G224(P) CHILD ABUSE RECORD KEEPING AND REPORT WRITING STANDARDS (CARRS)

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Child protection remains a sensitive issue in the UK and is a challenge to Paediatricians and other health care workers. It is well established that a high quality written report is of paramount importance and enables legal teams and juries to form conclusions in the best interests of the child. Unfortunately there are no structured guidelines or training course on how to write a medical report following a child protection medical.

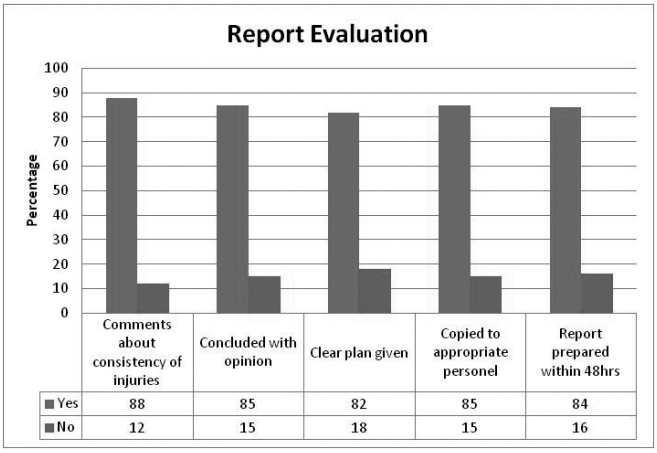
Aim We performed a semi-qualitative assessment of the medical record keeping and the report writing in child physical abuse cases.

Method This was a retrospective notes audit. 50 child protection medicals were audited which had been conducted across the three community paediatric centres for suspected physical abuse physical abuse between September 2010 and August 2011.

The medical reports and notes were assessed according to an audit proforma under 4 major headings: Demographic and referral route information, History recording, Consent, Opinion/Plan. These were further subdivided further into 18 points of information based on information requested on the clerking proforma provided for medical personnel. Data were analysed using excel.

Data collection quantitative points were assessed by the community specialist registrars and quality of reports and issues of consistency and opinion were assessed by the lead community paediatric consultant with experience and expertise in performing child protection medicals and in preparing medical reports.

Results The results of the audit are summarised in table 1 and figure 1. Generally quantitative information was collected adequately, although there are some administrative concerns around patient information labels being present on all pages of the proformas used which was not consistently adhered to. On qualitative assessment, in around 85% of cases it was felt that there was a clear and consistent opinion and plan made. Most reports were produced within 48 hours (84%) and copied to relevant professionals (85%).



Abstract G224(P) Figure 1 Tabulated presentation of observations

Given some of the loss of information from *handwritten proforma* to *typed report* and the wide variation in information provided in the typed reports audited, our Community NHS Trust services have designed a report writing proforma, in an attempt to improve the quality and consistency of information shared with other professionals following a child protection medical examination (Fig. 2: report writing proforma- available if accepted).

G225(P) SURVEY OF MRSA COLONISATION AMONG CHILDREN WITH SEVERE DISABILITIES ATTENDING COMMUNITY CHILD DEVELOPMENT CENTRE PLAYGROUP

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Aim To assess whether children with multiple disabilities attending play groups for severely disabled children at a community based Child Development Centre are colonised with Meticillin Resistant Staph Aureus (MRSA).

Background Meticillin Resistant Staphylococcus Aureus is an organism that is usually acquired from exposure to hospitals and

Abstract G224(P) Table 1

S. No	Activity	Recorded	Not recorded	Comments
1	Date and Time of start	65	35	Dates are recorded in all the notes. This percentage is combined representative of date and time documentation
2	Address labels	21	79	Few notes have written notes with no labels
3	Child protection register	87	13	Documentation was good in the written notes but information lost in reports
4	Indication/ source of referral	100	0	All reports and notes had clear mention of source and indication of referral.
5	Verbatim documentation	89	11	Few Hand written notes were difficult to interpret.
6	Who when, where about injuries	85	15	
7	Consent for photography and photography documentation in report	33	67	Very few notes had mention about the photograph taken.
8	Time interval between examination and report prepared <48 hrs	84	16	Most of the reports were done with in 48 hrs.
9	Reporting of Consistency of injury with history	88	12	in few reports skewed messages were given rather than clear documentation about consistency
10	Opinion regarding case and further clear management plan	85	15	Few ambiguous opinion were marked as not recorded after discussion with consultant
11	Report Copied to all appropriate personals involved	85	15	
12	Time of end of examination	0	100	Recorded in all reports

other healthcare facilities. It is resistant to a large number of antibiotics. MRSA bacteremia in children often has serious sequelae. Children with severe disability have chronic illnesses, receive frequent antibiotics, have invasive procedures and are more likely to be hospitalised multiple times. They are therefore assumed to be more at risk of MRSA colonisation.

