

of normal (ULN) with normal serum bilirubin should prompt repeat LFTs within 8 weeks.¹ ALT/AST greater than five times ULN, or greater than three times ULN with high bilirubin warrants treatment being interrupted.¹⁻³

Results 31 patients were reviewed. 30 patients (97%) had baseline LFTs. 10 patients (32%) had LFTs at 3 months. Of the 21 patients who did not, 15 of those had their first set of LFTs taken too early at 1 or 2 months and 6 were taken late at 4, 5 or 6 months. Zero patients had four sets of LFT results taken at the correct 3-monthly intervals in the first year. 4 patients (13%) had at least one set of abnormal LFTs. 50% of abnormal results were acted upon in accordance with guidelines.

Conclusion The results showed that, other than baseline monitoring, current practice is not in accordance with guidelines both in relation to frequency of LFT monitoring and appropriate action being taken on the finding of abnormal results. Further study is required to investigate the reasons for poor outcomes and how compliance with the guidelines can be improved. Encouragingly, the rate of liver impairment as an adverse drug reaction was low. Trial data should be reviewed to assess the significance of waiting until month 3 to start LFT monitoring (i.e. when do deranged LFTs typically first manifest?) and therefore whether early testing is problematic (in patients with no history of liver impairment). Guideline development should be an area of focus to put measures in place to improve guideline compliance. However, with MDT agreement, consideration should be given to adapting local practice to deviate from national guidance to better fit real-world practice.

REFERENCES

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CREATING A DIGITAL PATIENT HELPLINE FOR MEDICINES INFORMATION AT A SPECIALIST PAEDIATRIC HOSPITAL

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Aim To improve the patient facing aspect of a Medicines Information (MI) service by setting up a patient helpline that meets the needs and expectations of patients and carers at the Trust. The MI team identified a patient helpline as a potential area for improved visibility and growth within the service.¹ To align with other clinical workstreams within the Trust, the MI team decided to develop a virtual helpline within an existing patient facing app, a digital platform used by families to communicate securely with their clinical teams.

Method The MI team and the Trust ICT team worked together to create a contact box within the existing 'Medication' page on the app, through which patients can ask clinical questions about their medicines. All in-app messages arrive directly to an inbox within the EPMA system, ensuring patient confidentiality remains intact.

To limit enquiries unrelated to MI (requests for repeat prescriptions or supply of medication) and to give users an expected turnaround time for answers to enquiries, a brief description of the MI service was added to the Medication homepage. For all urgent enquiries and clinical emergencies, app users are signposted to a more appropriate service via an automatic response. Baseline data (number of enquiries) from patients or carers were retrospectively collated over an 18 month period prior to the intervention using MiDatabank software. Throughout the first 4 weeks of the service launch, all enquiries received via the app were recorded using Microsoft Excel. Relevant clinical enquiries were also inputted into MiDatabank following standard MI practice. The overall number of enquiries received during this time and the percentage answered on time were also recorded as part of standard MI Key Performance Indicators (KPIs).

Preliminary Results The MI team received 78 enquiries from patients or carers in the 18 months prior to the app service launch, 72 of these enquiries were relevant to MI (approximately 4 per calendar month). During the first 4 weeks, 82 enquiries were received via the app alone. Of these, 13 enquiries were relevant to MI with 69 enquiries relating to supply. Full analysis of key themes and trends is ongoing.

Conclusion The data have clearly demonstrated an increase in direct contact from patients and carers to the MI service; within 1 month there has been a 4-fold increase in enquiries compared to baseline data. The main limitation of the data used as a comparison is that it has only been collected over the first month of launch. To mitigate this the MI team will continue to collect data through 'snapshot' audits at months; 3, 6, 9 and 12. This will help identify whether the MI team are making a sustained impact to patient care through a digital patient helpline.

Given the significant increase in workload for the MI team, the data may be used to support additional staffing within the team.

REFERENCE

1. UK Medicines Information, Thames Valley and Wessex Chief Pharmacists Network. Implementing a medicines helpline for hospital patients: a practical guide for hospital pharmacy. January 2017.

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PHARMACIST LED ALLERGY CLINIC: IMPROVING PAEDIATRIC PATIENT CARE

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Problem Due to the increase in prevalence and burden of allergic disease, the demand for specialist hospital allergy services is significant,¹ and has given rise to the two main problems. Firstly, increased long waiting times for new and follow-up appointments and secondly patient safety being compromised.²

Aim By December 2019, to firstly reduce the outpatient clinic waiting time by 60% for those patients referred to pharmacist clinic for an eczema review after the initiation of topical immunomodulatory therapy. Secondly to complete 100% of medication reviews within 4 weeks for those patients referred to pharmacist clinic on multiple drug regimens with non-adherence issues.

Strategy for change Pharmacist to run one paediatric allergy clinic every two weeks. Plan 1: Eczema review after the