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.

REFERENCES

1. NHS England. Clinical Commissioning Policy: Rituximab for second line treatment for anti-NMDAR autoimmune encephalitis (all ages). March 2018.
2. Salvucci A, Devine IM, Hammond D, *et al.* Pediatric anti-NMDA (N-methyl D-Aspartate) receptor encephalitis. *Pediatric Neurology* 2014;**50**:507–510.
3. Summary of Product Characteristics. Cyclophosphamide 1000 mg Powder for Solution for Injection or Infusion. Last updated on eMC on 27-Jun-2017. Available at <https://www.medicines.org.uk/emc/product/3525/smpc#> [Accessed 04 July 2019]
4. Summary of Product Characteristics. CellCept 1 g/5 mL powder for oral suspension. Last updated on eMC on 16-Mar-2018. Available at <https://www.medicines.org.uk/emc/product/1569/smpc> [Accessed 04 July 2019]

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DO PAEDIATRICIANS RECOGNISE CHILDHOOD OBESITY?

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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.

REFERENCES

1. Public Health England. 2017. Health matters: obesity and the food environment.
2. Trust guidelines. 2017. Drug adjustments in obese patients.

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

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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

- percentage of patients that had received input from the ID team
- percentage of patients that had received input from microbiology
- the prevalence of antimicrobials prescribed
- the location of the patient's home residence
- patient/parent willingness to go home on OPAT.

The data for patient numbers and bed day savings was then extrapolated to 52 weeks in order to be indicative of one year.

Results Over the five days, 66 patients were identified that met the exclusion criteria to be referred for OPAT or IVOST. After clinical consideration the consultant deemed 4 patients to be suitable for OPAT and 19 for IVOST and discharge which generated a potential bed day saving of 38 bed days. This was comprised of 17 days through providing IVAs via OPAT and 21 days from timelier IVOST and discharge of patients. Extrapolated to be representative of one year, this would be a bed saving to the Trust of 1, 976 bed days.

Conclusion The potential has been identified for the hospital to make considerable bed day savings through the investment in an extended antimicrobial stewardship programme and establishment of a paediatric OPAT service. A business case has been submitted to the hospital board for consideration, with the hope that the service will be funded for a six month probationary period in order to assess its impact over the winter months, when demand for beds and pressures on PICU and theatres are highest.

REFERENCES

1. Patel S, et al. 2015. Good practice recommendations for paediatric outpatient parenteral antibiotic therapy (p-OPAT) in the UK: a consensus statement. *Journal of Antimicrobial Chemotherapy* 2015;702:360–373.
2. Carter B, et al. Delivery, setting and outcomes of paediatric outpatient parenteral antimicrobial therapy (OPAT): a scoping review. *BMJ Open*, 2018;8:e021603.
3. Hodgson KA, et al. The use, appropriateness and outcomes of outpatient parenteral antimicrobial therapy. *Archives of Disease in Childhood*, 2016;10:886–893.
4. Knackstedt ED, et al. Outpatient parenteral antimicrobial therapy in pediatrics: an opportunity to expand antimicrobial stewardship. *Infection Control & Hospital Epidemiology* 2015;36:222–224.

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ADVANCED NEONATAL NURSE PRACTITIONER (ANNP) REVIEW OF NEONATAL ANTIBIOTICS IN 36HOURS TO IMPROVE ANTIBIOTICS STEWARDSHIP

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Aim To ensure neonates in transitional care and postnatal wards are receiving antibiotics appropriately. NICE CG149¹ advises to consider stopping antibiotics at 36 hours in babies given antibiotics because of risk factors for infection or clinical indicators of possible infection where:

- the blood culture is negative,
- the levels and trends of C-reactive protein (crp) concentration are reassuring and
- no clinical indicators of possible infection

Neonatal unit was excluded from this study; since daily clinician led ward rounds to review antibiotics already occur. Antibiotics not reviewed in the 36 hour time frame were due to delays in receiving the second crp level. Daily ward rounds to review antibiotics in neonates were not happening on

transitional care and postnatal wards, thus to ensure regular care, advanced neonatal nurse practitioner led reviews were implemented.

Method A crp sample should be taken after delivery and in babies given antibiotics because of possible infection, the crp concentration is measured again 18–24 hours after presentation. The role of the ANNP is to ensure both crp levels are checked and the blood culture is negative, with the aim of stopping antibiotics at 36 hours before the second dose of gentamicin is due. In summary neonates that do not need antibiotics should have only had approximately 3 doses of benzylpenicillin and 1 dose of gentamicin. Audits were carried out on neonates in transitional care and postnatal wards who were receiving antibiotics. The initial base line audit was done over 3 months to assess if antibiotics were reviewed in 36 hours. This was deduced by a signature from the ANNP either stating on the drug chart that antibiotics would continue for 5 days until crp has decreased or the antibiotic would be discontinued if the crp was low. This audit was repeated a year later.

Results During the first 3 months audit the proportion of babies having their antibiotics reviewed within 36 hour time frame rose from 3% in month 1 to 25% and 50% in months 2 and 3 consecutively. During the second 3 month audit, the proportion of babies having their antibiotics reviewed was 78% in month 1 and 80% in the following two months. The first audit showed a rapid improvement, whereas the second audit showed a significant improvement compared to the end of the first audit, which was sustained throughout the full three months.

Conclusion The ANNP was a simple and no cost solution in ensuring antibiotic stewardship was consistent throughout neonates, reducing the length of stay of neonates and their mothers. The 20% of babies who are still not having a 36 hour review may be because of delays in blood cultures reaching the laboratories to commence incubation.

REFERENCE

1. Neonatal infection (early onset): antibiotics for prevention and treatment. NICE CCG149 2012.

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STANDARDISING STRENGTHS OF UNLICENSED MEDICINES IN A LARGE LONDON HOSPITAL TRUST

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Background A UK national position statement on standardised strengths of unlicensed liquid medicines recommend that when children require unlicensed liquid medications, they should receive the recommended strength. By standardising strengths of these medicines, the risk of errors being made in the doses given to children will be reduced and prevent accidental under and overdoses.¹ Our Trust has 4 hospital sites since merging in 2012, we found the process of switching to a standard strength far from simple.

Methods The strengths of unlicensed liquid medicines listed in the position statement available on the pharmacy dispensing system (JAC) were identified, along with the speciality users. Pharmacy and clinical leads were consulted for agreement to switching to the standardised strengths. Pharmacy procurement identified new products in standardised strengths and products were reviewed for suitability by paediatric pharmacist. A cost