Depending on the circumstances, such as in a situation where the patient lacks mental capacity, most students believe that it is ethical to administer medicine covertly. In contrast to a situation where the patient has mental capacity, the majority of students believe that it is unethical for covert medication administration to be used. Furthermore, when applying the use of covert medication administration in children, majority of students believe that it is appropriate to act in the best interests of the child and for parents and carers to administer medicine covertly.

Conclusion This study has enabled the gap in knowledge to be identified, where there is a need for further research which explores the legal and ethical implications of the use of covert medication administration in children.

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P46 REVIEW OF MEDICATIONS/SUPPORTIVE CARE ITEMS PRESCRIBED AT DISCHARGE FOR PAEDIATRIC FRAME PATIENTS

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Aim Paediatric orthopaedic frame patients require a specific list of medications and supportive care items at the point of discharge, to adequately manage pain and to ensure that pin sites are well managed.[1 2] Currently there is no SOP/guideline that states what is needed on discharge, instead relying on doctors, nurses and pharmacists to remember what is needed, meaning there is a risk of omitting essential items. Therefore, this audit was undertaken to review if patients were prescribed essential items and the results used to implement a new guideline/SOP to aid prescribing.

Method As there is no existing guideline/SOP for items required at discharge, standards were defined using a poster previously created to remind doctors, nurses and pharmacists of what to prescribe and supply on discharge. Data was collected from all paediatric frame patients (n=25) admitted to hospital from January 2019 to July 2021. Data was obtained from CareFlow EPR (electronic prescribing software) and JAC (medicine management software) to determine items prescribed and quantities supplied at discharge. Data was collected and analysed using Microsoft Excel.

Results 21/25(84%) of patients were prescribed paracetamol, 23/25(92%) were prescribed tramadol, 20/25(80%) were prescribed diazepam, 23/25(92%) were prescribed an antibiotic and 23/25(92%) were prescribed an appropriate antibiotic at discharge. Of patients prescribed tramadol at discharge, only 4/25(16%) were given a 14 day supply (correct quantity to supply), 15/25(60%) were given a 7 day supply, 1/25(4%) was given a 4 week supply, 1/25(4%) was given a 10 day supply, and 1/25(4%) was given a 5 day supply. 2/25(8%) were not prescribed tramadol. 14/25 (54%) had a request for their GP to continue the supply if needed. Of the patients prescribed diazepam at discharge, 18/25(72%) were prescribed diazepam short-term and only 2/25(8%) had a diazepam wean plan. 5/25(20%) were not prescribed diazepam. 21/25(84%) were prescribed sodium chloride 0.9% sachets, 21/25(84%) were prescribed Allevyn dressings, 22/25(88%) were prescribed chlorhexidine and 21/25(84%) were prescribed alcohol hand gel. Only 1/25(4%) patient was prescribed an NSAID on discharge (usually avoided in frame patients) and no rationale was documented.

Conclusion Although many patients were prescribed appropriate medications and supportive care items at discharge, the audit demonstrated essential items are omitted and that there is great variation in supply of these items. Patients received from as little as a 5-day supply of tramadol to 4 weeks' worth, and just under half of all patients did not have a request for their GP to continue supplying tramadol if needed. If a patient is not seen by their GP within 2 weeks of being discharged, this may lead to patients not being prescribed adequate analgesia. In addition, although many patients were prescribed diazepam at discharge, almost all patients had no clear plan of how to wean diazepam. An SOP/guideline would help standardise frame patients' discharges, ensuring essential medications and supportive care items are not omitted, and ensuring appropriate supplies of these are given on discharge.

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P47 IMPACT OF INCREASED PHARMACIST RESOURCE ON A LEVEL 3 NEONATAL UNIT

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Situation Pharmacists are fundamental components of the neonatal workforce and should have job plans with protected capacity for providing advice and support in neonatal pharmacy.[1] Using Neonatal and Paediatric Pharmacists Group staffing recommendations[2] a shortfall of 0.675 whole time equivalent (wte) band 8a pharmacist resource was identified. A business case was developed and funding was approved to increase the existing neonatal pharmacist's input to the neonatal intensive care unit (NICU) from 0.325 wte to 1 wte from June 2021. The main driver was the number of medication incidents reported, particularly involving gentamicin. Prior to June 2021 the neonatal pharmacist was part of a multi-disciplinary task and finish group established to reduce medication, especially gentamicin, errors. A detailed action plan and a new gentamicin guideline and prescription were developed which included significant training and teaching of both medical and nursing staff. A review of all gentamicin errors reported electronically via Datix from June 2019 to June 2022 was undertaken. A reduction in gentamicin errors was achieved prior to June 2021 and was successfully sustained up to June 2022.

Also feedback was sought from a multi-disciplinary team to ascertain the impact of increased pharmacist resource. The following improvements were identified:

- Sustained improvement in other medication related incidents.
- Bedside teaching for nursing and junior medical staff
- Pharmacist attendance at handover and on ward rounds.
- Co-operative decision making on neonatal treatments in real time with consultants.