maintenance therapy a week after. The specialist pharmacist explained the individualised treatment plan for the patient to the MDT and ensured measures (hydration and mesna) for the prevention of cyclophosphamide-induced haemorrhagic cystitis were appropriately prescribed on the electronic prescribing system with the appropriate timings of administration. Monitoring parameters to determine adverse effects were closely observed. A local guideline was developed during the treatment cycles to ensure all members of the MDT were following the correct procedures.

Outcome The patient responded to cyclophosphamide and clinically improved after the completion of three cycles of monthly treatment. Maintenance mycophenolate mofetil was subsequently stopped a month after the last cycle of cyclophosphamide due to neutropenia. A review of the patient one year after first presentation shows the patient is almost back to their baseline.

Lessons Learned Although there are potentially serious side effects, cyclophosphamide and mycophenolate mofetil has been successful in the treatment of anti-NMDAR encephalitis. The recovery of this patient required extensive support from the entire MDT.

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DO PAEDIATRICIANS RECOGNISE CHILDHOOD OBESITY?

¹Elsbeth Ferguson, ²Claire Hannah, ³Emily Stewart*. ¹Sheffield Teaching Hospitals; ²Sheffield Children's Hospital; ³University of Sheffield

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Aim The obesity epidemic in England is growing, with 22% of 4 and 5 year olds and 34% of 10 and 11 year olds being overweight or obese.¹ With obesity being linked to several different illnesses including type 2 diabetes and hypertension, it is vital that clinicians are recognising obesity among children as early as possible.

This study aims to:

- Carry out an audit of identification of obesity in paediatric outpatients to determine whether paediatricians are effectively identifying overweight and obese children, and whether practice conforms to standards in medical guidelines.
- Explore the barriers to discussing overweight and obesity with parents.
- Carry out a prescription audit and compare against current medical guidelines.²

Method A retrospective review of all new medical patients seen during a one-week period in July was used to determine their weight status and whether they had correctly been identified by clinicians. A short questionnaire was distributed to all clinics at the chosen hospital during a one-week period in October to determine reasons why clinicians may not choose to discuss obesity with patients and their families. A prescription audit was carried out examining the drug cards of all

new overweight and obese patients admitted to wards in the chosen hospital to determine if drug doses had been correctly adjusted for weight.

Results 21% (21) patients in the retrospective audit were classified as either overweight or obese. 28.6% of 4 and 5-year olds were found to be either overweight or obese and 14.3% of 10 and 11-year olds. Only 3 of the 21 overweight or obese patients had been recognised as overweight or obese by clinicians in their notes. The questionnaire found that the most common reasons for not discussing overweight and obesity with patients and their families was concerns about maintaining doctor/patient and doctor/parent relationships. Other reasons given were that there was not enough time in clinic appointments or that the family was already aware. Four overweight or obese patients had been prescribed drugs based on their actual weight rather than ideal weight and therefore had received an overdose. All doses for these patients were adjusted accordingly and re-prescribed in line with trust guidelines.

Conclusions The results of our study indicate that there is need for regular height and weight checks for all paediatric patients to ensure correct identification and management of overweight and obese children. Ways of doing this may involve more regular height measurements and providing guidelines for medical professionals in how to breach the topic of weight with patients and carers. The results of our pharmacy audit indicate that some overweight and obese children are being prescribed inappropriate doses of medication with clearly shows that there is need for more monitoring of prescribing practices in overweight and obese patients.

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IMPLEMENTATION OF A PAEDIATRIC OUTPATIENT PARENTERAL ANTIBIOTIC THERAPY (P-OPAT) SERVICE AT A SPECIALIST CHILDREN'S HOSPITAL

Hannah Porter, Kate Stock*. NHS Greater Glasgow and Clyde

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Aim The aim of this project is to optimise patient care, enhance patient experience, improve antimicrobial stewardship and assist patient flow through the hospital.

Method Data collection was conducted one day a week over five consecutive weeks. All eligible wards were visited. Patient medication charts were inspected to see if intravenous antimicrobials were prescribed and a patient - specific data collection form was then completed. All the patients that met the eligibility criteria to be put forward for OPAT referral were then considered from a clinical perspective by a paediatric consultant as to their suitability for OPAT or IVOST and discharge. If the patient was deemed suitable for an OPAT discharge or IVOST and discharge a decision was made as to what antimicrobials they would theoretically have been on when discharged home. The number of potential bed days saved was calculated as the number of days between the patients review by the consultant (ie the day of data collection) and the date of their discharge prescription from that episode of care.

The following was examined

- percentage of patients with identified pathogens