Method As part of the trust infection control surveillance, the trust funded a pilot survey of MRSA colonisation among 25 children who attended the play group for severely physically disabled children at the child development centre. All children were under three years of age, wheel chair bound or with multiple disabilities. All had disabilities from birth or soon after and 80% had spent time in the neonatal unit. More than 50% of the children had had invasive procedures such as placement of a nasogastric tube or a gastrostomy or had cardiac surgery. All children had been hospitalised on more than one occasion and in more than one hospital. These factors were considered to place them at higher risk of being colonised with MRSA.

25 children were swabbed after obtaining informed consent from their parents. 2 Swabs were taken from the nostril, axilla or groyne of each of the 25 children and transported in appropriate media directly to the laboratories for testing for MRSA. The swabs were taken opportunistically by the doctor from each child when they attended clinic for their medical review.

Results All the swab results were reported negative for MRSA.

Conclusion The severely disabled children in our survey were not colonised with MRSA inspite of multiple predisposing factors. The risk of spreading MRSA within the playgroup was low and the children could continue to participate fully in communal activities.

G226(P) WHY DO WE REVIEW CHILDREN?

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Background The waiting list for review appointments in our Community Paediatric clinics is getting longer. We get frequent calls from parents and other professionals regarding delayed appointments. This audit was undertaken to attempt to change the mind-set of clinicians about offering review appointments "just in case".[1]

Aims To identify the main reasons for offering follow-up appointments and to explore whether children could be reviewed by methods other than 'face to face appointments'. We also looked at whether some children could be reviewed by other health professionals.

Methods The audit was conducted prospectively on all patients seen by Community Paediatricians from 1st May to 31ST May 2012. A form (table 1) was devised and agreed at the team meeting to be completed on all children who were offered a further follow-up appointment.

Results In total 305 forms were completed. The main reasons for follow up were to monitor developmental progress, to review children with complex special needs and medication review. 16/305 was offered further appointment on parental request. For 247/305 (81%) children, continuing with 'Face to face' review in clinic was the preferred option. For 44/305 (14%), Clinicians felt the children could be reviewed in an alternative way. In this group, for 34/44 children the preferred option was by another trained professional and for 10/44, by telephone review. It was identified Team around Child meetings was not a suitable option to review children.

Conclusions Most children still need to be seen at 'face to face' clinic review. However in 14% (1 in 7) of children, alternative methods to review children can a preferred option. This can offer opportunity to increase capacity without adversely affecting quality of care.[2]

Specialist Health Visitors, Nursery Nurses, and Tier 2 Primary Mental Health Workers were identified; as possible professionals who can be trained to review children. Following the audit it has been planned to develop a system to record a specific reason why Clinicians wish to offer follow-up appointments and to develop a pathway to identify children who can be seen by other professionals with appropriate training. A monthly telephone review clinic will also be piloted.

Abstract G226(P) Table 1

Why do we review children?

Main reasons:

- Monitor developmental progress ☐
- Medication review ☐
- Complex special needs ☐
- Parental request ☐
- Special schools(MLD/SLD) ☐
- Safeguarding concerns ☐
- Other .....

Review after:

- 3 mths ☐
- 6mths ☐
- 9mths ☐
- 12mths ☐
- Other .....

Could this be done differently?

YES ☐ NO ☐

If yes please select the correct method -

Tel ☐

School Nurse/ Specialist HV ☐

TAC/ESP meetings ☐

Other .....

REFERENCES

1. http://www.improvement.nhs.uk/heart/sustainability/outpatients/one_stop.html accessed on 27/07/2012
2. I Ahmed-Jushuf, V Griffiths and Six Sigma study group. Reducing follow-ups: an opportunity to increase the capacity of genitourinary medicine services across the UK. Int J STD AIDS 1 May 2007 vol. 18 no. 5 305–307.

G227(P) AUDIT OF RCR 2008 STANDARDS FOR RADIOLOGICAL INVESTIGATIONS OF SUSPECTED NON ACCIDENTAL INJURY

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Aim Review compliance with above guidelines and compare with performance from a previous year.

Background RCR and RCPCH consider imaging the injured child critical to the process of child protection. The RCR guideline published in March 2008 seeks to provide an evidence based framework which supports the radiologist in contributing to child protection. It encourages best practise and communication between different agencies working together to safeguard children in the investigation of suspected physical abuse. This follows recommendations from the Climbie enquiry and ensuing legislation.

Methodology We compared the performance before (2007–08) and after (2009–10) RCR guidelines were published. Notes were