

**Aim** To evaluate the effect of targeted consultant time in sharing mental models with parents and nursing staff for children with medical complexity (CMC).

**Background** CMC are part of a mixed caseload covered by the acute paediatric team. We define them here as children with a length of stay  $\geq 7$  days with  $\geq 2$  system involvement. Feedback shows these children experience prolonged length of stays (LOS) with a need for coordination of care often between different teams. Parents have highlighted that better communication with them, within teams and between different teams could improve their child's journey.

**Methods** All team members were briefed using written and verbal communication as were parents and children taking part. Patients were allocated a weekly slot over a four week period to meet with the MICMAC consultant and a member of the nursing team. Sharing of mental models was facilitated using a targeted proforma covering current expectations and barriers to discharge. The MICMAC consultant was briefed by the service team prior to the meeting and handed back afterwards. Qualitative feedback was obtained using structured debriefing interviews with ward managers and parents. Group debriefing sessions were carried out with the junior medical team and the consultant body covering key themes highlighted by the parental feedback.

**Results** A total of 12 patients with an average LOS of 90 days (range 13–241) over 6 wards were included. 11 consultants led a total of 34 meetings. 3 children were discharged home and 2 patients had withdrawal of care. A total of 6 nursing manager interviews and 9 parental interviews and one substituted lead clinician interview were undertaken. Debriefing of the medical teams was undertaken in 2 group sessions. Positive feedback was centred around improved coordination of care, understanding of overall direction and sharing of information.

**Conclusions** The CMC group is recognised as an expanding patient group. Key factors influencing their inpatient journey involve communication between caregivers and the responsible teams. We highlight how a simple targeted communication tool can improve quality of patient journey.

### G302(P) OBESITY – WHY DO CLINICIANS STILL TURN A “BLIND EYE”

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Approximately 3 in 10 children aged 2–15 years are overweight or obese. This is concerning because weight problems in childhood often continue into adulthood. NICE guidance states that healthcare professionals should ‘aim to create a supportive environment that helps a child who is overweight or who has obesity, and their family, make lifestyle changes’.

#### Aims

1. Determine the prevalence of obesity amongst paediatric outpatients
2. Audit practice against NICE guidance
3. Collect qualitative data on clinician attitudes towards obesity

**Methods** This prospective audit assessed the weight, BMI, ethnicity and outcome of patients presenting to the paediatric outpatients department (POD) over a 10 week period. Patients were audited from all clinical specialities using the POD.

Overweight and obese children were identified as having a weight above the 91<sup>st</sup> and 98<sup>th</sup> centiles respectively and

underweight children a BMI below the 0.4<sup>th</sup> centile on the appropriate RCPC Body Mass Index (BMI) charts and growth charts. The only exclusion criteria were children under 2 and over 16 years of age. Qualitative data was collected via structured interviews with clinicians working in the POD.

**Results** 569 children were audited of which 407 met the inclusion criteria. The cohort's demographics were as expected for the area. The prevalence of overweight and obese children from this cohort was 14% and 11% respectively. Of those identified as either overweight or obese only 2% and 34% respectively were offered an intervention. Interventions included; advice, investigations, or referral. Interestingly all underweight children were investigated and given follow up support. Qualitative data from structured interviews demonstrated that clinicians were aware of obesity as a health issue but failed to act for a variety of reasons including a lack of time and for fear of damaging the doctor-patient relationship.

**Analysis** Clinicians are not complying with NICE guidelines for a range of reasons including; time constraints, a lack of training and concerns over damaging the doctor-patient relationship. We are currently training an obesity nurse specialist to support clinicians during outpatient clinics and to offer additional training and educational support with a view to changing clinician attitudes towards obesity.

### G303(P) AWARENESS OF HEALTHCARE PROFESSIONALS ABOUT THE POSSIBILITY OF SUBSTANDARD MEDICINES

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**Aims** The number of reports per year by the MHRA of substandard medicines is rising. The aim of this study was to examine healthcare professionals' (HCPs) willingness to consider and report defective medicines. To gauge their awareness of reporting systems designed for HCPs to report defective medicines, issues related to medicine quality and the official online pharmacy logo (as the marker of legitimate online pharmacies).

**Methods** This pilot study involved HCPs (paediatric doctors, pharmacists, and children's nurses) and used self-administered questionnaires containing case scenarios derived from actual reported incidents. An invitation letter and questionnaire were sent to each doctor and nurse working at Derbyshire Children's Hospital, as well as pharmacist members of the Nottinghamshire and Derbyshire Local Pharmacy Forum.

**Results** 30 doctors (60% response rate), 31 pharmacists (2.7%), and 47 nurses (42%) responded, a total of 108 HCPs. Only 27 HCPs (23% doctors, 39% pharmacists, and 17% nurses) considered the possibility of manufacturer error when a medicine's defect was obscure (fentanyl transdermal system with manufacturer error causing excessive release of the medicine). Most HCPs (77%, 74%, and 66%) responded that they would report such an incident via the Yellow Card Scheme, established to gather reports of adverse drug reactions. Most HCPs (100%, 87%, and 81%) agreed with the statement that ‘medicines in the UK are manufactured to a high standard’, though more than one-third (40%, 39%, and 30%) believed that poor-quality medicines existed in the medicine supply chain in the UK. However, only 5% of HCPs were aware of the defective medicines reporting system and few (7%, 16%, and 6%) were aware of the official online pharmacy logo.

