Hospitals Leicester policy, including compliance rates for HU initiation in eligible patients, monitoring and dose escalation.

Standard 1: 100% of all appropriate patients have a baseline pregnancy test

Standard 2: 100% of patients are started on the correct dose mg/kg.

Standard 3: 100% of patients with FBC after 8–12 weeks.

Standard 4: 100% of patients with dose increase have FBC after 2 weeks.

Standard 5: 100% of patients have dose increased by 5 mg/kg

Method We completed a retrospective analysis of all patients who received hydroxycarbamide on ward at University Hospitals from 01/09/2020 till 01/09/2022 resulting in 36 patients. Raw data including sex, weight, and dose and blood results were documented and anonymised, data were then assessed if the audit criteria were met.

Results The use of hydroxycarbamide is in perfect adherence with BSH guidance. None of the patients in this group were post-pubescent females thus none required a pregnancy test, this criteria was not monitored. 94% of patients started on 20 mg/kg/day dosing. 6% (2 patients) were started 15 mg/kg/day alongside guidance due to clinical co-morbidities. 71% of patients from the total cohort had their doses optimised, with all patients whom had a dose increase done by the appropriate 5 mg/kg/day. All patients had blood tests 2 weeks after a dose change, and 8–12 weeks routinely.

Conclusion The audit shows an excellent adherence to BSH guidance, 100% compliance.

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P15 PAEDIATRIC PRESCRIBING TEST AT A TERTIARY CHILDREN'S HOSPITAL – OBSERVATIONS AND REFLECTIONS

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Aims All new cohort of prescribers are required to complete a paediatric prescribing test (paper based) prior to working on the paediatric wards. The test is based on local prescribing drug charts (paper based), guidelines and Trust policies and processes such as prescribing antibiotics for suspected sepsis in a term neonate, prescribing fluids and insulin in DKA and controlled drug prescribing on discharge (CD TTOs).

Method 10 questions developed and agreed by a paediatric pharmacist and three consultants that lead on education and training in the paediatric department. Each question is assessed as a pass or fail and total score presented as a percentage. It was agreed that a pass mark was 80% and a re-test would be needed if a score was less than 70%. All prescribers (irrespective of their score) would have to meet with their clinical supervisor for feedback. If a re-test (different set of questions and mark scheme) was needed then this would need to be completed within one week of the first test score. If re-test was failed then the educational supervisors would need to meet to discuss a plan to manage the prescriber and their prescribing practice.

Results From April 2021 to April 2023 a total of 125 prescribers (from 11 cohorts) took the test. Prescribers who passed 1st time were on average about 45% for all cohorts (lowest cohort 15% and highest cohort 78%). Average 1st time score for all cohorts was 71% (lowest cohort was 59% and highest cohort was 83%). Out of the 125 prescribers about 35% needed to do a re-test. Only three out of the 125 (about 2%) failed the re-test. Heat map data of which questions for each cohort that was not answered correctly indicates more complex prescribing scenarios i.e. in DKA or CD TTO can be challenging.

Conclusions Scores based on grade of prescribers that passed the 1st time: 45% of FY1s passed the test the 1st time, FY2s 25%, ST/SpR 41%, GP trainees 53%, SHO/MT 0% and unknown grade 39%. The test is an opportunity to introduce the concepts of paediatric prescribing (i.e. drug handling) to new prescribers and for those that have paediatric prescribing experience elsewhere the local prescribing policies and procedures. However, seniority/grade of prescriber does not indicate likelihood of passing/not passing the test but factors such as over-confidence might explain why senior vs. junior test scores are varied and unpredictable. Almost half of the prescribers needed a re-test and this may act as a prompt at the start of the rotation that they need to pay more attention to their prescribing and raise awareness of differences between prescribing i.e. adults vs. children and/or prescribing compared to other hospitals or systems (paper based vs. electronic [EPMA]).

The data has prompted revising our approach towards education and training[1–3] and focusing on personalised feedback and simulation events based on poor prescribing practice for each cohort rather than a generic approach. This may help our prescribers prescribe safely and effectively.[1–3]

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P16 AUDIT ON INITIATION, PRESCRIBING, AND ADMINISTRATION ON STANDARDISED, CONCENTRATED, ADDITIONAL MACRONUTRIENTS, PARENTERAL NUTRITION

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Aims To assess the level of adherence with current local guidelines for the initiation, prescribing, and administering of SCAMP[1] in the neonatal intensive care unit (NICU) and special care baby unit (SCBU) in a district general hospital.[2–4]