other healthcare facilities. It is resistant to a large number of antibiotics. MRSA bacteremia in children often has serious sequelae. Children with severe disability have chronic illnesses, receive frequent antibiotics, have invasive procedures and are more likely to be hospitalised multiple times. They are therefore assumed to be more at risk of MRSA colonisation.

Method As part of the trust infection control surveillance, the trust funded a pilot survey of MRSA colonisation among 25 children who attended the play group for severely physically disabled children at the child development centre. All children were under three years of age, wheel chair bound or with multiple disabilities. All had disabilities from birth or soon after and 80% had spent time in the neonatal unit. More than 50% of the children had had invasive procedures such as placement of a nasogastric tube or a gastrostomy or had cardiac surgery. All children had been hospitalised on more than one occasion and in more than one hospital. These factors were considered to place them at higher risk of being colonised with MRSA.

25 children were swabbed after obtaining informed consent from their parents. 2 Swabs were taken from the nostril, axilla or groyne of each of the 25 children and transported in appropriate media directly to the laboratories for testing for MRSA. The swabs were taken opportunistically by the doctor from each child when they attended clinic for their medical review.

Results All the swab results were reported negative for MRSA.

Conclusion The severely disabled children in our survey were not colonised with MRSA inspite of multiple predisposing factors. The risk of spreading MRSA within the playgroup was low and the children could continue to participate fully in communal activities.

G226(P) WHY DO WE REVIEW CHILDREN?

doi:10.1136/archdischild-2013-304107.238

G Bhusari, S Gopinathan, K Banerjee. *Community Paediatrics, SWECS, North East London Foundation Trust, Grays, UK*

Background The waiting list for review appointments in our Community Paediatric clinics is getting longer. We get frequent calls from parents and other professionals regarding delayed appointments. This audit was undertaken to attempt to change the mind-set of clinicians about offering review appointments "just in case".¹

Aims To identify the main reasons for offering follow-up appointments and to explore whether children could be reviewed by methods other than 'face to face appointments'. We also looked at whether some children could be reviewed by other health professionals.

Methods The audit was conducted prospectively on all patients seen by Community Paediatricians from 1st May to 31st May 2012. A form (table 1) was devised and agreed at the team meeting to be completed on all children who were offered a further follow-up appointment.

Results In total 305 forms were completed. The main reasons for follow up were to monitor developmental progress, to review children with complex special needs and medication review. 16/305 was offered further appointment on parental request. For 247/305 (81%) children, continuing with 'Face to face' review in clinic was the preferred option. For 44/305 (14%), Clinicians felt the children could be reviewed in an alternative way. In this group, for 34/44 children the preferred option was by another trained professional and for 10/44, by telephone review. It was identified Team around Child meetings was not a suitable option to review children.

Conclusions Most children still need to be seen at 'face to face' clinic review. However in 14% (1 in 7) of children, alternative

Abstract G226(P) Table 1

Why do we review children?

Main reasons:

- Monitor developmental progress ☐
- Medication review ☐
- Complex special needs ☐
- Parental request ☐
- Special schools(MLD/SLD) ☐
- Safeguarding concerns ☐
- Other .....

Review after:

- 3 mths ☐
- 6mths ☐
- 9mths ☐
- 12mths ☐
- Other .....

Could this be done differently?

YES ☐ NO ☐

If yes please select the correct method -

- Tel ☐
- School Nurse/ Specialist HV ☐
- TAC/ESP meetings ☐
- Other .....

methods to review children can a preferred option. This can offer opportunity to increase capacity without adversely affecting quality of care.²

Specialist Health Visitors, Nursery Nurses, and Tier 2 Primary Mental Health Workers were identified; as possible professionals who can be trained to review children. Following the audit it has been planned to develop a system to record a specific reason why Clinicians wish to offer follow-up appointments and to develop a pathway to identify children who can be seen by other professionals with appropriate training. A monthly telephone review clinic will also be piloted.

REFERENCES

1. http://www.improvement.nhs.uk/heart/sustainability/outpatients/one_stop.html accessed on 27/07/2012
2. I Ahmed-Jushuf, V Griffiths and Six Sigma study group. Reducing follow-ups: an opportunity to increase the capacity of genitourinary medicine services across the UK. *Int J STD AIDS* 1 May 2007 vol. 18 no. 5 305-307.

G227(P) AUDIT OF RCR 2008 STANDARDS FOR RADIOLOGICAL INVESTIGATIONS OF SUSPECTED NON ACCIDENTAL INJURY

doi:10.1136/archdischild-2013-304107.239

G Popli, M Ganesh. *Telford and Shropshire Community Trust, Child Development Centre, Telford, UK*

Aim Review compliance with above guidelines and compare with performance from a previous year.

Background RCR and RCPCH consider imaging the injured child critical to the process of child protection. The RCR guideline published in March 2008 seeks to provide an evidence based framework which supports the radiologist in contributing to child protection. It encourages best practise and communication between different agencies working together to safeguard children in the investigation of suspected physical abuse. This follows recommendations from the Climbié enquiry and ensuing legislation.

Methodology We compared the performance before (2007-08) and after (2009-10) RCR guidelines were published. Notes were