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.

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

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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 health-care 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 followed by delaying initiating a new medication (7/32, 20.6%). No respondents indicated that they had not started a new prescribed medication. Six (17.6%) respondents indicated that they had not followed the medication instructions. Four (11.8%) respondents advised that they had withheld their child's medication. Four (11.8%) respondents communicated that they had given a higher than prescribed dose and four (11.8%) a lower dose. Three (8.8%) respondents adjusted how they gave their child's medication to aid administration.

Conclusion Half of respondents made changes to their child's medication without consultation with a healthcare professional. Commonly changes were made to fit around daily life. The decision to prescribe medication should be undertaken in partnership with patients.¹ Adherence to medication in long-term paediatric conditions is particularly complex requiring parents to balance the daily needs of their child taking medication with everyday life.² Strategies to support medication adherence include self-management programmes, simplified dosing regimens and pharmacist led medication reviews.³ Parents/carers

may benefit from a structured medication review for their child although further research is required to determine the effectiveness of such an intervention. This study has identified parent practices that could be included in such a review.

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

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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 dips 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 0.5lpm 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,¹ 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.^{2 3} 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.⁴ This system is not the primary regulator of respiration,⁴ 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