of age (26% of patients). At present no patient post HSCT has developed VOD requiring treatment. One patient developed sub-clinical VOD which required no treatment and resolved spontaneously. Another patient received defibrotide as prophylaxis for VOD due to severe liver dysfunction prior to HSCT. There were substantial cost savings following the discontinuation of prophylactic defibrotide with a total of 2876 vials (180 vials/patient) saved during this time period.

Conclusion This audit validates our decision to discontinue use of prophylactic defibrotide and reserve its use for treatment of early VOD.

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P041

MORAL DILEMMAS AND ETHICAL DISCOMFORT IN PAEDIATRIC PHARMACISTS

Nicola Wilson, Elaine Liston, Lauren Williams. *Royal Hospital for Children, Glasgow, Greater Glasgow and Clyde Health Board*

10.1136/archdischild-2019-nppc.51

Situation A five week old infant admitted to a tertiary paediatric hospital with coryzal symptoms on a background of Edwards Syndrome (Trisomy 18) and congenital cardiac disease. Despite her grave prognosis, she was intubated and ventilated. She spent many months in hospital, eventually having surgical repair of her cardiac defect which had little or no effect on her clinical condition. She was discharged to a children's hospice after seven months in our hospital (with short periods at home and her local hospital), at the age of eight months, for end of life care. As pharmacists actively involved in her care, but with limited input to her ethical situation, we suffered moral distress.

Background Edwards Syndrome is a rare genetic condition which occurs in 1 in 5000 live births. Infants are severely disabled. Accurate figures for miscarried or terminated pregnancies are not available. Only 8% of babies survive beyond one year unless they have a less severe form (mosaic or partial).¹ Our patient had a post-natal diagnosis and her parents were determined that she be given every opportunity that would be offered to a non-Edwards child. We are three pharmacists who work in paediatric intensive care and paediatric cardiology. We were actively involved in the care of this patient and her family for several months. Although we work closely with the multidisciplinary team, we were not included in discussions about appropriateness of interventions. We were however, expected to speak to her parents about medicines on a regular basis, including during a very difficult and prolonged wean of sedation which was causing physical distress to the patient and her parents.

Outcome Being involved in interventions which are unlikely to improve or extend a patient's life is difficult, but especially so when you have had little or no influence on the original decision. The eventual outcome was exactly as predicted on admission: she was discharged to a hospice and expected to deteriorate slowly. Her discharge was written by one of the

PICU pharmacists and her parents were counselled by another, so we were involved until the end of her admission.

Discussion As a pharmacy team, we only have each other to talk to: our distress cannot compare to that of medical or nursing staff who are more closely involved in the patient. We are limited in what we can discuss outside of work due to patient confidentiality. With the relatively recent introduction of pharmacist independent prescribing in our PICU and cardiology wards, we are often asked to prescribe outwith our comfort zone and are able to refuse. As our prescribing roles become more embedded, our comfort zone will expand and we will be expected to prescribe in morally ambiguous situations such as this one. Studies have shown that community pharmacists are prone to moral distress,² as they work in a highly regulated profession and their actions are often bound by laws and contracts over which they have little control, and in hospital we suffer the same fate.³

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P042

EVALUATION OF 'LET'S TALK MEDICINES' HELPLINE

Sarit Shah. *Evelina London Children's Hospital*

10.1136/archdischild-2019-nppc.52

Introduction Studies and research have shown that providing patient education through knowledge and counselling of the disease process and subsequent treatment empower patients and carers to improve patient's health. Through understanding rationale for treatment, implications of non-compliance, non-adherence, disease progression and adverse effects of therapy, pharmacy staff are perfectly placed to empower patients and carers with evidence based knowledge and information to make their own educated decisions regarding therapy. The 'Let's Talk Medicines' telephone service was set up in 2015 for exactly this purpose. It is a dedicated medicines information (MI) service aimed at patients, parents and carers, giving the opportunity to ask questions and obtain advice from specialist paediatric pharmacists about their child's medicines once leaving the hospital. The services have vastly expanded over the last 2 and half years with the addition of an email address as an alternative means for contact. The helpline number and email address are heavily publicised to parents and carers through posters throughout the hospital, details published on all paediatric discharge summaries and printed information cards given to all outpatients during counselling.

Aim To evaluate the service progression by analysing the sheer volume and types of queries over the last 3 years to identify how beneficial the novel service has proven to be.

Methods To retrospectively analyse data from 3 monthly reports over the last 2.5 years of the service to identify number of calls, emails, types of queries received and users of the service.

Results The current service relies on all members of the pharmacy team answering calls on a dedicated patient line on an