in the UK and Ireland. The CLLG and members of the Paediatric Oncology Pharmacists (POP) group worked together in reviewing and comparing a selection of PILs already available, in addition to agreeing a standardised format and outline of headings for proposed factsheets. Drafts were produced for 10 of the most common oral chemotherapy drugs used in children. These were reviewed for content, language, punctuation, grammar and structure by a wide range of end users, such as parents of children on treatment, parents of children whose treatment had finished, clinical nurse educators, paediatric oncology/haematology consultants, clinical nurse specialists, ward managers and different members of the POP group. Feedback and comments were collated. Proposed changes suggested were either actioned or reasons for not actioning documented on a change log. This process repeated until a final version was agreed.

**Results**
Of the 12 PTC’s, 5 had their own oral chemotherapy PIL’s, with the range of leaflets available varying across these five centres. Only 1 PTC had their own intravenous (IV) chemotherapy PIL’s. Information provided varied from centre to centre with drug information also provided from treatment protocols, the Macmillan website or from the manufacturers summary of product characteristics (SPC). Factsheets for the following oral chemotherapy drugs have been produced; chlorambucil, cyclophosphamide, dexamethasone, etoposide, imatinib, lomustine, mercaptopurine, methotrexate, procarbazine and temozolomide. A factsheet on the ‘safe handling of oral chemotherapy’ was developed alongside these to further support parents in managing their child’s oral chemotherapy safely at home.

**Conclusion**
User engagement is paramount in producing information that is clear, accurate, up-to-date, easy to understand and practical. Factsheets are available to order/download free of charge providing equal access to all healthcare professionals, parents/careers and patients across the UK and Ireland, ensuring families are not disadvantaged by geographical treatment location. Current multimedia technology offers the benefit of increased and fast access to information; however, a further survey of families is required to establish whether parents drug information needs have been met though the availability of these factsheets.

**REFERENCES**


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**07** GENERAL PHARMACEUTICAL COUNCIL REVALIDATION: WHAT IS THE BEST APPROACH FOR CONDUCTING A PEER DISCUSSION FOR PAEDIATRIC PHARMACISTS?

Stephen Morris, Teresa Brooks. Leeds Teaching Hospitals NHS Trust

10.1136/archdischild-2019-nppc.7

**Aim**
In 2018 the General Pharmaceutical Council (GPhC) made it mandatory for pharmacists and pharmacy technicians in the UK to conduct a peer discussion as part of their annual revalidation assessment. The criteria from the GPhC states that a practitioner must record why a peer was chosen, how the process of peer discussion has benefited their practice and how the process of peer discussion has benefited the people using their services. The GPhC describes several examples of who can act as a peer; for example a line manager, colleague or other healthcare professional. However, there is no specific format for the discussion, but it may include personal development plans, recent successes or challenges to the individual, medication related incidents or quality improvement work. Case based discussion (CBD) is a tool used for peer discussions, primarily in medical training. They are used to assess a clinician’s knowledge of a condition, the potential management options available to them and decision making abilities. It allows a clinician to objectively reflect on their own practice, and allow for abstract conceptualisation. This is a vital process that links learning to practice, as described by Kolb’s experiential learning theory.

The aim of this project was to assess whether a case based discussion between two experienced paediatric pharmacists will fulfil the GPhC requirements for revalidation.

**Methods**
Two experienced paediatric pharmacists participated in this study. Each took the turn as the subject and the peer. As part of the pre-discussion phase and with agreement from senior management, a job swap was arranged for two weeks to allow each pharmacist to gain an understanding of the demands of their colleague. At the end of this period, the two CBDs were conducted using cases selected from the 2 week period.

**Results**
The two pharmacists selected were practicing in neonatal intensive care and paediatric intensive care. Each CBD lasted approximately one hour and both were conducted in the clinical environment. Using this format provided discussion around a variety of elements of paediatric pharmacy practice; such as clinical assessment skills, interpreting evidence and applying guidelines to practice, identifying knowledge gaps and exploring medication safety issues. The result of each CBD was that each pharmacist was able to successfully complete a peer discussion record that complied with the GPhC criteria.

**Conclusion**
This abstract has highlighted that peer discussion has the potential as a powerful tool for ensuring quality and improvement in paediatric pharmacy practice. This is especially applicable to specialist practice. The Neonatal and Paediatric Pharmacist Group is a potential peer network for facilitating collaborations between paediatric pharmacists. The lack of specific framework is an opportunity for future development.