**Conclusions** HCPs' awareness of the possibility of defective medicines was low. The vast majority were unaware of the defective medicines reporting system and of the official logo of registered online pharmacies in the UK. Findings suggest a need to increase HCPs' awareness of these measures.

### G304(P) RCPCH BEST PRACTICE GUIDELINE TO NEWBORN EXAMINATION TO REDUCE THE PREVALENCE OF DELAYED DETECTION OF CLEFT PALATE (CP)

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**Introduction** The UK prevalence of Cleft Palate (CP) without cleft lip is 1 in 1,750 live births. Half of CP have associated malformations and syndromes. The prevalence of delayed detection in the first 24 h after birth is 30%, 16% more than 72 h, 7% under three months of age, 3% under year and 2% over one year old. Potentially unnecessary delay in appropriate management, parental distress, and litigation occur. Strong circumstantial evidence suggests the method of palate examination as the cause.

**Aim** Develop recommendations for optimal examination of the palate during routine newborn examination to ensure early detection of CP.

**Methods** A consensus guidelines group was led by the RCPCH, including parent groups and key professional stakeholders. The RCPCH standards for development of clinical guidelines in paediatrics and child health were followed. A systematic review with methodological advice from the RCPCH clinical standards team was undertaken. Where there was limited evidence to support recommendations for practice a Delphi consensus method was carried out. When Delphi consensus was not reached, recommendations were based on working group consensus.

### Results

1. Examination of the newborn baby's hard and soft palate should be carried out by visual inspection and recorded in the Child Health Record.
2. Use a torch and method of depressing the tongue to visualise the whole palate.
3. Parents should be informed if the whole palate (including the full length of the soft palate) has not been visualised.
4. Failure to visually inspect the whole palate at first attempt should be followed by repeat visual examination within 24 h.

**Conclusion** Trusts should provide training on the correct method of visual inspection of the palate to all healthcare professionals required to carry out newborn examinations.

<http://www.rcpch.ac.uk/improving-child-health/clinical-guidelines-and-standards/published-rcpch/inspection-neonatal-palate>

### G305(P) REFERRAL AND INVESTIGATION OF PAEDIATRIC URINARY TRACT INFECTIONS IN A GENERAL PRACTICE SETTING – ARE WE GETTING IT RIGHT?

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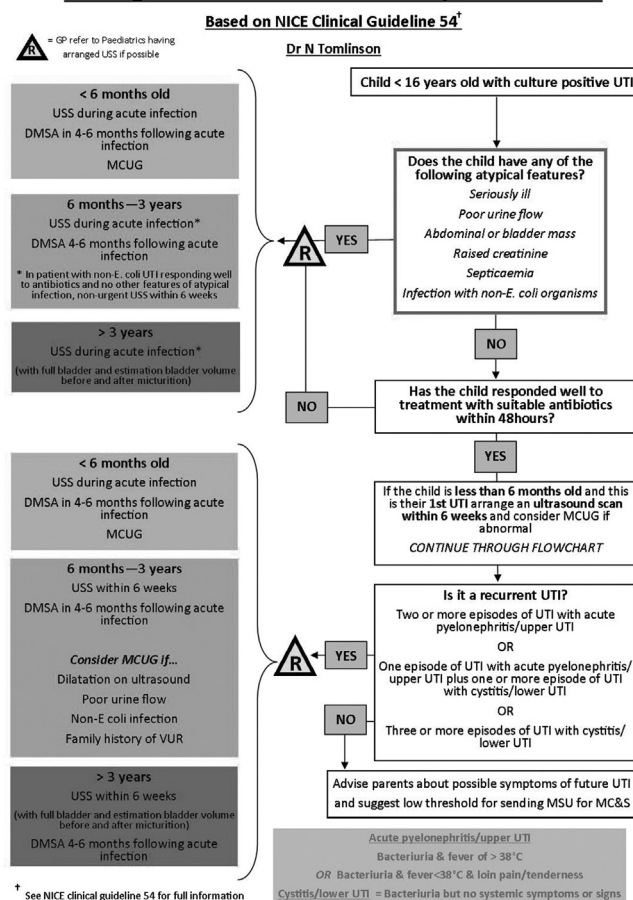
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**Introduction** Urinary Tract Infection (UTI) is a common bacterial infection. Natural history in children has changed over the last 30–50 years due to antibiotics and improvements in healthcare. There remains uncertainty about the most appropriate and effective way to manage UTIs in children including whether or not investigations, follow-up and prophylaxis are justified. The correct timeframe during which these should occur depends on presentation and age of the child.

**Aims** NICE clinical guideline 54 is often confusing due to the complex nature of follow up and the range of investigations required depending on presentation and age. The guideline can be quite challenging to follow in a busy general practice environment. The aim is to assess current management in terms of referral and further investigations and suggest any necessary improvements to facilitate this process.

**Method** Retrospective audit looking at management of patients under 16 years old presenting to an inner city general practice from September 2010–14 with suspected UTI. Culture positive UTIs were identified and patients who fulfilled the NICE criteria for referral were highlighted. Referrals were categorised as appropriate, inappropriate or missed. Grade of clinician who

### Investigation of Children With Urinary Tract Infection



Abstract 305(P) Figure 1