

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*

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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*

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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

ad-hoc basis with several specialist pharmacists reviewing queries on a daily basis. Average call durations were between 5 to 8 minutes with more complex queries requiring in depth data search taking up to 30 minutes. All queries are logged on paper and then reviewed on a monthly basis as they are entered onto a database. Since the introduction of the service, the volume of calls received has increased by more than 50% with average of 35 per month in 2015 and 54 in 2017. Originally, the service was designed primarily for patients, parents and carers. Due to the increased recognition, the service has now been expanded to a variety of internal and external healthcare professionals, community practitioners and pharmacies, drug companies, commissioning staff, researchers and students. The types of queries range from supply issues, procurement of unlicensed medicines, to adverse effects, administration advice and complex pharmaceutical queries.

Conclusion The service has grown and developed with focus based around improving patient care, medication adherence and minimising medicines related risks. Through providing accurate, up-to-date and evidence based information its appeal has reached a wider audience including healthcare professionals. Combined with an increase in the number of calls and technological advances, a new email service has been rolled out in 2017, as an alternate means to contact the service. Direct comments from users of the service has shown positive feedback and trust.

P044

CAN AN ELECTRONIC PRESCRIBING SYSTEM ENSURE CLEAR ANTICOAGULATION DISCHARGE COMMUNICATION?

Susie Gage. *Bristol Royal Hospital for Children*

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Aim The National Patient Safety Agency (NPSA)¹ identified heparin as a major cause of adverse events associated with adverse incidents, including some fatalities. By ensuring good communication, this should be associated with risk reduction.¹ The aim of this study was to ensure there is clear anticoagulation communication on discharge, from the paediatric intensive care unit (PICU) electronic prescribing system (Philips), to the paediatric cardiac high dependency unit and paediatric cardiac ward. To investigate whether the heparin regimen complies with the hospital's anticoagulant guidelines and if there is any deviation; that this is clearly documented. To find out if there is an indication documented for the heparin regimen chosen and if there is a clear long term plan documented for the patient, after heparin cessation.

Methods A report was generated for all patients who were prescribed a heparin infusion on PICU, between 1st January 2018 and 30th June 2018, from the Philips system. All discharge summaries from the PICU Philips system were reviewed. Only paediatric cardiac patients were included that had a heparin infusion prescribed on discharge, all other discharge summaries were excluded from the study. Each discharge summary was reviewed in the anticoagulant section; for the heparin regimen chosen, whether it complies with the hospital's anticoagulant guidelines and if there was any deviation whether this was documented. The indication documented of which heparin regimen was chosen and whether a clear long term plan was documented after heparin cessation;

for example if the patient is to be transferred onto aspirin, clopidogrel, warfarin or enoxaparin.

Results 82 discharge summaries were reviewed over the 6 month period between 1st January 2018 and 30th June 2018; 16 were excluded as were not paediatric cardiac, leaving 66 paediatric cardiac discharge summaries that were reviewed. 45 out of 66 (68%) complied with the hospital's heparin anticoagulation guidelines. Of the 32% that deviated from the protocol; only 33% (7 out of 21) had a reason documented. Only 50% (33) of the summaries reviewed had an indication for anticoagulation noted on the discharge summary and 91% of discharge summaries had a long term anticoagulant plan documented.

Conclusion The electronic prescribing system can help to ensure a clear anticoagulation communication as shown by 91% of the anticoagulation long term plan being clearly documented; making it a more seamless patient transfer. On the Philips PICU electronic prescribing system there is an anticoagulant section on the discharge summary that has 3 boxes that need to be completed; heparin regimen, indication and anticoagulation long term plan. However, despite these boxes; deviations from the anticoagulant protocol were poorly documented as highlighted by only 33% having the reason highlighted in the discharge summary, only 50% of the indications were documented. Despite having prompts for this information on the discharge summary, the medical staffs needs to be aware to complete this information, in order to reduce potential medication errors and risk.

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P045

VALUE FROM YOUR VITAMINS – OPTIMISING VITAMIN SUPPLEMENTATION IN CHILDREN WITH CYSTIC FIBROSIS

Eleanor Turner. *Royal Manchester Children's Hospital*

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Aim To optimise fat soluble vitamin supplementation in children with CF in a tertiary children's hospital and primary care. To compare supplementation of individual vitamins and supplementation with a new multivitamin preparation against national guidelines, cost and patient acceptability.¹

Methods Comparison of current practice (supplementation of individual vitamins) with a new multi-vitamin preparation, Paravit-CF. Form and dose of each of the fat soluble vitamins was compared against national CF Trust guidelines for nutrition.¹ Cost of treatment per day was compared. Patient acceptability was explored by comparing medication burden and with a focus group made up of representatives from the CF multi-disciplinary team (MDT) including, consultants, specialist nurses, dieticians and a pharmacist.

Results Current approach to vitamin supplementation is not in line with the CF Trust guidelines for nutrition. Supplementation with Paravit-CF preparations meets recommendations made in the CF Trust guidelines for nutrition for patients of all ages except for infants. Infants will receive vitamin A at higher doses than recommended. Cost of vitamin supplementation is reduced by approximately 50% when using Paravit-CF compared with current practice. Medication burden is reduced by more than 50% when using Paravit-CF compared with