

Appendix B

Examples of patient-specific, risk-adapted pharmaceutical training in the intervention group (IG).

Patient 1: 6-year-old boy, generalized epilepsy, while medication reduction

Prescribed medication and dosage	Sodium-Valproate 300 mg modified-released capsule, hard ½-0-½		
Handling processes	Opening capsule Dose splitting Crunching of modified-released minitablets (capsule content) Sprinkling capsule content onto food Storing half of the capsule content that was not immediately administered		
Committed medication errors (ME) prioritized to patient-specific intervention	Clinical risk of ME	Intervention	
Storage	<p>Missing labelling of sub-quantity of the capsule (= modified-released minitablets)</p> <p>Incorrect storage of solid drugs: hygroscopic modified-released minitablets are not stored protected to humidity</p>	<p>4</p> <p>3</p>	<p>Handout of written information about medication storage; Provision of a helping tool: Eppendorf vial for humidity protected storage, further labeled with brand name/active ingredient/strength</p>
Preparation	Inaccurate dosing of solid drugs - Intended dosage not exactly obtained: Capsule could not have been split into two equal doses	4	Handout of an illustrated handling algorithm and dummy-model based practical training of the use of a helping tool: division spoon provided by the manufacturer
Oral administration	<p>Crunching of modified-released minitablets that may lead to adverse drug reactions (e.g., dose dumping or unintended drug loss when minitablets remain in interdental spaces)</p> <p>Inappropriate body position for drug</p>	4	Handout of a drug individualized written information , among others, recommending using sparkling water or piece-less food to sprinkle the minitablets on; Handout of written information on correct drug intake of solid oral dosage forms , among

	administration: patient does not sit in an upright position	4	others, recommending taking medication with an upright position of at least 45° of the upper body; both interventions were highlighted by color in the text and explained to the parents
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Patient 2: 5-year-old boy, epileptic syndrome with complex focal seizures

Prescribed medication and dosage	Lacosamid 10 mg/mL Sirup 11 mL-0-11 mL		
Handling processes	Dosing sirup by syringe without bottle adapter		
Committed medication errors (ME) prioritized to patient-specific intervention	Clinical risk of ME	Intervention	
Storage	Opening date missing on liquid drug (e.g., date of opening is not noted on the package)	5	Handout of written information about medication storage , among others, recommending labeling medication bottle with date of opening and end of expiry period, which was highlighted by color in the text and explained to the parents
Preparation – package removal	Difficulties in removing the drug from the primary packaging	5	Provision of a helping tool: bottle adapter and oral syringe; handout of an illustrated handling algorithm on correct liquid drug use , among others, demonstrating shaking suspensions properly and exact dosing via bottle adapter and oral syringe (both highlighted by color in the text); dummy-model based practical training on correct suspension handling with bottle adapter and oral syringe
Preparation – Dosage	No appropriate shaking of sirup Inaccurate dosing of liquid drug - Intended dosage not exactly obtained (imprecise measuring)	5 5	
Hygiene	Pouring excess fluid back into the bottle	5	

Patient 3: 4-month-old boy, complex focal epilepsy, neonatal seizures

Prescribed medication and dosage	Newly prescribed medication: Phenobarbital 15 mg tablets 1-0-1		
Handling processes	Crushing tablet Suspending tablet		
Committed medication errors (ME) prioritized to patient-specific intervention		Clinical risk of ME	Intervention
Preparation – Package removal	Opening primary package not possible (not able to open child-resistant fastening)	5	Handout of a drug individualized written information , among others, demonstrating how to open primary package (highlighted by color in the text); dummy-model based practical training on how to open primary package
Preparation – Manipulation of dosage form	Prescribed preparation of solid drug not possible (not able to suspend tablet)	5	Provision of a helping tool: oral syringe; handout of an illustrated handling algorithm on correct suspending of tablets in an oral syringe ; dummy-based practical training of entire process of safely suspending a tablet in an oral syringe and explanation of correct liquid drug administration via oral syringe and with an upright body position by putting the patient on a voluminous pillow
Oral administration	Inappropriate body position for drug administration: patient does not sit in an upright position	4	Provision of a helping tool: oral syringe; handout of an illustrated handling algorithm on correct suspending of tablets in an oral syringe ; dummy-based practical training of entire process of safely suspending a tablet in an oral syringe and explanation of correct liquid drug administration via oral syringe and with an upright body position by putting the patient on a voluminous pillow
	Unintended loss of drug during medication administration (e.g., user spills content of syringe while administering or loss of drug in neonates/infants due to intense salivation or tongue thrust reflex)	5	
Hygiene	No use of gloves in presence of CMR (carcinogenic/mutagenic/toxic for reproduction) drugs (while crushing tablet)	3	Intervened by changing preparation process to suspending in an oral syringe without crushing
Knowledge	Missing knowledge as to whether prescribed drug that is solved/suspended/diluted is soluble/suspensible/dilutable	5	Handout of a drug individualized written information , among others, specifying allowed manipulation of prescribed tablets

Additional to patient-specific interventions and general written information handouts used for patient-specific interventions, parents have been further provided basic information on safe drug storage.