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)

[1]A Habel, [2]J Dudley, [3]J Allister, [4]D Elliman, [5]M Jokinen, [6]N Marlow, [7]C Marsh, [8]H McElroy, [9]R Preston, [10]R Slator, [11]A Soe, [12]M Tuckey, [13]S Haveron, [14]L Hunter. *[1]North Thames Cleft Unit, Great Ormond Street Hospital, London, UK; [2]Renal Department, Bristol Childrens Hospital, Bristol, UK; [3]Independent Advisory Group, General Practice, Peterborough, UK; [4]Community Paediatrics, Great Ormond Street Hospital, London, UK; [5]Practice and Standards Advisor, Royal College of Midwives, London, UK; [6]Neonatology Department, University College Hospital, London, UK; [7]South West Cleft Unit, Bristol Dental Hospital, London, UK; [8]Paediatric Department, Medway NHS Foundation Trust, Rochester, UK; [9]Cleft Lip and Palate Association, London, UK; [10]Cleft Lip and Palate Services, Birmingham Childrens Hospital, Bristol, UK; [11]Neonatologist, Medway NHS Foundation Trust, Rochester, UK; [12]Parent representative; [13]Clinical Standards, Royal College of Paediatrics and Child Health, London, UK; [14]Royal College of Paediatrics and Child Health, London, UK*

10.1136/archdischild-2015-308599.281

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?

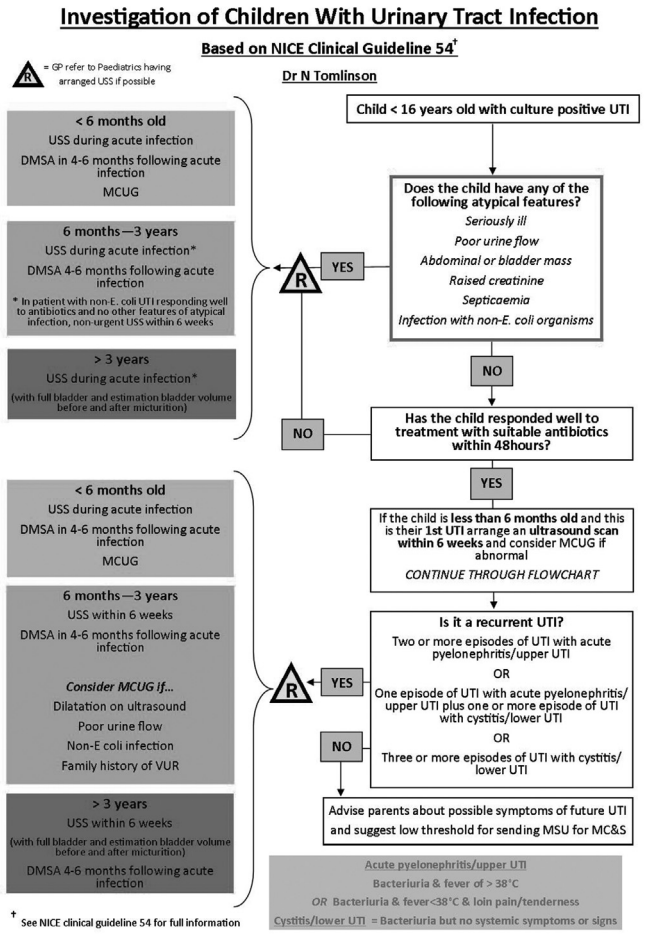
N Tomlinson. *Block Lane Surgery, Oldham, UK*

10.1136/archdischild-2015-308599.282

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



Abstract 305(P) Figure 1

assessed the patient was also categorised as trainee, GP or locum. Results: n = 15. Overall 13% referrals were appropriate, 33% inappropriate and 53% missed. 100% trainee referrals were inappropriate, 80% GP referrals were missed and 50% locum referrals were inappropriate. There was confusion about whether to refer to paediatric urology or paediatrics (40% and 30% respectively). 88% missed referrals related to atypical UTIs.

Conclusion NICE clinical guideline 54 is not easy to follow in a time pressured environment. This is evident across all grades of clinician. It was noted that patients presenting to out-of-hours or A&E often do not have a urine sample sent for culture, hindering decisions regarding referral and further investigation. There was confusion about whether to refer to paediatrics or paediatric urology. Atypical UTIs were most likely to be mis-managed. An intuitive UTI flowchart has therefore been designed to facilitate easier identification of children who require tertiary referral and hence improve management.

