asked about the problems the most common response being supply of medicines or administration difficulties. 79% reported that parents/carers at their hospital were given the opportunity to administer medicines whilst their baby was an inpatient.

Conclusion Preliminary results show there is room for improvement with the information and support provided to parents/carers. The timing that the information is provided is key with 'throughout the hospital stay' being the most popular parent/carer response however, only 24% of HCPs reported information being given throughout the hospital stay. Both groups identified some of the same challenges.

P01 REDUCING INTERRUPTIONS DURING ADMINISTRATION OF MEDICINES TO CHILDREN

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Aim Many studies have identified that interruptions occur frequently during administration of medicines and may cause errors.[1–3] Bundles of interventions aimed at reducing interruptions have been investigated in adults.[4] This study aimed to determine whether a 'Do not interrupt' bundle of interventions on paediatric wards, would reduce the number of interruptions to medicines administration and whether this would reduce the number of administration errors reported.

Method Six paediatric wards in a specialist children's hospital was included in the study. Three were designated as 'control' wards and 3 as 'intervention wards'. Baseline observations were undertaken on all 6 wards prior to the introduction of a 'Do not interrupt' bundle on the intervention wards. Four weeks later observations were repeated on all 6 wards. Electronic surveys were circulated to staff before and after the introduction of the bundle.

The 'Do not interrupt' bundle consisted of staff education; information for parents/patients; red aprons; banners; posters and 'Distraction free zone' floor stickers.

Results Red aprons were worn during 82% episodes of medicines administration on the intervention wards compared with 43% on the control wards. 92% of medicines were prepared in a designated 'distraction free zone' on the intervention wards.

There was at least 1 interruption during medicines administration for 69% of patients. The number of interruptions per 100 patient episodes reduced from 157 to 135 (14%) on the intervention wards compared to an increase from 191 to 218 (14%) on the control wards. Nurses were most often observed to be responsible for causing interruptions (48%) compared with other staff, parents/patients, buzzers etc. The most common types of preventable interruptions on all wards were social conversation and missing equipment or keys. Use of 'distraction free zones' did not prevent interruptions.

Reported administration error incidents increased from 2 to 7 per month (350%) on the intervention wards and from 4 to 15 (375%) on the control wards. This increase corresponded with an increase in activity and winter pressures across the hospital.

15% of nurses responded to the electronic survey. 76% thought the bundle did not make a difference, however 85% wanted the interventions to continue. Nurses disagreed with the finding that they were the most common cause of interruptions.

Conclusion Use of red aprons increased following introduction of the bundle indicating it did have some effect. Overall, interruptions occurred more frequently than expected. Interruptions appear to have reduced on the intervention wards although this wasn't significant. Nurses were the most common cause of interruptions although they thought other staff and parents were. Many interruptions happened when medications were prepared near the nursing station, despite these being 'distraction free zones'. The bundle does not appear to have influenced the number of administration errors reported.

The 'Do not interrupt' bundle requires revision prior to trust-wide roll out. This will include provision of more education for staff, especially nurses, regarding interruptions; a focus on the awareness of preventable interruptions and strategies to avoid preparation of medicines at nursing stations.

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P02 USE OF INTRATHECAL FLUORESCEIN TO IDENTIFY CEREBROSPINAL FLUID (CSF) RHINORRHEA IN PAEDIATRICS: A CASE REPORT AND LITERATURE REVIEW

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Early identification of CSF rhinorrhoea can reduce the risk of meningitis and potentially decrease the length of hospital stay. To determine the exact site of leak, intrathecal fluorescein (IF) is frequently used as a diagnostic tool adjunct to repair surgery in rhinorrhea. Although this is generally considered safe, there is a slight risk of seizures, radicular symptoms such as numbness and transient paraparesis.[1]

Miss. AB, a 20 month old child weighing 11.6kg with history of traumatic subdural collections was admitted with episodes of absence seizures, ataxia and unresponsiveness. Initial investigations involved an electroencephalogram which reported a normal background rhythm. A follow up MRI scan reported no definite site of abnormal CSF leak to confirm the working diagnosis. Hence, IF was proposed as a diagnostic tool to identify the location of a possible leak. The pharmacist conducted a therapeutic review with the aim of appraising existing evidence for the use of IF in paediatrics.

A total of 12 articles were identified using Medline and Embase. 5 case series and 1 case report were selected for further review to determine the safety profile, optimal dose and appropriate formulation for the diagnostic procedure. Studies showed at lower concentrations, with doses ranging from 25-100mg the rate of minor complications such as