developed to encourage safer prescription of gentamicin. However, despite this safeguard, the risk of error remains.

Our Quality Improvement Project was created in response to a significant documentation error which resulted in an infant receiving an extra dose of gentamicin. The primary aim of this project was to improve GAP by promoting use of the gentamicin safety checklist; with a minimum completion of 50%. Secondary aims included identification of barriers to safer GAP and provision of staff training.

Methods A retrospective audit carried out from February-March 2021 identified all neonates treated for EONS on the postnatal ward. Of these, a sample of patient notes were audited to review; satisfactory completion of gentamicin safety checklist, duration of antibiotics, appropriate monitoring of gentamicin levels and identification of GAP errors.

In April-May 2021, we provided teaching to the medical staff to promote the use of the gentamicin safety checklist and to identify perceived barriers impeding safe GAP. A sample of charts from May were subsequently audited and his formed the basis of our first PDSA cycle.

A second PDSA cycle was performed focusing on addressing some of the barriers to safe GAP identified from the survey. The commonest of these was finding a second person to check medications, usually a midwife. We presented our interim findings to the Multidisciplinary Obstetric and Neonatal Faculty Meeting in May to raise awareness of our project and the importance of second checker availability, then re-audited safety checklist completion in June.

Results
February-March 2021 Audit (n=22) • Total EONS cases: 73
  * Number of fully completed safety checklists: 0%.
  * >36 hours duration: 11 infants.
  * Correct monitoring and interpretation of results: 100%.
  * GAP errors: 1 serious prescription error.

Survey (n=7) • 86% felt >4/5 confident prescribing Gentamicin.
  * 0% awareness of safety checklist.
  * 86% checked antibiotics with midwifery staff.
  * Perceived barriers:
    – o Difficulty finding a second person to complete checks.
    – o Time constraints due to work load.
    – o Interruptions.
    – o Handover efficiency.

PDSA Cycles:
1. May 2021 (n=13): 62%
2. June 2021 (n=8): 50%

Serious Errors Identified 0

Conclusion Accurate prescription and administration of medications is a fundamental cornerstone of safe clinical practice. Our project demonstrated that provision of postnatal antibiotics represents a significant burden to postnatal paediatric doctors, with at least 1 infant per day being diagnosed with EONS. Moreover, it highlighted multi-disciplinary lack of awareness of pre-existing safeguards which could have prevented the error upon which this project was based. This project demonstrates successful improvement in completion of safety checklists through teaching and raising awareness. However, we recognize that further multidisciplinary engagement and addressing of other barriers to safe GAP will be required to ensure sustainable and long-lasting change.

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across all four criteria was achieved for 13% of patients attending the clinic from our baseline measure of 10%.

**Conclusion** Introducing frequent, small change ideas through PDSA cycles allowed us quickly to identify our most successful interventions to address the frustration surrounding communication breakdown shared by all service users. This process will also be useful in the induction of new trainees managing the clinic. Targeted interventions resulted in a safer, more efficient service. Ongoing feedback continues to guide strategies for change as we strive towards improving the quality of post-discharge care for children and young people. Future work will focus on capturing patient experience and improving patient-centred outcomes.

**1276 STRIVE TO PRESCRIBE AND DO NO HARM**

Kopila Rai, Wynn Aung, Ebraheem Junaid, Sarah Driscoll, Laura Roe. UHNH NHS Trust

10.1136/archdischild-2022-rcpch.780

**Aims** Prescribing medication is a common intervention and hence prescribing errors are not uncommon events. Ghaleb et al 2010 showed that 13% of paediatric prescriptions contain errors and recently Elliot et al 2020 estimated that 66 million of the 237 million prescription errors had potentially clinically significant outcomes. This has been highlighted following a recent critical incident and, as part of the learning recommendations, a multidisciplinary team approach was formed to improve departmental prescribing education. The aim was to reduce the number of prescribing errors, therefore reducing harm to patients and improving care. This was achieved through the joint efforts of trainees and ward pharmacist by developing a robust evidence based teaching programme not only at induction but as rolling sessions throughout the year which, due to COVID 19 restrictions, was delivered virtually on Tealn in conjunction there was also a revision of the induction prescribing test, regular review of the number of prescribing error incidents and drug chart audits with cycle completion and implementation of changes. The teaching programme and audits were started in December 2020 and are on-going.

