851

AUDIT ON PRESCRIBING FOR CHILDREN AT THE QUEEN ELIZABETH HOSPITAL, KINGS LYNN

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Introduction: Dosage and frequency of same drug vary with age in paediatric groups unlike adults. Drug errors are more common in paediatric population for the same reason. With frequent change at junior doctors level makes it even more likely for these errors to happen.

Method: We looked at the drug charts of inpatient between October and November 2010. We looked for several standards as mentioned in guidance for prescription in children BNF.

Results: There was 100% compliance in standards like Name, date of birth, address, weight of patient, frequency of dose, consideration to unit/mass and legible writing. 11% of drug charts did not have date of admission and in 31% of drug charts did not have history of allergies documented. About 30% had incorrect drug names or drug strength and the common ones were Augmentin, movicol, septrin and oromorph. 17% of charts did not have minimum time between doses on as required prescriptions. Only 29% of charts had 100% compliance with all the standards.

Recommendations: Documentation of date of admission and history of allergy should be written before giving any drugs. Commercial name of the drugs should not be used and BNF for Children should be referred to for every prescription. Review of drug charts by senior member of staff as part of the ward rounds and corrections should be brought to the attention of prescribers for them to change their practice.