**REFERENCES**


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**08** SUPPRESSED VANCOMYCIN REACTION IN A PATIENT RECEIVING PARENTERAL CORTICOSTEROIDS

Peter Mulholland, A-M Heuchan. Royal Hospital for Children, Glasgow

10.1136/archdischild-2019-nppc.8

**Background**
A baby boy, (37 +6 weeks, 3 kg) was admitted on day 1 of life with an ante-natal diagnosis of a right side...
congenital diaphragmatic hernia (CDH). The patient was commenced on Extra Corporeal Membrane Oxygenation (ECMO), inhaled nitric oxide and parenteral nutrition. Baby was commenced on morphine, midazolam, vecuronium, dopamine, milrinone and adrenaline infusions. In addition to routine empirical antibiotics hydrocortisone at a dose of 2.5 mg/kg four times daily was commenced to treat hypotension. On day 8 a continuous vancomycin infusion was commenced in line with the network protocol. Two days later the infusion was stopped after a level of 41 mg/L was recorded (therapeutic range 15–25 mg/L). Treatment was recommenced at a lower rate and all following levels were within normal limits. On day 20 of life the patient was noted to have a widespread maculopapular erythematous rash which was most florid on the upper chest, feet and hands. The patient was apyrexial but had a persistently raised CRP. A dermatology review was undertaken and the patient was prescribed a total body application of Daktacort cream. The clinical pharmacist also suggested, and prescribed, a one off dose of alimemazine. The following day the rash had become progressively worse and the possibility of a vancomycin reaction was considered. An internet image search showed that the rash was typical of vancomycin. The most common reaction to vancomycin is ‘red man syndrome’ however this is associated with rapid infusion at a rate greater than 10 mg/min. Patient’s vancomycin rate was equivalent to 2 mg/hour (0.035 mg/minute). Following discussion with microbiology treatment was changed from vancomycin to linezolid.

**Investigations** A review of the patient’s medication history showed a total of 11 different continuous drug infusions and six intermittent medicines. It was noted that the hydrocortisone, which had been weaning over a period of 14 days had been discontinued four days prior to the initial presentation of the rash.

**Outcome** Four days after cessation of the vancomycin infusion the rash had resolved. A yellow Card detailing the reaction was completed. We have since had a second patient with a similar rash appearing two days following cessation of hydrocortisone treatment.

**Discussion** In seven years of using continuous vancomycin infusion in neonates we had never encountered this type of reaction in neonates. Given the proximity between the cessation of steroid treatment and the appearance of the rash, together with the rash resolving following cessation of vancomycin treatment it is likely that this was a true reaction to the drug. The possibility of a suppressed ‘red man’ type reaction to vancomycin should be considered in babies receiving concurrent steroid treatment.

**REFERENCES**

**Introduction** Pharmacist independent prescribers have become common in both community and hospital environments. However most prescribing courses contain limited clinical skills and diagnosis training. NHS England conducted a study to assess the benefit of having pharmacists in the Emergency department (ED). They found that in order to have the biggest impact pharmacists would need additional training above that of an independent prescriber particularly clinical examination and diagnosis skills. One pharmacist from the audit hospital completed the post graduate certificate in Advanced Emergency Medicine at Manchester University. The assessments taught included Respiratory, Gastroenterology, Musculoskeletal, Neurological and ENT examinations.

Additionally, it required 210 hours of in practice training. On completion of the course the local centre had no resources to appoint an APPP in ED. Instead the APPP took up the role within the respiratory team due to experience within this speciality. An APPP now reviews new and follow up patients in clinic as well as those acutely ill. As this was a new role it was decided to perform an audit of parent perception of the role.

**Methods** Questions were integrated into every consultation for a two month period. Pre-clinic: Are you happy to see the pharmacist today instead of the consultant? (Yes/No/Will wait to see outcome) Post-clinic: Did you think a pharmacist could perform this role? (Yes/No). Do you feel like you need to see the consultant still? (Yes/No) Were you happy with the consultation? (Yes/No)

**Results** 132 separate consultations were included. 45 of these were new referrals, 67 were follow up appointments and 20 acute examinations. In 124 consultations parents stated they would decide if they needed to see the consultant after. Of these all were happy with the outcome post consultation and did not see the consultant. 9 parents had no reservations to the pharmacist running the consultation from the outset and remained happy post consultation. 126 stated they did not realise a pharmacist could perform this role. Comments received included ‘I had no idea a pharmacist could perform clinical examinations’; ‘At first I had reservations however if the hospital felt comfortable with you running clinic I am happy’; ‘You took the time to make us feel at ease’; ‘You are always approachable when my child is acutely unwell…you know our child better than any ED doctor and would rather see you’.

**Conclusion** As with Advanced Nurse Practitioners (ANPs) it will take time for parents and patients to adapt to a pharmacist diagnosing and managing them instead of a doctor. This audit has shown the pre-conceptions of what a pharmacist can do could hold some back; however after seeing the pharmacist all were happy with the consultation. This is an exciting new role for pharmacists however it is essential to undertake advanced clinical and diagnosis skills in order to make it a successful.

**REFERENCES**