required intervention). Many patients within the unit are nil-by-mouth and 77.5% (n=31) of the interventions reported were associated with medicines prescribed via the intravenous route with intravenous antibiotics accounting for 52.5% (n=21) of the total interventions reported. Most errors occurred during a long day shift and were near misses that did not reach the patient.

Conclusion The results show that the incidence of prescribing errors per patient was high but per number of prescriptions this is lower than comparable studies.1 Prescribing errors were most common for antimicrobial and intravenous medication and therefore these should be the focus of future reforms. The next steps will include a multidisciplinary team meeting to identify potential causes of error and solutions to overcome these. These are likely to reflect those reported in the literature such as raising awareness of errors, educational prescribing sessions, introduction of prescribing prompts, and a new system approach such as electronic medicines administration and prescribing systems, all of which have proven efficacious in reducing prescribing errors on PICUs.2 In order to implement and determine the impact of any changes a quality improvement approach of plan-do-study-act cycles will be adopted.3 This will help us meet the Trust target of a 20% reduction in errors.

REFERENCE
DRC software aims to reduce dosing errors, however, it is concerning to see that several significant and serious prescribing errors occurred despite an alert generation. This potentially suggests that alert fatigue may counteract the error preventing effects of DRC alerts. Therefore, further refinement of DRC systems is required to reduce alert fatigue. Unfortunately, increasing the acceptable dose range limits from 5 to 10% does not appear to be a simple way of sorting this problem. Removing ‘missing value’ alerts would significantly reduce the number of alerts generated. Including in-house guidelines alongside BNfc dose recommendations into the DRC software would also reduce unnecessary alerts.

REFERENCES

P18 ROLE OF THE PHARMACY TEAM IN PAEDIATRIC PALLIATIVE CARE
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Background In 2016, NICE published a guideline on ‘End of life care for infants, children and young people with life-limiting conditions: planning and management’. These guidelines recommended that pharmacists should be embedded in every paediatric palliative care team.

Aim To identify the roles of pharmacy teams in paediatric palliative (PP) care and examine the effectiveness of their services as perceived by PP doctors and nurses. To compare 2020 survey results with a study conducted in 2014 by Khan et al to assess whether any changes could be observed.

Method This was a repeat of the study conducted in 2014 by Khan et al. A SurveyMonkey link was emailed to members of the APPM (Association for Paediatric Palliative Medicine) and NPPG (Neonatal and Paediatric Pharmacists Group) as well as to community pharmacies working closely with local children’s