Abstracts

development. A range of care units, clinically judicious limits, weight bands and therapeutic categories were designed to accommodate diverse paediatric and neonatal populations. Agreed parameters were manually input to the CMS before exporting as files for pump upload. For each iteration, drug library files are uploaded onto infusion pumps for testing and verification against CMS-exported reports, ensuring rigorous validation processes. Reference material and rationale for decisions were made and stored using a commercial medicines information software application.

Results A master library containing 216 drug lines within 7 specialty-specific care-units and 7 therapeutic categories across 5 weight bands was developed. Drug lines included: majority of commonly used medications (both continuous and intermittent, including loading and bolus doses), parenteral nutrition, IV fluids and blood products. This represented a 270% increase on the originator paediatric library. Individual drug libraries were developed for use in: tertiary paediatric sites (with PICUs), maternity hospitals (with NICUs/Special-care baby units), adult ICUs/regional hospitals. Supporting documentation, including training materials, standard operating procedures, and SCI tables were developed. Updates to the relevant monographs of the lead site’s paediatric formulary, available as an app and on hospital desktops, were made to reflect drug library contents. Implementation has occurred in all paediatric intensive care units (PICUs) and tertiary paediatric emergency departments (EDs), paediatric and neonatal transport services and 6 of 19 neonatal sites. Implementation into the pilot adult ICU is due in Q3 2021, with phased implementation into remaining neonatal sites, adult ICUs and EDs of regional hospitals planned.

Conclusion Optimisation of smart-pump CMS functionality can support development of comprehensive drug libraries suitable for use in a range of clinical settings. Centralised processes, with dedicated pharmacy resources, are key to standardisation of infusion processes at a national level in line with internationally recognised best practices.1–3

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P32 CHILDREN’S HOSPITAL DISCHARGE COLLABORATIVE: GETTING HOME IN TIME FOR TEA

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Aim The Children’s Hospital Discharge Collaborative (CHDC) team are a multi-disciplinary group of staff members passionate about improving the quality and efficiency of our discharges. The aim of this project is to increase the number of patients being discharged within working hours in order to facilitate a safe return to routine for families, improve patient flow within the hospital and ultimately improve patient experience.

Method As a collaborative we have trialled interventions in ward areas, learnt what works and what needs improvement, all of which has enabled us to roll out evidence based changes throughout the Children’s Hospital. We have held monthly meetings and received good engagement from ward areas and a broad range of specialties which has meant that we have collaborated and shared ideas. The CHDC team have utilised existing morning huddles to identify potential discharges as early in the day as possible, or even the day before, as well as communicating this by the use of a discharge board visible to all staff members meaning that this information is readily available. We also challenged existing norms, and empowered leadership from within ward areas to drive projects. We have encouraged the early preparation - sometimes overnight - of quality discharges using a new acronym for electronic discharge advice notes (eDANs - Easy to read, Drugs, Advice, Next Steps). We have facilitated nurse-led and criteria led discharges as well as increased our safe use of over-labelled discharge packs. Another quality improvement project piloted the process of finalising the discharge medicines before the clinical information was completed enabling earlier dispensing.

Results In the period from October 2020 to July 2021 the median percentage of weekly discharges before 1500 hours has risen from 36% to 49%. In patient terms, this means approximately 18-20 more patients per week being discharged home before 1500 hours.

Conclusion and Future Aspirations The CHDC team have increased discharges before 1500 hours across the Children’s Hospital by 13% over the last 9 months by working collaboratively and enthusiastically to rethink the existing processes used. This also equates to 1 or 2 wards full of patient space that is free for the next family that needs it. We hope to continue this good work and improve on this further by collecting some qualitative data from families to explore their thoughts about the discharge process.

The Trust is now investigating a re-design of the eDAN process to enable a change in discharge process across specialties, meaning that the whole Trust could benefit from this project’s initial work. The CHDC team also plan to continue to collaborate and celebrate our achievements, both locally and nationally by completing positive feedback forms, issuing certificates and ‘Discharge Champion’ badges and sharing our learning by presenting our work.

P33 MODIFIED POINT PREVALENCE STUDY OF ANTIFUNGAL USE IN PAEDIATRICS

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Background The incidence of invasive fungal infections in adult and paediatric patients has increased, particularly among immunocompromised patients with mortality in the setting of hematopoietic stem cell transplantation ranging from 30–40% for yeast infections and up to 70% for mould infections.1 Although many hospitals categorise antifungals as ‘restricted agents’, they are frequently used as part of haematology, oncology and cystic fibrosis protocols. This study was undertaken in an Irish, tertiary paediatric hospital and aimed to record the prevalence and pattern of antifungal prescribing and document indications for use. While there is an Antimicrobial Stewardship Policy in place in this hospital, there is no formal Antifungal Stewardship (AFS) Programme.

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