

present during hospitalisation. Twenty five questionnaires have been collected (response rate 53%). Among patients there were 18 infants and toddlers, 3 children and 4 adolescents. Mean length of stay in the PICU was 11 days, 60% of admissions were unplanned. Questionnaires were completed mainly by mothers (84%). Not satisfactory opinions have been given mainly for understandable information on examinations and tests (12%) and on possibility to stay close to the child during intensive procedures (16%). All of parents declared that the team worked efficiently and the team showed respect for the patients but only 72% of parents responded that during stay in the PICU the staff regularly asked for parent's experiences.

Conclusions The EMPATHIC-30 empowers parents to provide feedback on their experiences in paediatric intensive care and may facilitate health care professionals to improve quality of care. Following a single centre experience the EMPATHIC 30 Poland study should be continued as a national project.

PO-0275 ASSESSMENT AND COMPARISON OF A LAB-SCORE AND A CLINICAL PREDICTION MODEL FOR DETECTING SERIOUS BACTERIAL INFECTIONS IN FEBRILE YOUNG CHILDREN

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Background and aims C-reactive protein and Procalcitonin have been lately the most researched biomarkers in identifying serious bacterial infections (SBI) in febrile children. The Lab-score (2008) includes CRP, PCT and urinalysis for detecting SBI and the Clinical Prediction Model (CPM) (2013) combines clinical variables with CRP value for detecting pneumonia and other SBI separately. We aimed to assess and compare the value of the Lab-score and the CPM in identifying febrile children at risk for SBI in the Emergency Department (ED).

Method This survey is part of a prospective observational study aimed to identify children with fever without source at risk for SBI. Patients were recruited from Tirgu Mures Emergency Clinical County Hospital, Romania. SBI diagnosis was based on urine, blood and CSF cultures and chest radiographs. For children included, aged 1 to 36 months, the Lab-score and the CPM were calculated. Positive and negative likelihood ratios and post test probabilities were calculated for each test.

Results From 134 children, SBI was diagnosed in 31 (23.13%): 11 pneumonia and 20 other SBI, mostly urinary tract infections. Positive and negative likelihood ratios for Lab-score (≥ 3), CPM-Pneumonia ($\geq 10\%$) and CPM-Other SBI ($\geq 10\%$) were 7.25/0.25, 22/0.65 and 5.23/0.50 and the post test probabilities were 69%, 66% and 48% for the same cut-off values.

Conclusions Both the Lab-score and CPM-Pneumonia are valuable tools in detecting SBI in febrile young children. CPM-Other SBI showed less performance than Lab-score and CPM-Pneumonia, possibly due to the lack of urinalysis value in CPM-Other SBI, which are mostly UTI.

PO-0276 FEVERISH CHILDREN IN A DGH IN NORTHERN IRELAND –WHAT ARE WE DOING?

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Aims We undertook this audit to review the management of feverish children in our emergency departments (ED) compared to The College of Emergency Medicine (CEM) standards.

Methods The data was collected using a tool designed by CEM. Entry criteria: under 5 years old and temp $>38^{\circ}\text{C}$ on arrival.

Results Total number of patients was 50. The assessed risk profile for this population (using NICE guidelines) were 24 low risk, 14 intermediate risk, 11 high risk and 1 we were unable to risk stratify from the clinical notes. Nine children were prescribed antibiotics (5 low risk, 2 intermediate and 2 high risk).

Of the 11 patients who were high risk, 7 had a clear source of infection. Of the 4 who had no source identified, one had bloods and urine performed in ED but these were not recorded in the notes. 2 had bloods performed on the paediatric ward.

For the 14 patients in the intermediate risk, 8 had a source of infection, 5 had no obvious source identified and one was not clearly documented. No patients without a source were prescribed antibiotics. No documentation was recorded about discharge advice.

18 patients (36%) did not have a blood pressure (BP) or a capillary refill time (CRT) documented in the notes and 10 patients (20%) did not have their GCS or APVU recorded.

Conclusions There are areas that require review. Improvements must be made to ensure a full set of observations are recorded, emphasising the importance of BP/CRT as well as GCS/APVU.

PO-0277 REVIEW OF THE MANAGEMENT AND OUTCOME FOR PATIENTS TREATED FOR WHEEZE IN A TERTIARY PAEDIATRIC EMERGENCY DEPARTMENT (PED)

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Background and aims To review the management of patients who were treated for wheeze in the PED and compare them to those in the British Thoracic Society (BTS) Guidelines.

Methods Reviewed PED flimsy of those patients over 2 who were treated for wheeze in PED in March.

Results Number of patients 46.

93% received bronchodilators while 7% were given Prednisolone only. 65% were given maximum nebulised bronchodilator therapy (x3 sets). 89% received steroids and 2% received IV medication. 41% received antibiotics in ED and 50% had a chest x-ray performed.

Of those discharged (n = 32), 75% were discharged within 4 h. 31% patients were discharged within 1 h of last bronchodilator and a further 41% within 2 h.

Of those treated with maximum nebulised bronchodilators (n = 30), 43% were admitted, 23% discharged within 1 h post last bronchodilator and a further 27% within 2 h.

8% re-attended within 48 h -4% due to elevated temperature, 2% were uncertain with inhaler technique and 2% due to increase in symptoms.

No patient had documented evidence of written asthma management plan given or to attend primary care for review within next 48 hrs.

Conclusions The low re-attendance rate is supportive that those attending received good clinical care and in a timely manner, with 75% of patients being discharged within the 4 h target. However, education is required to ensure patients stay 3–4 h post last bronchodilator and the need for documented discharge