G306(P) RESEARCHAND PUBLIC AWARENESS PRIORITIES FOR SOUTH ASIAN CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES: A COLLABORATIVE PARTICIPATORY APPROACH TO PRIORITISATION

[1,2]L Manikam, [3]K Reed, [2,4]G Santini, [5]R Shah, [1,2]M Lakhanpaul. *[1]Population, Policy and Practice Programme, University College London Institute of Child Health, London, UK; [2]Child Health Working Group, South Asian Health Foundation, Birmingham, UK; [3]Kings College London School of Medicine, Guy's and St Thomas NHS Foundation Trust, London, UK; [4]Independent Community Facilitator, Leicester, UK; [5]Neonatal Unit, Homerton University Hospital NHS Foundation Trust, London, UK*

10.1136/archdischild-2015-308599.283

Aims To undertake a prioritisation exercise involving healthcare professionals (HCPs) and South Asian (SA) families to develop child health research and public awareness agendas'

Methods A two-stage process was adopted. A HCP scoping survey was undertaken to generate topics important for SA child health (1) research (2) public awareness and (3) outcome indicators. Ranked lists were discussed in four focus groups of SA adolescents and families.

A Punjabi and Urdu speaking community facilitator moderated groups with a British Sign Language interpreter assisting in the deaf group. Concordant and discordant themes between HCPs and SAs were identified.

Results 27 HCPs participated in the survey. Table 1 summarises their priorities

Abstract G306(P) Table 1 Top HCP topics/outcome indicators

Public Awareness	(1) Obesity and diet
	(2) Mental health illness recognition
	(3) Healthcare access and health seeking behaviour
	(4) Vitamin D and rickets
	(5) Routine health checks
Research	(1) Nutrition, obesity and physical activity
	(2) Diabetes
	(3) Healthcare access and health seeking behaviour
	(4) Health education
	(5) Parent-child relationships and child care dynamics
Indicators	(1) Growth, development and physical activity levels
	(2) Health knowledge
	(3) School attendance and literacy levels
	(4) Healthcare utilisation
	(5) Quality of life (QOL) scores

Abstract G306(P) Table 2 Topics prioritised/not prioritised by South Asians

Priorities	Not Priorities
(1) Concordance and shared decision making	(1) Genetic disorders and consanguinity
(2) Primary care access	(2) Diabetes
(3) Mental health	(3) Education/Literacy/School attendance
(4) Obesity and diet	(4) Parenting methods
(5) Blood and Organ donation	(5) QOL scores
(6) Alternative medicine effectiveness	
(7) Routine health monitoring	

35 individuals (Age range: 16–74 and UK stay length: 3–57 years) participated. Groups varied by settings (Inner vs. Outer city), religion, descent and disability.

Engagement was highest on public awareness and lowest on outcome indicators. Lack of awareness of research undertaken by funders (NIHR, Wellcome Trust, MRC) were cited. Table 2 summarises their priorities.

Conclusion Community engagement yielded research and public awareness priorities which differed with HCPs. In line with NHS England and NIHR national strategies, collaboration with communities whose views are not traditionally considered is essential to determine service and research agendas important to families, professionals and providers.

G307(P) EVALUATING AND REDUCING PAEDIATRICS MEDICATION ERRORS BASED ON TWO AUDITS. "A MULTIDISCIPLINARY APPROACH"

DC Atukorale, A Bhatti, R Jayatunga, A Ahmed. *Paediatrics, Sandwell and West Birmingham Hospitals NHS Trust, West Bromwich, UK*

10.1136/archdischild-2015-308599.284

Aims Medication errors occur and are more significant in paediatrics, despite standards being set on safe prescribing (BNF &Trust Prescribing Policy, 2007). Errors are frequent during prescribing, dispensing and administration of medications as shown by the EQUIP study (2009). We aimed to identify the incidence and types of medication errors and implement strategies to minimise these errors.

Method 1st audit – was carried out to assess prescription charts against thirteen Good Prescribing standards (BNFC), in the inpatient unit.

2nd audit – A retrospective analysis was done of all incident reporting on paediatric medication errors within the Trust, over a 17 month period (January 2013–May 2014). Different types of medication errors, their location and the severity scoring was identified. The results were compared with a previous similar audit carried out in January 2011–May 2012, after which several interventions were implemented to reduce these errors.

Results Most of "Good Prescribing Practice"standards were met (>80%), except for antibiotic indication and duration (Standard 13) (20%).

Total Trust medication errors in January 2013–May 2014 were 10%, out of which paediatric medication errors was 1/5th. Administration errors (47%) dominated followed by prescription errors (42%). 3% were dispensing errors. Commonest administration error was failure to administer a prescribed medication and the commonest prescribing error was failure to prescribe a recommended medication. Errors on inpatient wards exceeded OPD/Community.