Aim We present a case study of the development of a structured, holistic, multidisciplinary prescribing teaching program for medical students in our paediatric department. The aim was to integrate theory and practice into one multidisciplinary delivered teaching session.

Method Prescribing is an area that medical students consistently report as challenging with poor teaching and minimal paediatric specific prescribing teaching as an undergraduate. After collaboration with our pharmacist colleagues the agreed objective was to design a teaching session run by doctors and pharmacists together in order to more accurately simulate paediatric specific prescribing teaching as an undergraduate.

Prescribing is an area that medical students consistently reported as challenging with poor teaching and minimal paediatric specific prescribing teaching. When asked the question ‘how prepared do you feel for prescribing in paediatrics?’ and asked to rank themselves from 1 (not at all) to 5 (very well) the average improved from 1.44 pre session to 3.53 post session. The feedback was consistent between sessions demonstrating no significant variation between facilitators. This highlights that the standardised, formal structure of the session allows it to be delivered by pharmacists and doctors of different grades and levels of experience without changing the success of the session for the students.

Results Both facilitators and students very enthusiastically received the session with phrases such as ‘amazing session thank you!’ added to the feedback forms. Feedback was gathered from 32 students over the first 8-week cycle of the project. The majority of students stated that prior to this session they had little or no paediatric prescribing teaching. When asked the question ‘how prepared do you feel for prescribing in paediatrics?’ and asked to rank themselves from 1 (not at all) to 5 (very well) the average improved from 1.44 pre session to 3.53 post session. The feedback was consistent between sessions demonstrating no significant variation between facilitators. This highlights that the standardised, formal structure of the session allows it to be delivered by pharmacists and doctors of different grades and levels of experience without changing the success of the session for the students.

Conclusion This project demonstrates that there is a significant gap in undergraduate teaching on prescribing, especially paediatric prescribing. This teaching session is low cost, produces similar feedback despite variation in facilitators between sessions demonstrating no significant variation between facilitators. This highlights that the standardised, formal structure of the session allows it to be delivered by pharmacists and doctors of different grades and levels of experience without changing the success of the session for the students.

This is a national area that requires focused educational attention.
DEVELOPING A PHARMACIST PRESCRIBING ROLE WITHIN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

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**Aim** CAMHS were unable to achieve the waiting time target for the Attention Deficit Hyperactivity Disorder (ADHD) titration clinic due to ongoing medical staff vacancies. Patients were waiting up to 7 months after diagnosis to commence medication which has a significant impact on quality of life and education. The aim of this project was to utilise the skills of a pharmacist independent prescriber to initiate medication and review the response and to evaluate the impact on waiting times.

**Methods** Following funding approval, resource was made available to release an independent prescribing pharmacist for 1.5 days a week. Over a period of 8 weeks the following training was undertaken: shadowing clinics; reading books; national and local guidelines; accessing IT systems eg, TrakCare, EMIS, Winscribe; measuring height, weight and blood pressure; attending training sessions; appointing patients to the pharmacist led clinic from January 2018. The patient attends a baseline appointment where ADHD symptoms are assessed and medication options are discussed. The most appropriate medication is initiated at the lowest dose and is reviewed and adjusted at appointments every 2 weeks. On average it takes 4–5 appointments to complete a titration and stabilise the patient on a regular dose. Upon completion of the medication titration, a request is sent to the GP to commence repeat prescribing as per the local protocol. The patient is then appointed to the specialist nurse 3 month review clinic list.

**Results** Following a review and update of the ADHD titration waiting list, there were 78 patients to be initiated on medication with new patients being added each week following their end of assessment diagnosis. Over the last 6 months, the pharmacist has titrated 28 patients (36%) onto ADHD medication. 3 patients did not respond to the first line stimulant and 1 patient has not responded to the first or second line stimulant and is currently being titrated onto a non-stimulant option. All patients on the list have been appointed to a clinic run by a non-medical prescriber or a nurse with support from a medical prescriber. Moving forward, the new pathway allows newly diagnosed patients to start medication either at their diagnosis appointment or given an appointment with the pharmacist for the following week. This may result in no waiting list at all. The service has also benefitted from having a pharmacist available every week to discuss issues with clinical governance processes and high risk medication.

**Conclusion** The pharmacist independent prescriber played a significant role in the reduction of the waiting list for initiation of medication to treat ADHD. Due to the number of titrations completed within the last 6 months, there is now pressure on the 3 month review waiting list. By continuing to utilise the pharmacist independent prescriber to initiate and titrate medication, this will free up specialist nurse time to focus on initial assessments and the review clinics. As a result, the clinical group are planning to provide permanent funding for this role to continue to support the new model of ADHD clinic.

**REFERENCE**