

availability of shared electronic prescription data will make this type of study much more feasible in the future. The overall MPR was higher than expected, but this might be related to the role of parents, we would like to continue this work with more of our adolescent patients and those who have recently transitioned to adult services.

REFERENCE

1. Modi AC, Lim CS, Yu N, *et al.* A multi-method assessment of treatment adherence for children with cystic fibrosis. *J Cyst Fibros* 2006;**5**:177–185.

03 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.¹ 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

1. National Institute for Health and Care Excellence. *Attention deficit hyperactivity disorder: diagnosis and management*. London: NICE [NG87] March 2018

04 DETERMINING THE ACCURACY OF GP RECORDS IN PAEDIATRIC MEDICINES RECONCILIATION

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Aim Medicines reconciliation (MedRec) is a process undertaken on admission to hospital to obtain an accurate list of patients' current medication.¹ National guidance for MedRec is available only in adults. Previous studies looking at accuracy of sources for MedRec in paediatrics are scarce in the United Kingdom. A few studies have shown that General Practice (GP) records do not match the patients' current medicines lists in 29–45% of patients.^{2 3} The primary aim is to determine the accuracy of GP records in paediatric Med Rec, exploring types of discrepancies and any potential relationships between discrepancy rates and polypharmacy. The secondary aim is to audit compliance with local MedRec standard operating procedures (SOPs).

Methods Prospective observational multicentre study (Site A: general district hospital; Site B: tertiary care hospital) that will take place over a 4 week period during three consecutive years. HRA approval was granted (IRAS ID 234128).

Participants received an age appropriate study information sheet and were consented to the study by pharmacy staff. Consent gave the researcher access to summary care record (SCR) and hospital records. All data was anonymised. Patients who were on no medicines at home, patients who had never been home, and those transferring from another Trust were excluded. Using the SCR, the patients' GP repeat medication list was compared to the list compiled during MedRec by hospital pharmacy staff. Statistical relationships between polypharmacy and discrepancies were explored using the contingency Fisher's Exact Test.

Results 63 patients were recruited- 27 patients (43%) on site A and 36 (57%) on site B. The study showed that the SCR did not match (medication omitted, differences in dose, frequency of formulation) the patient's actual MedRec in 54 (86%) patients. Discrepancy rates per patient were higher at site B (94%, n=34) than site A (67%, n=18). The study included 347 medicines- 95 on site A (27%) and 252 (63%) on site B. The discrepancy rate looking at the total number of medicines included in the study was 51% (n=177). Overall, the most common type of discrepancy was 'medication omitted', accounting for 114 (64%) of discrepancies. Looking at the omitted medicines, 25 (22%) were unlicensed or off-label.