**Methods** From December 2020 to May 2021, audits were undertaken initially using the GMC prescribing standards. We later revised the audit tool to reflect the standards defined in our hospital inpatient prescribing policy which incorporated the GMC standards. 30 random drug charts from across 3 paediatric inpatient wards were analysed every month with the aim to achieve greater than 90% in each standard (taking into account a baseline level of human error) and then to maintain this over time. To achieve this, learning from the audit was fed back to all members of the team via regular electronic and visual/verbal reminders and the teaching programme was amended to include troublesome topics. Adverse incidents were reviewed and teaching from this was also included in the teaching programme.

**Results** Since December 2020, it took 6 months for the number of incidents due to prescribing errors to reduce from 14 in 6 months (December 2020-May 2021) to 10 in 6 months (June-November 2021). Audit results showed that since December 2020 we were scoring >90% in 3 out of the 10 domains. 3 months into the teaching programme this improved to 4 out of 10 of the domains and at 6 months, 6 out of 10 domains. When we re-audited with our revised audit tool, we achieved >90% initially in 10 out of 16 domains and then consistently maintained our standards across 11-12 out of 16 domains over a 4 month period (October 2021-January 2022).

**Conclusion** This project has shown that despite a global pandemic, a combination of innovation, education, technology, multidisciplinary skills and team-working can implement and embed change to improve patient safety. When considering the bigger picture, we are reminded that this is a small part of the larger systemic processes that can influence medication errors and that with perseverance, we can aim to reduce the risk of adverse events due to medication errors and therefore provide the best care for our patients.

**1280 DON’T LOSE YOUR HEEADSSS – A STUDENT QUALITY IMPROVEMENT PROJECT**

1Prachi Patel, 1Lucas Wilmshurst, 1Laura Appleton, 1Zaynah Qamar, 2Mark Butler. 1Kings College London; 2Gays and St Thomas’ NHS Foundation Trust, London

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**Aims** HEEADSSS (Home, Education/employment, Eating, Activities, Drugs/drinking, Sexuality, Self-harm/depression/suicide and Safety/social media) is a tool used to structure the psychosocial assessment of adolescents in order to encourage a more holistic understanding of adolescent patients’ health needs, and to build rapport between staff and patients. However, a previous internal audit on the usage of the HEEADSSS assessment on our general paediatric ward found that only 1/97 young patients (aged 11-16 years) admitted between 01/02/20 to 20/05/20 had received a formal HEEADSSS assessment.

This Quality Improvement Project therefore aimed to increase the proportion of HEEADSSS assessments completed for eligible adolescent patients (aged 11-17 years) admitted onto the general paediatrics ward between 15/10/21 to 15/02/22 to 50%.

**Methods**

**Quantitative data** A baseline value for the number of HEEADSSS assessments performed on patients admitted to the ward was measured from 01/09/21 to 14/10/21.

Three interventions were then trialled to educate staff on the importance of HEEADSSS and how best to conduct the assessment. The first intervention involved two circular email reminders sent on 15/11/21 and 03/12/21. The second intervention involved the use of staff-facing and patient-facing posters promoting the use of HEEADSSS placed on 15/12/21. For the third intervention, a HEEADSSS teaching session was delivered as part of the junior doctor teaching programme on 02/02/22.

The number of HEEADSSS assessments performed on patients admitted to the ward was continuously audited from 15/10/21 to 15/02/22.

**Qualitative data** Supplemental qualitative data was obtained from staff and patients (11-17 years) via survey responses and interviews, respectively, to understand attitudes towards the HEEADSSS assessment and identify potential barriers.

**Results**

**Quantitative results** For the retrospective baseline data collection (01/09/21 to 14/10/21), 1/50 patients received a formal HEEADSSS assessment (3.3%) [figure 1]. For the continuous data collection (15/10/21 to 15/02/22), 5/81 patients received a formal HEEADSSS assessment (6.2%) [figure 2].