are available within the panel. Microbiology, pharmacy and the antibiotic policy group reviewed and approved the panel.
Conclusion We hope that this teicoplanin prescribing panel will standardise prescribing and TDM, thus improving care for our patients by ensuring safe, optimal dosing. Teicoplanin prescribing will be reaudited in one year.

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P22 AUDIT OF CONTROLLED DRUGS NOT ISSUED ON DISCHARGE TO THE PATIENT

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Aim Following on from identification by the medication safety collaborative that wards had a build-up of Controlled Drug (CD) medication not given on discharge this audit aims to establish why CD medications that had been dispensed by pharmacy as part of a patients take home medication (TTO) had not been issued to patients at the point of discharge.
Method Pharmacy completed an audit of all ward areas that routinely discharge patients' home (therefore excluding Intensive Care and High Dependency Unit) on one set day to establish the number of uncollected CD medications. Data collection included the total number of CD items dispensed by pharmacy but not issued upon discharge to the patient, the details of what these CD items were and the ward staff comments as to why the item had not be given upon discharge.

As these items belonged to patients no longer being treated within the trust they were appropriately returned to pharmacy, to ensure the correct denaturing of the CD was undertaken prior to disposal. It was at this stage that the amounts of CD medication wasted as dispensed products unable to be used was also recorded.
Results The data collected established that all 7 inpatient ward areas had at least 1 CD medication that had been dispensed as part of the patients TTO but not issued on discharge. The were a total of 28 CD medications stored in trust CD cabinets not given on discharge of which 39% involved a legally classified schedule 2 or 3 CD. 54% of the unissued medications involved Morphine oral solution 2 mg/ml amounting to a total waste of 653 ml.

In 71% of the situations staff commented the CD medication had not been issued upon discharge as it was unwanted by the patient or parents of the child or staff had concluded the medication to no longer be clinically necessary for the patient as the TTO had been completed in advance of the discharge date and the clinical picture had changed. or they did not retrieve it from the cabinet at the point of discharge.
Conclusion This audit suggests there is a flaw in the discharge of patients who are prescribed CD items. It has flagged the need for an immediate review of the discharge process to ensure that discharge paperwork reflects that certain items have not been provided upon discharge. We need to incorporate a system that closes the loop in relation to CD governance whereby we can be assured that the CD medication dispensed by pharmacy is issued to the patient.

Pharmacy should embed the return of unnecessary CD medication as part of routine practice and challenge patterns of not issuing dispensed medication. As a result of the high amount of CD waste we are also considering the practicality of ward level destructions to reduce any potential safety incidents, ie; some of the unissued CD medication found in the CD cabinets was found to be out of date.

P23 MODERNISING THE DISCHARGE PRESCRIPTION PATHWAY FOR SURGICAL DAY-CASE PATIENTS

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Aim The aim of the project was to reduce prescription waiting times and release pharmacy staff resource by modernising the discharge pathway on the paediatric surgical day-case ward. To achieve this, TTO (To Take Out) medicines and unlabelled paracetamol and ibuprofen oral suspensions, were utilised, where possible, as an alternative to pharmacy dispensing.
Method To define the need for change, an audit of prescribing and dispensing practice was first undertaken over the course of two weeks on the surgical day-case ward. The results supported the need to change practice and were communicated by pharmacy via a Situation, Background, Assessment, Recommendation (SBAR) tool to the multidisciplinary team. Recommendations were made to begin utilising available TTO medicines and unlabelled paracetamol and ibuprofen oral suspensions, prescribed according to manufacturer age based dosing instructions, to facilitate ward dispensing where possible.

Once the new prescription pathway was approved, education and training materials were developed and delivered by pharmacists in one to one sessions to applicable nursing and medical staff. These covered the new prescription pathway, patient inclusion and exclusion criteria and the documentation process for issuing medicines. An updated stocklist and appropriate place to store the medicines were agreed and implemented, prior to commencing. Following implementation, a second audit was undertaken over two weeks on the ward to measure the impact of the change.
Results The impact of the change in practice meant the majority of patients, 65%, were able to have their prescriptions dispensed from the ward and significantly reduced their prescription waiting times by over two hours on average (from 3 hours 30 minutes to 1 hour 16 minutes). A further 6% of patients could have benefited from ward dispensing, but their prescriptions were dispensed by pharmacy without clear reason, indicating the need for ongoing education and training of ward staff. The remaining 29% of prescriptions required pharmacy dispensing due to limitations on available TTO medicines. Ward dispensing reduced the demand on pharmacy services, contributing to a reduction in waiting times for the pharmacy dispensed prescriptions by half (to 1 hour 45 minutes on average) for the ward. The assessment of prescribing and ward dispensing demonstrated that 100% of medicine issued were clinically appropriate for age and weight and documentation was completed correctly 100% of the time. This indicated prescriptions could be supplied through the new prescription pathway safely without compromising patient care.

