		YES	NO
		YES	NO
Presenting problem	Gastroenteritis type illness?		
Past Medical History	Born after April 2009 and presumed normal Guthrie?	*Reassuring*	
	Normally well, no PMH of note?		
	Previous hx of low blood sugars?		
Focused History	Previous viral type illnesses with normal recovery?		
	Can have period of fasting (e.g overnight) without compromise?		
	Previous unexplained morning drowsiness?		
Family History	Previous neonatal or infancy death in family?		
	Consanguinity?		
Examination & Observation	Unusual odour/ breath?		
	Enlarged liver?		

Abstract G121 Table 2

We introduced a simple screening pathway for infants and children found to have hypoglycaemia. This approach remains in line with NMBN guidance.

It has resulted in >50% reduction in hypoglycaemia screens performed. The cost savings are based upon reduced numbers of hypoglycaemia screens (£214), overnight admissions (£380/nt) and follow-up (£226).

The findings suggest that it may be possible to further refine our approach thereby reducing the number of hypoglycaemia screens performed without compromising patient safety.

G122 SAFETY NETTING BEHAVIOUR OF PRIMARY HEALTHCARE PROFESSIONALS FOR ACUTELY SICK YOUNG CHILDREN: A QUALITATIVE STUDY

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Aims Acute illness is a frequent reason for consultation in primary care and an important cause of child morbidity and mortality. Healthcare professionals cannot correctly diagnose 100% of childhood illnesses at first consultation, so safety netting is used to extend the consultation and provide parents with information and resources to re-attend if necessary. UK childhood deaths from illnesses presenting to primary care exceed rates elsewhere in Europe, and safety netting has been introduced as a NICE quality standard for bacterial meningitis and meningococcal septicaemia; yet there is no standardised safety netting procedure. We aimed to explore the safety netting behaviour of frontline UK healthcare professionals for parents of acutely sick children under 5-years-old, including frequency, content, mode of delivery, and consistency.

Methods We conducted semi-structured focus groups and interviews with 16 doctors and nurses from general practise, emergency department and out-of-hours settings in the East Midlands, as part of the ASK SNIFF (Acutely Sick Kids, Safety Netting Intervention for Families) project. Data were analysed according to the grounded theory approach.

Results The content and delivery of safety netting was not consistent within or between organisations, whether it was written or verbal: *"we've probably all got our favourite patient information leaflets that we give… not at the moment standardised across the practise"* (GP surgery doctor); *"I know what I say but you know, do we all say the same thing¿"* (Paediatric ED doctor). Factors influencing safety netting provision included perceived parental anxiety and confidence, healthcare professional parental status and experience, and time. Participants highlighted difficulty in knowing how often safety netting occurs, whether it is understood by parents, and its effectiveness: *"often they'll nod their heads and say yes I understand everything you say and walk off and they might have no idea what we've just said"* (Regular ED nurse). Other limitations were the broad, nonspecific nature of childhood illnesses, and parental difficulty interpreting information.

Conclusion Healthcare professionals lack standardised methods of safety netting. Addressing this gap in the management of acutely sick children may have potential to improve the efficiency of acute children's services, and reduce avoidable morbidity and mortality.

G123 USE OF NON-PRESCRIBED MEDICINES, SUPPLEMENTS AND THERAPIES BY CHILDREN WITH A CHRONIC ILLNESS AND CHILDREN WITH AN ACUTE INJURY – A COMPARATIVE MIXED-METHODS STUDY IN UK

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Aims To quantify, describe and compare non-prescribed agent (NPA) use by children with, and without, chronic illness

To explore families' experience and motivations for giving (or not) NPAs

Methods A questionnaire and semi-structured interview study using an explanatory sequential approach. Parents of children attending fracture, cystic fibrosis (CF), haemato-oncology, neurology and children's development clinics were recruited at first attendance during October-December 2011. Children attending fracture clinic with a chronic illness were re-categorised. Quantitative data were analysed using descriptive statistics and group-wise comparisons using chi-squared and unpaired t-tests. Qualitative data, collected from interviews until data saturation, were coded then thematically analysed independently by three researchers.

Results During the study period 664 families attended clinics, 295 completed a questionnaire (response rate 44.4%). Response rates varied by clinic (fracture clinic 33.8%, chronic clinics 57.8%). 60.3% children were male with a mean age of 9.16 years (sd 4.87). Children with a chronic illness were younger ($p < 0.001$). Overall prevalence of NPA use was 37.3%. Specific prevalences – 10% fish oils, 16% vitamins, 15% probiotics, less commonly noted included homoeopathy and hyperbaric oxygen. Differences in NPA use between clinics were small (33%-41.6%, $p = 0.21$). NPA use was not associated with age, gender, or socioeconomic status. 46.3% parents reported having told their doctor about NPA use.

