current practice and agree the new standardized formulations and develop guidelines for use. These were based on European Society of Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) and British Association of Perinatal Medicine (BAPM) guidelines and expert opinion. Advice on stability and compounding was sought from commercial experts. Assistance to award a contract to supply the network was sought from a group purchasing organisation to ensure capacity planning and cost effectiveness.

**Results**

Consensus on four concentrated formulations was agreed by the network group and all six units within the network are now successfully using these.

**Conclusion**

This has been a lengthy process but it was possible to establish agreement of a structured set of standard bags that would deliver nutritionally complete PN to the cohort of babies in our network. Re-audit is now underway in house to compare to previous practice and we hope to shortly roll this audit out across the network. Future aspirations are to devise a system to manage stock control across the entire network, work towards reaching national consensus, work with commercial partners to obtain extended expiry with peditrace addition and to work in partnership with commercial companies to formulate licensed products.

**REFERENCES**

scheme. 30 participants were aware that parents could report using the scheme. 10 participants had been aware of an adverse drug reaction but decided not to report it. The most common reason for this was being too busy. The most common suggestion on how to improve accessibility to the Yellow Card Scheme was the implementation of a mobile phone application.

Conclusion Most participants were aware of the Yellow Card scheme although undergraduates less so. Many had reported, although some had chosen not to report because they were: too busy; not being concerned enough; not knowing how to; having forgotten. An app already exists, but awareness of this appears low, as it was the commonest suggestion to aid the low reporting.

Abstracts

P016 PARENT/CARER INTENDED NON-ADHERENCE TO THEIR CHILD’S MEDICATION REGIMEN

1Jeff Aston, 2Keith Wilson, 3David Terry. 1Birmingham Women’s and Children’s NHS Foundation Trust; 2University, Aston

Aim To identify intended non-adherence reported by parents/carers of children/young people taking long-term medication.

Methods A 10 question postal survey was sent to 180 parents of patients receiving medication via homecare at a tertiary paediatric hospital with a single repeat mailing. Demographic details collected were age, current prescribed medication and duration. Participants were asked about changes that they had made to their child’s medication without consulting a healthcare professional. They were asked about delaying/not starting new medication, compliance with medication instructions, with-holding medication, altering the dose of medication, altering medication taking to fit in with daily life and strategies to aid administering medication. The data were analysed using SPSS version 23 and NVivo version 11.

Results The response rate was 32/180 (17.8%). The mean age of respondents was 8.4 years (range 0.83 to 17 years). One hundred and fifty-eight medications were prescribed with a mean of 5 medications per patient (range 1 to 15). In total, 16/32 (50%) respondents had made changes to their child’s medication. The most common change (9/32, 28.1%) was adjusting the medication regimen to fit around daily life and strategies to aid administering medication. The most common reason for this was being too busy. The most common suggestion on how to improve accessibility to the Yellow Card Scheme was the implementation of a mobile phone application.

Conclusion Most participants were aware of the Yellow Card scheme although undergraduates less so. Many had reported, although some had chosen not to report because they were: too busy; not being concerned enough; not knowing how to; having forgotten. An app already exists, but awareness of this appears low, as it was the commonest suggestion to aid the low reporting.

P017 BLUE BABY BLUES – A CASE REPORT: IMPLICATIONS OF MATERNAL SELECTIVE SEROTONIN REUPTAKE INHIBITOR USE FOR SUDDEN INFANT DEATH SYNDROME

Peter Mulholland, Alexander Simpson, Jonathan Coutts, Royal Hospital for Children

Background A baby girl, (38 +2 weeks, 3.026 kg) was admitted on day 3 from home following 2 cyanotic episodes. The pregnancy was uneventful, the mother was prescribed fluoxetine 20mg daily during pregnancy.

Investigations Respiratory studies revealed significant hypoxia in air with episodes of hypoventilation and apnoea. Time spent below 94% saturation was 19%, 68 dps per hour >4%, pCO2 was raised at 7 kPa. She had a normal cranial MRI. Genetic testing for PHOX2B polyalanine expansion mutation was normal excluding Congenital Central Hypoventilation Syndrome (CCHS).

Outcome Incremental increase in the prescription of low flow oxygen normalised her saturation study. She was discharged home on day 14 with an oxygen prescription for 0.3lpm and an apnoea monitor. Parents and family members were taught basic life support. Clinic follow up at 5 months shows baby is thriving, developing normally and the oxygen flow rate has been reduced to 0.3lpm following repeat saturation studies.

Discussion Hypoventilation is not a recognised complication of maternal fluoxetine usage. A population based health registry study found exposure to SSRI in utero increased the rate of neonatal deaths, although a causal relationship could not be established. Two separate randomised controlled trials have looked at the relationship between maternal SSRI use and neonatal death. Neither demonstrated a statistically significant correlation, although both showed odds ratios approaching statistical significance (95% confidence intervals 0.82–1.99 and 0.97–3.94 respectively). Mouse models demonstrate the respiratory response to acidosis is abolished by drugs targeting the serotonergic system. This system is not the primary regulator of respiration, and there may be a multi-factorial aetiology to any link between SSRI exposure in utero and the development of hypoventilation. This hypothesis somewhat correlates with the ‘triple-risk model’ for Sudden Unexpected Death in Infancy (SUDI), which describes three important risk factors; a critical development period, an exogenous stressor and an underlying vulnerability. It is possible that this underlying vulnerability could potentially be accounted for by down-regulation of the serotonergic respiratory response in association with maternal fluoxetine use. Fluoxetine is the preferred

REFERENCES