

'The GP surgery couldn't find the clinic letter that had been sent to them, so he missed a couple of days of his inhalers whilst we sorted out the issue'

2. Improvements in transfer of care:

'I struggle to get things added onto the repeat slip after a clinic appointment. When I have gone to collect my child's prescription from the pharmacy the medications have not been updated. This then takes a while to sort out and has meant that my child has missed a couple of days of their inhalers.'

'I wanted to confirm why my child was using their new inhaler as a reliever as this went against what I had been told previously that steroids were to prevent asthma attacks.'

Conclusions Medication changes made in out-patient clinics are either not transferred accurately or no changes appear in primary care records nearly 50% of the time. Better communication between care providers is required for more effective care.

Future research could explore digital solutions such as Electronic Prescribing System (EPS) and Pharmoutcomes[®] or AccuRx[®] to facilitate better cross sector communication, in addition to utilization of the Discharge Medication Service (DMS) and New Medications Service (NMS).

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SP8

EMBEDDING 'PILL' SWALLOWING TRAINING ACROSS A UK SCHOOL OF PHARMACY

Alice McCloskey. *Liverpool John Moores University*

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Aim To validate an educational tool (Health Education England Learning for healthcare 'KidzMed' programme) to prepare student pharmacists for patient counselling on effective swallowing of solid oral dosage forms ('pills').¹ Through receiving and applying their learning in a simulated environment it was hoped that participants would feel confident to teach children to swallow pills.

Method University ethics was sought and granted (PBS/2020-21 04). Our final year MPharm students completed a KidzMed workshop within their paediatric module. Students completed an eLearning component (15-minute video, 30 minute interactive content) as pre-work prior to attending a 90 minute in-person simulation and supported workshop with experienced pill school trainers. Participants role played in pairs using sports-capped water bottles and pill packs containing sweets and HPMC capsules of various sizes. Participation was entirely voluntary.

Pre and post training data collection was anonymous via Microsoft Forms. Pre-training data included participant reflection on their own pill-swallowing experiences and pill swallowing difficulties using a validated tool PILL-5.² Post training session participants repeated PILL-5 and provided feedback on the learning and its usefulness for future practice.

Results Overall, 81 students were trained with 65 completing the post-training feedback. At baseline 12 (15%) had a PILL-5 scored ≥ 6 indicating pill swallowing difficulties (similar to published pill swallowing difficulty 12-54% prevalence in non-dysphagia adults).^{3,4} Post-training, all 65 (100%) reported

successfully swallowing the 'pills' provided. Participants recognised the benefits of this learning for both children and adults (n= 61), 3 viewed it as suitable for children only, and 1 adult only. All agreed/strongly agreed that pill swallowing training is useful and their comfort in counselling patients, parents/carers. Feedback was positive with the pre-work and workshops viewed as 'just right'. They described the interactive nature, transferability and benefits of the learning for future practice. A handful expressed awkwardness acting with their peer group. All would recommend the training to a colleague or friend.

Conclusions In a UK first, we successfully tested pill swallowing training within a School of Pharmacy MPharm curriculum. A blended method was welcomed by students who enjoyed the simulated sessions. Students with pre-existing swallowing difficulties successfully learnt to swallow solid oral dosage forms from each other. Counselling on effective medicines use is a key role for pharmacists and students see its relevance to future practice.

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SP9

HOW TO MANAGE PATIENTS WITH A FOOD ALLERGY WHO NEED PARENTERAL NUTRITION

Stephen Morris. *Leeds Teaching Hospitals NHS Foundation Trust*

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Introduction Food allergies are commonly encountered in children and young persons in the UK.¹ This is problematic for healthcare providers who need to use medicines that are derived from food sources. One example is parenteral nutrition (PN), which contain lecithin as an emulsifying agent which is derived from eggs.

Using PN in patients with food allergies is listed as a contra-indication according to the marketing authorisation of a commonly used formulation.² The aim of this abstract is to describe how we approached challenging a patient with a known food allergy.

Situation The patient was a 2-year-old who was admitted to critical care with acute liver failure. They were fluid overloaded, had gut failure and were not tolerating enteral feeding. His parents reported anaphylactic reactions to eggs and nuts in the past that had been confirmed by a specialist paediatrician in allergies.

As per local protocol, parenteral nutrition was started on day 5 of intensive care admission. Initially, with an aqueous component only (glucose, amino acids, electrolytes, and water-soluble vitamins) to avoid using lipids. Attempts to remove fluid by haemofiltration were complicated by a life-threatening allergic reaction to the filtration circuit.

By day 7 the patient remained on trophic enteral feeds and was still fluid restricted. Their nutrition target was 770kcal but only 400kcal were being given, i.e. 50% of requirements. The multidisciplinary team agreed it would be in the child's