Sixteen parents completed an interview, representing all groups. Ten themes were identified, including the parental intention in providing (or withholding) NPAs. Themes describing why parents did, or did not, provide their children with NPAs included a wish to take an active role, trust (in health professionals, or in the remedy of choice) and accessibility of doctors or NPAs.

Conclusions This is the first UK-based study to compare NPA use between children with and without chronic illness, detailing parental motivators. These are complex but relate to intent, trust, and a wish to take an active role in their child's healthcare. The prevalence of NPA use in this study is similar to others. We found no association between NPA use and chronic illness.

G124 BIG POISONS: WHAT INGESTED SUBSTANCES CAUSE SIGNIFICANT HARM TO YOUNG CHILDREN?

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Accidental poisoning of young children by ingestion of medicines and other substances is a relatively common reason for attendance at hospital in the UK, but infrequently results in significant harm. There is limited data regarding which substances cause major morbidity and mortality. This study aimed to identify which medicines and other substances are associated with death and serious illness in pre-school children.

The Office of National Statistics (ONS) was contacted and provided data relating to deaths in children due to poisoning between 2000 and 2010. The UK Paediatric Intensive Care Audit network (PICANet) was contacted and provided data relating to children admitted to intensive care as a result of poisoning between 2002 and 2012. Where possible, demographic data and the individual substance or class of drug was extracted.

21 deaths of children aged under 5 years occurred where the primary cause was poisoning due to medication between 2000 and 2010. Methadone was responsible for 9 of these deaths. 214 children (124 male:90 female) aged under 5 years were admitted to PICU between 2002 and 2012 as a result of poisoning with a median length of stay of 1 day (range 0.1 – 17.2 days). The causative medicine was often not recorded and admissions due to therapeutic misadventure or idiosyncratic drug reactions were included within these numbers. The commonest medicines, where recorded, were benzodiazepines (24 admissions) and methadone (19 admissions). 4 children died (2 methadone, 1 benzodiazepine and 1 caustic alkali).

Existing databases are useful sources of data relating to poisoning in children but are limited, and it is not possible to differentiate easily between exploratory poisoning and therapeutic misadventure. However, the data available suggest that methadone is a significant danger to young children. It is vital that the presence of young children in the households of those on methadone programmes are taken into account, and alternatives are explored. More robust and systematic data collection might help identify other substances associated with significant risk and assist with targetted prevention measures.

G125 PRIMARY AND SECONDARY CARE MULTI-SITE AUDIT OF NICE GUIDANCE ON URINARY TRACT INFECTIONS IN CHILDREN

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Aims Children and families should expect to receive NICE compliant care before and after diagnosis of UTI and independently of where this diagnosis is made. We aim to highlight the challenges faced by different healthcare providers in the diagnosis and management of children with UTI by evaluating the implementation of key aspects of the 2007 NICE guidance across primary and secondary care. We report on the findings of this national multi-site health quality improvement partnership (HQIP) project.

Methods Retrospective audit of 900 consecutive children <16 years based in 4 areas across the UK. 4 secondary care providers and 10 GP centres representing a diverse patient group were involved. 7 criteria based on 3 key NICE priorities (improving diagnosis, improving clinical evaluation and providing guidance in follow up after diagnosis) were audited in total with a standard of 100% compliance set for each.

Results Through a manual search of health and microbiology records, data was collected over a period of 12 months in 2010 on 1018 children.

Testing for UTI within the recommended time frame in cases of unexplained fever in children <3 years was poor (35% of cases in secondary care, 34% of cases in primary care). Only 52% of infants <3 months were treated appropriately with parenteral antibiotics. Recording of salient points in the history of children with suspected UTI was poor. Follow up investigations were organised appropriately in only 46% and 55% of cases from primary and secondary care respectively. Urinary dipstick testing as a first line strategy for diagnosis was performed relatively well in 67% and 75% of confirmed UTI cases in primary and secondary care respectively. 84% of infants <3 months with suspected UTI were referred appropriately to specialist services.

Conclusions This audit has highlighted areas of weakness in the management of children with UTI, in particular, accuracy of diagnosis in children <3 years and the recording of historical features that differentiate typical and atypical UTI. Our enhanced awareness of best practise will improve the outcomes for children with UTI in the long term.