medicines following discharge from neonatal units in UK and Ireland.

Method HCPs in the UK and Ireland were identified using a stakeholder map. An electronic survey was developed and circulated to HCPs involved in the care of neonates at the five study sites and shared on social media. Parents were recruited via social media, parent support groups, in-patient and clinic settings.

Results HCPs 155 HCPs responded: 41% nurses, 34% pharmacists, 11% doctors; the remainder were a mixture of professions. The majority had over 5 years' experience. 58% were aware of medicines resources or information being used at their hospital, the most popular method being face to face information given individually, followed by written information.

When asked which HCPs were best placed to provide information about medicines, 'nurses' were the most common response. When asked about the best time to provide information, 'throughout the stay' was felt to be the most appropriate time, however, in practice they reported that information was typically given immediately prior to discharge. The move to Family Integrated Care has led to improvements with many units now involving parents in the medicine administration process at a much earlier stage.

Parents A total of 87 parents/carers completed the e-survey. 72% parents/carers had 'none', or 'very little experience' of giving medicines to children prior to their baby's hospital stay. Only 53% received information about medicines prior to discharge. However, 48% of respondents were administering 4 or more medicines on discharge. 24% of parents/carers reported feeling stressed about giving medicines. Challenges with medicines following discharge were reported by 47%. Printed information was the preferred format for medicines resources (57%).

Conclusion The findings from HCPs highlighted the importance of the 'timing of information' and involving parents at an earlier stage could be helpful in preparation for discharge. The results from parents show there are significant shortfalls in the existing provision of information about giving medicines to their babies at home. These findings will inform the co-design of new information resources about medicines for parents and carers taking babies home.

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SP3 OPTIMISING PRESCRIBING OF MEDICINES TO CHILDREN BY FORMULARY INTERFACE PHARMACISTS

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Context Unlicensed and off label drug use in children is common and leads to well recognised problems. It has been shown that there is an association between unlicensed drug use in children and particularly neonates, and increased risks of medication errors, due to prescribing, dispensing and administration.[1] Alongside this, the variation in strengths of oral liquid products, adds to the potential for harm to be caused to children due to a lack of awareness and education on these issues.

Quality improvement initiative A UK CCG funded two specialist paediatric pharmacist posts with the aim of rationalising, standardising, and optimising the prescribing of unlicensed medicines to children. The aim was that these pharmacists would create an interface link between primary and secondary care, to empower healthcare professionals to prescribe and supply medicines to children safely and effectively.

Work undertaken ePACT2 prescribing data highlighting variation in strength, formulation and cost of unlicensed medicines supplied; feedback from colleagues across all sectors of healthcare; NPPG position statements and MHRA alerts were used to identify areas to focus interventions. Examples of the work undertaken includes:

- Led webinars on prescribing medicines to children to healthcare professionals across the CCG
- Met with ~70% of GP practices, either individually or as groups e.g. PCNs across the CCG
- Initiated standardisation of liquid strengths kept across 3 hospital trust and primary care
- Identified areas for medication safety team work e.g. prescribing of multiple strengths of medicines to children, prescribing of alcohol–containing phenobarbital to children
- Worked with CCG Medication Safety Officers to provide a response, advice and information on MHRA alerts e.g. chloral hydrate prescribing to children
- Worked with medicines optimisation CCG teams on communication tools e.g. bulletins
- Created a paediatric guidelines and pathways section on the CCG webpage
- Created a paediatric formulary pharmacist group with representatives across all 3 hospital trusts to meet monthly and foster collaborative working.

Measure of improvement Through regular feedback, meetings, and email communication it can be noted that the links between primary and secondary care have been strengthened. Praise has been received for the help and support provided and for the openness to amend and adjust work plans based on the priorities and needs of the CCG. Through monthly ePACT2 data in the form of excel specials dashboard the reduction in variation of strengths being supplied to children can be seen, with in most cases an accompanying reduction in spend.

Lessons learned Although much has been publicised on the importance of nationally standardising concentrations of liquid medicines[2], this initiative has shown that there is still much work to be done. Dedicated pharmacists have been able to make progress in standardising the range of unlicensed medicines recommended in the local formulary and ensure that this is well communicated across both primary and secondary care. Interface links between care settings are vital if we are to achieve substantial harmonisation of medicines prescribed to children.

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