

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.¹ 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 afebrile 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'² 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

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09

ARE PARENTS AND PATIENTS HAPPY TO SEE AN ADVANCED PAEDIATRIC PHARMACIST PRACTITIONER (APPP)?

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Introduction Pharmacist independent prescribers have become common in both community and hospital environments. However most prescribing courses contain limited clinical skills and diagnosis training.^{1 2} 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.³ 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) Further comments

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

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