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.

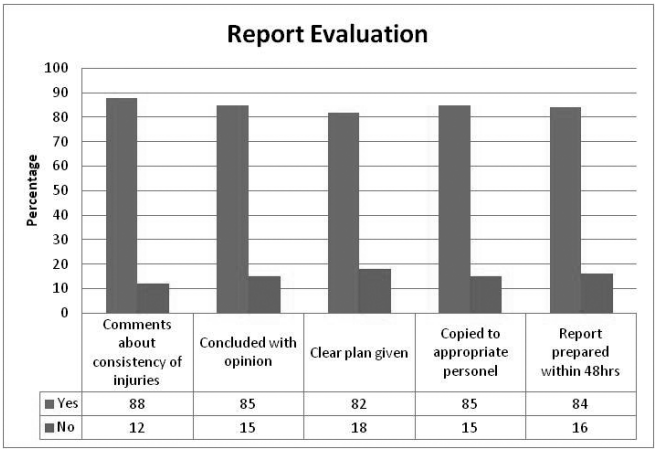
Aim We performed a semi-qualitative assessment of the medical record keeping and the report writing in child physical abuse cases.

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