

all eligible patients have been targeted, and to exclude a “drop-off” in compliance.

G81(P) SAFETY OF “SINGLE CHECKER” PATIENT GROUP DIRECTIVES FOR SELECTED MEDICATIONS DURING INITIAL NURSE ASSESSMENT IN THE EMERGENCY DEPARTMENT (ED)

¹C Bird, ¹S Hartshorn, ²A Sinclair. ¹Emergency Department, Birmingham Children's Hospital, Birmingham, UK; ²Pharmacy Department, Birmingham Children's Hospital, Birmingham, UK

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Aims Innovative ways to optimise ED patient flow, without sacrificing quality of care, are at a premium.² Within our own paediatric ED, it was observed that inefficiency occurred whenever a triage nurse had to leave the assessment room in order to find a colleague to check the dose of a Patient Group Directive (PGD), including those for simple, over-the-counter medications. Doubt has been cast on the efficacy of double checking in all but high risk medications.²

We aimed to evaluate the safety of a “single checker” PGD process at triage for paracetamol (pain and fever), ibuprofen (pain and fever), oral rehydration salts (ORS) and topical 4% tetracaine gel (Ametop) to improve patient flow.

Methods Single-checker PGDs were devised for the medications and indications listed above, to be used exclusively within the triage/assessment area by nurses who had completed PGD competency training. The process change was approved by the Trust Drug and Therapeutics Committee, after assurance that robust safety nets were in place (including the production of weight/dose tables for paracetamol and ibuprofen which were displayed in the assessment room).

At launch, a 3 month audit (August–October 2011) was conducted, in which all single checker PGDs were logged.

Subsequently, the hospital incident reporting system was reviewed for any medication errors associated with PGDs from ED.

Results During the first 3 months of the use of single-checker PGDs, no errors in dose were identified.

To date, no medication errors associated with ED PGDs have been identified within the hospital incident reporting system.

Benchmarking data regarding the prevalence of this practice within EDs in the PERUKI network will be identified.

Conclusion There were no drug errors with single checking by protocol of simple emergency medications at triage, within one of the UK's busiest paediatric EDs. Further research is required to quantify the time and resources saved on the patient journey.

REFERENCES

- 1 Sinclair D. Emergency department overcrowding – implications for paediatric emergency medicine. *Paediatrics Child Health* 2007;**12**:491–494
- 2 David U. Double checking: does it work? *Can J Hosp Pharm*. 2003;**53**:167–169

G82(P) EXPLORING THE ACCEPTABILITY OF A CLINICAL DECISION RULE TO IDENTIFY PAEDIATRIC BURNS DUE TO MALTREATMENT

¹EL Johnson, ¹SA Maguire, ²LI Hollén, ¹AM Kemp. ¹College of Biomedical and Life Sciences, Cardiff University, Cardiff, UK; ²Centre for Child and Adolescent Health, University of Bristol, Bristol, UK

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Objective A Clinical Decision Rule (CDR) was developed from a systematic review and epidemiological study to identify burns due to child maltreatment. Prior to an implementation evaluation, we wish to explore clinician's response to the CDR, and the likelihood that it would influence their decision making.

Methods A semi-structured questionnaire of 55 Health professionals in 8 Emergency Departments (3 paediatric) and two burns unit's explored demographics, recognition of maltreatment utilising four case vignettes (1: suspect maltreatment, 2: consider maltreatment, 1: likely unintentional), and likelihood of taking action recommend by CDR. Analysis: Fisher's exact test and logistic regression.

Results In an analysis of potential variables, (professional grade, child protection (CP) training or paediatric burns training), the most influential in accurately identifying maltreatment was professional grade (Odds Ratio 2.95, 95% CI 1.39–6.25). Lower grade doctors were most likely to take the action recommended by the CDR, whilst higher grade doctors would do so with a proviso e.g. senior CP colleague advice. More CP training did not correlate to accuracy in identifying suspected or concerning cases, but did correlate with correctly identifying the unintentional case ($p = 0.041$) and with a proviso to taking CDR recommended action ($p = 0.056$). Paediatric burns training was not an influential variable.

Conclusions While lower grade doctors are the least accurate at identifying burns due to maltreatment, they are the most likely to follow this CDR. However, those with the least knowledge of CP are least likely to follow the CDR recommended action.

G83(P) EMERGENCY DEPARTMENT MANAGEMENT OF CHILDREN WITH DECOMPENSATING INHERITED METABOLIC DISEASE

¹MW Gillam, ²E Chronopoulou, ³MD Lyttle. ¹General Practice, Great Western Hospital, Swindon, UK; ²Emergency Medicine, Royal Bristol Hospital for Children, Bristol, UK; ³Metabolic Medicine, Royal Bristol Hospital for Children, Bristol, UK

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Background and aims Metabolic decompensation may occur in patients with disorders of intermediary metabolism during intercurrent illness. Early intervention strategies are crucial in order to halt decline. This poses a particular challenge in emergency departments (EDs), particularly at peak times. Impending deterioration may not be clinically apparent, and so may not result in prioritisation for initial assessment or subsequent triage categorisation. It is therefore crucial to ensure appropriate care pathways are in place, yet there are no existing national guidelines regarding timeliness of ED assessment for these patients. We therefore aimed to assess current practice to inform service development.

Methods Retrospective electronic database and medical chart review over a 3 month period. Nine standards were set through consensus between the ED and inherited metabolic disease (IMD) teams, relating to timeliness, notifications and assessment criteria (grade of clinician and assessment performed).

Results Of 38 IMD presentations, 30 were deemed at risk of decompensation due to their condition. 33 (92%) had an electronic diagnosis alert, 28 (83%) had a specific electronic ED management plan. 21 (54%) were triaged within 15 min of arrival, and following triage 8 (21%) and 19 (50%) were seen within 10 and 30 min respectively. There was no apparent correlation with triage category. 8 were discharged prior to senior review 6 of which were at risk of decompensation. 13 of the