

tone and an increase in ability to tolerate feeds with weight gain, that has persisted despite weaning of other concomitant medications.

## REFERENCES

- McConnel N, Beattie LM, Richards CE, Protheroe S, Barclay AR. Nabilone for gastro-intestinal dystonia: a single centre case series. *Journal of Paediatric Gastroenterology and Nutrition* 2018;**66**(suppl 2):1002.
- Nabilone capsules 250 micrograms and 1 mg capsules Summary of Product Characteristics, UK. Last Updated 07/2021. [www.medicines.org.uk](http://www.medicines.org.uk) (Accessed 09 March 2023).

P42

## PAEDIATRIC PALLIATIVE CARE AND ANTICIPATORY PRESCRIBING: JUST WASTEFUL ARE WE?

Bhumik Patel\*. *Great Ormond Street Hospital, London*

10.1136/bmjpo-2024-NPPG.52

**Aims** A fundamental right for patients and their families presented with life-limiting condition, is maintaining choice, in terms of place of care and of death, with evidence to suggest that most patients and their families would prefer home.<sup>1</sup> Numerous studies have sought to evaluate patient and family preference for choice of place of care and death as well as factors that may influence this choice.<sup>2 3</sup> These studies, however mostly focus on offered place and the narrative dialogue that influences choice. No studies have looked how access to medications may impact the choice, or even if factored into discussions.

Despite this lack of data, anticipatory prescribing is deemed a hallmark of effective end of life care for children as well as adults. Anticipatory prescribing is recommended practice by NICE guidance (NG31) as well as CQC standards. International consensus also recommends anticipatory prescribing as best practice, all despite the practice being seemingly underpinned by clinical perception rather than evidence, with anticipatory prescribing providing reassurance, that medicines for symptom management are available at time of need, often be out-of-hours. Medication often prescribed in an anticipatory manner include high risk medications.

Research from adult palliative care suggest that of those medicines anticipatory prescribed. 40 to 54% go unused.<sup>4</sup> To date there has been no similar assessment in paediatrics or potential medications wastage. We conducted a retrospective chart review to determine whether anticipatory prescribing of medicine was cost effective.

**Method** A retrospective chart review of patients referred to paediatric palliative care team at Great Ormond Street Hospital was conducted over an 8 month period. Charts were reviewed to identify those who died with a pre-emptive symptom management plan at death. Charts were then assessed to determine what medication was administered at time of death, in the last week of life of life and compared to the medication pre-emptively requested on management plans. A cost analysis was conducted, of medication requested compared to medication used, pricing of medicines was based on NHS indicative price or drug tariff price.

**Results** 69 patients died in the study period, only 43 died with a management plan. 3 patients were not included in the analysis. Most frequent enteral medicines used were opioids (57.5%), midazolam (37.5%), movicol (17.5%), ketamine/glycopyronium (15%). The most frequent injectable medicines used were opioids (81%), midazolam (59%), levomepromazine (11%).

On average at end of life we identified that the total drugs cost for all drugs requested and dispensed was £33,692.28. The total cost of all drugs used was £7,966.76. The total cost of medication wastage was £25,708.79.

**Conclusions** Nationally and internationally, that anticipatory prescribing for end of life care in both adults and children, is recognised as best practice. However, this is not based on any level of evidence. Our retrospective chart review suggests that anticipatory prescribing in paediatric palliative is not a cost effective use of medication potentially costing the NHS in excess of £25,000 per year, and an urgent systems review required. This waste represents an environmental cost of 3,875 grams of CO<sub>2</sub>e over the 8 month period.

## REFERENCES

- Hechler T, Blankenburg M, Friedrichsdorf SJ, Garske D, Hubner B, Menke A, Zernikov B. Parents' perspective on symptoms, quality of life, characteristics of death and end-of-life decisions for children dying from cancer. *Klinische Padiatre* 2008;**220**:166–174.
- Kassam A, Skiadareis J, Alexander S, Wolfe J. Parent and clinician preferences for location of end-of-life care: home, hospital or freestanding hospice? *Paediatric Blood and Cancer* 2014;**61**:859–864.
- Vickers J, Thompson A, Collins GS, Childs M, Hain R. Place and provision of palliative care for children with progressive cancer: a study by the paediatric oncology Nurses' Forum/United Kingdom Childrens' cancer study group palliative care working group. *Journal Of Clinical Oncology* 2007;**25**:4472–4476.
- Bowers B, Howard P, Madden B, Pollock K, Barclay S. Is end of life anticipatory prescribing always enough? *British Medical Journal* 2023;**381**:1106.

P43

## AN AUDIT ASSESSING FUNGAL INFECTION RATE IN PAEDIATRIC PATIENTS UNDERGOING ALL INDUCTION

Elin Fflur Wyn Jones, Ka Yu Yung\*. *Great Ormond Street Hospital, London*

10.1136/bmjpo-2024-NPPG.53

**Introduction** Leukaemia is the most common cancer in children accounting for around a third of all cases and acute lymphoblastic leukaemia (ALL) is the most common of all leukaemias.<sup>1</sup> The intense induction treatment for ALL results in patients becoming immunocompromised and susceptible to infections.

It was noticed that many patients undergoing ALL induction required antifungal treatment courses when attending outpatient clinic. It is not standard practice to give patients upfront antifungal prophylaxis in ALL treatment.

**Aim** The aim of this audit was to identify the number of patients undergoing induction phase of ALL treatment who end up developing a fungal infection and require treatment. To identify whether it would be necessary for patients undergoing ALL treatment to receive antifungal prophylaxis.

**Method** A list of all patients treated for induction ALL was collected between 1/9/21–1/9/22. Data was collected retrospectively by looking through each patient's medical notes to identify whether they developed a fungal infection during or 1 week after completing their induction.

**Results and Discussion** 59 out of the 99 patients audited (n=58%) developed a fungal infection. 42 patients were prescribed antifungals when attending the outpatient clinic and their treatment was managed at home. The remaining 14 patients required antifungal treatment at their tertiary hospital (n=12) or at their local hospital (n=2). Oral thrush was the most common infection developed during induction accounting for 40% of infections and nappy rash was the second most common infection developed during induction accounting for 46% of infection cases. 72% of patients only required 1