Conclusion In the care of paediatric surgical day-case patients the utilisation and supply of TTO medicines and unlabelled Paracetamol and Ibuprofen oral suspensions reduced prescription waiting times and the demand on pharmacy services. As a result, it will improve patient flow within the hospital and allow the reprioritisation of pharmacy resource for other roles.

P24 PILL SCHOOL: THE TOOLKIT

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Aim It has been identified that children aged as young as four could potentially swallow tablets.[1] 'Pill Schools' have been created in hospitals across the UK with the aim of teaching children to swallow solid oral dosage forms, such as tablets or capsules. Solid dose forms offer significant advantages over liquids for patients, families and healthcare professionals across primary and secondary care.[2] Whilst this has been successfully implemented within several Trusts, there is no standardised toolkit available nationally to support this. Members of the paediatric team at Nottingham University Hospitals (NUH) are currently implementing 'Pill School' using resources provided as part of the 'KidzMed project'[2] and have devised a toolkit to support other Trusts with launching this scheme.

Method We were inspired by the work from the Northern Paediatrics Kidzmed project. Following a pilot using a 'pill swallowing kit' in one clinic, a bid was successfully submitted to the hospital charity to produce additional kits to enable easy access to resources in wards and clinics. These were allocated to the play specialists, after a training session, and staff were also signposted to the Kidzmed e-learning.[3] A project steering group was set up to implement training, kit maintenance, a communication strategy, data collection and evaluation, with the aim to roll out to two wards initially.

Kits contained water bottles with straws (which give a good flow of water to aid with the swallowing technique), cake decorations, other small sweets and dummy capsules to practice with, and a guide to running a session. Train the trainer sessions were offered to build staff confidence and promote the project.

Additional visual resources were developed, including a poster, screensaver and a logo to use on stickers and certificates. Questionnaires were designed to collect patient and medication details and to allow follow up for qualitative and quantitative data analysis. Letter templates were created for GP surgeries to provide updates about training provided in hospital, if this had been successful and if any drug formulations could be switched.

Outcomes We are at the point of implementing this across a small number of wards initially with the aim of scoping this out to the entire Children's hospital across inpatient and outpatient areas. Initial progress has been slower than hoped due to time taken to set up processes and produce resources but we now aim to expand quickly to fully understand and appreciate the benefits to patients and primary and secondary care teams. Involvement of play specialists and the dedicated pharmacy technician time has been key to facilitate patient training and collection of data. Our aim is to identify cost savings that can hopefully be utilised to maintain pharmacy technician support as part of the wider roll out of the project.

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P25 MANAGING ADVERSE EFFECTS WITH CFTR MODULATORS

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Background Cystic fibrosis transmembrane conductance regulator (CFTR) modulators were initially commissioned for use by NHS England in 2019 and since then the age of eligibility has reduced to include younger patients.[1] The introduction of these therapies has been readily welcomed by patients, families and Cystic Fibrosis (CF) healthcare teams.[1] Pharmacists have been instrumental in the initiation of these life-altering treatments for patients across the country. More recently, the focus for pharmacists has changed to understanding and altering treatments in response to adverse effects patients may be experiencing. Whilst manufacturers provide information about managing derangement of liver function tests, there is little information available nationally about how to manage adverse effects such as behavioural changes and sleep disturbances. We would like to share our experiences from within the paediatric CF multidisciplinary (MDT) team.

At present, we have 131 patients actively on CFTR modulator treatment – 5 on ivacaftor, 19 on Orkambi and 107 on Kaftrio.

Our team has seen behavioural changes in 1 patient on Orkambi, 1 patient who was on Symkevi (but stopped taking this) and 5 patients on Kaftrio who experienced behavioural changes and/or sleep disturbances.

Our MDT decisions around managing these side effects were as a result of discussion with other centres across the country, communication with the Medicines Information department at the manufacturer Vertex and always in conjunction with our patients and their families. With any patients with significant changes in behaviour (to include but not limited to aggressive or highly emotional verbal and physical outbursts at home and/or school) we've utilised different approaches that have been individual to the child or young person in question. We adopted a number of strategies to manage issues around sleep disturbances and encouraged patients and their families to keep diaries whilst implementing any recommendations. Overall, any issues affecting sleep have resolved.

Lessons learned The CF Trust highlights the importance of access to a CF pharmacist for all patients, particularly as we enter an era of unknowns, with new treatments available and complications that may be a result of an ageing CF population.[2 3] As a team, we have appreciated the importance of communication with other centres in this post CFTR-implementation era, particularly as we learn more about these