KAWASAKI DISEASE BPSU SURVEY IN GREAT BRITAIN AND IRELAND

Introduction Kawasaki disease (KD) is the commonest cause of acquired heart disease in the western world. We report here on the preliminary data for the first year of a 2-year national survey in Great Britain and Northern Ireland.

Methods Using standard BPSU methodology, children with Kawasaki disease (KD) were identified and data collected. 180 children had complete data sets. The steering committee reviewed cases that were unclear or incomplete.

Results 192/196 paediatric services enrolled. 186 units provided service descriptor data, 174 clinical audit data and 145 PREM data. The clinical cohort consisted of 3449 patients; median age 5.2 years; male: female 55.4%. Anonymised PREM data were received from 2335 parents, carers, children and young people. 45% of first assessments occurred within an acute presentation. 35% of children had features of KD at 12 months. 22.6% of children had a documented neuroisodiasis.

68% of paediatric services now have at least one Epilepsy Specialist Nurse (ESN). There has been a significant increase in percentage of children having ESN input; access to a paediatrician with expertise in epilipies; appropriate assessment, classification and investigations in 2014 compared to 2012. PREM data showed 88% (1897/2148) overall satisfaction with services; 20% thought that staff are not good at working together.

Conclusion There is evidence of significant improvements in the provision of medical and nursing epilepsy care. However, many children still do not receive recommended practice and access fully resourced paediatric epilepsy services.

PAEDIATRIC PREPARATION DAY: SMOOTHING THE TRANSITION FOR YORKSHIRE AND THE HUMBER FOUNDATION AND GP TRAINEES

Background Delivery of safe, high quality healthcare relies upon adequate training and education. Concern exists regarding the preparedness of junior doctors for their expected clinical roles despite Tomorrow’s Doctors and the implementation of the Foundation Programme. Foundation and General Practice (GP) trainees rotate through secondary care paediatric rotations expected to perform clinical skills. Yet, the vast majority will have very limited practical paediatric experience. As traditional teaching methods including ‘see one, do one, teach one’ become increasingly unacceptable, simulation-based medical education (SBME) is being advocated to provide opportunities for deliberate practice and avoidance of patient harm. Internationally, paediatric bootcamps are starting to emerge. However, both regionally and nationally, bespoke opportunities for Foundation and GP trainees to develop practical paediatric skills prior to paediatric rotations are lacking.

Methods A one-day regional paediatric and neonatal skills course was developed and piloted for Foundation and GP trainees rotating into secondary care paediatrics. This provided trainees with the opportunity to observe and practice fundamental procedural and resuscitation skills on part-task trainers and low-fidelity manikins under the supervision of senior paediatric trainees. Course evaluation was achieved through a comparative pre and post-test design using confidence levels and a bespoke MCQ to assess knowledge acquisition for qualitative and quantitative data respectively.

Observation/Evaluation 58 doctors attended four pilot courses. Complete pre and post-course comparison data was achieved from 57 trainees. The mean MCQ score rose from 60.7% (95% confidence interval, 58.5% to 62.9%) to 83.9% (82.4% to 85.3%), p < 0.0001. Although statistically significant increments in mean confidence levels were demonstrated for every skill, the largest increases were associated with performing lumbar punctures, paediatric and neonatal life support, cannulation and venesection.

Conclusion This simple intervention is a feasible way to support Foundation and GP trainees ahead of paediatric rotations. This should facilitate a smoother transition into their clinical roles, when complemented with departmental induction programmes. The opportunity to practice skills in a safe
Early experience with electronic growth chart use throughout a local health board

Aims Electronic patient records are the future. We are proceeding toward full digitisation of the past, and, until direct electronic entry is fully established, contemporaneously for written notes and other documents. However a scanning solution cannot be applied to the growth chart. Developing our own electronic version was for control of development, and ensuring integration with the established portal to all electronic records (CWS) in the Health Board. CWS is available to all 9000 clinical users in primary, secondary and community care.

Methods Development was clinically led, working with the company conducting digitisation of medical records. A graphing product plots measurements onto a chart image. Images were created from growth data available from the Medical Research Council. Charts are for 0–2, 0–4, 0–18 years, boys and girls, with ability to display gestation correction, bone age and target height. Charts can be optionally displayed in any age range, either as a single measurement or in combination of height and weight. Table information shows calculations of BMI, and height velocity. Location of data entry is mandated, and user identity recorded according to the CWS login. Different levels of access, determined by clinical role, and training allow measurements to be entered from any site.

Results A pilot phase began June 2014. By October the use of paper was supplanted for most patients. Presently 3199 children have active growth charts with data entry largely from secondary care, but use is rapidly increasing, and becoming more established from community and primary care. Feedback overall has been very positive, with many examples where clinical practice has been enhanced, primarily related to the fact that all clinicians in all settings can see and use the same chart on-line. Refinements are steadily being added, influenced by user opinion. A Down syndrome chart will shortly be available.

Conclusions The electronic growth chart is proving a successful substitute to paper, and working well across our Health Board. Future development and design will be directly influenced by user feedback. There is enormous potential in future enhancements, including use on mobile devices.

References

1 Department of Health. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March 2015
3 Matheson C, Matheson D. How well prepared are medical students for their first year as doctors? The views of consultants and specialist registrars in two teaching hospitals. Postgrad Med J. 2009; 85:582–589

Abstract G287 Figure 1 DNA rate results

IMPACT OF TELEPHONE REMINDERS ON ATTENDANCE RATE AT PAEDIATRIC CLINICS

1 S Chinnappan, 2 E Gole, 2 B Martin, 1 M Ahmed. Paediatrics, Queen’s Hospital, Burton-Upon-Trent, UK; University of Leicester, Leicester, UK

Background Non-attendance in clinics has a major economic impact in the National Health Service. Literature review indicates that the major reason for non-attendance is patients or parents forgetting their appointment and reminders before clinic appointment reduces the “did not attend” (DNA) rate. Telephone call reminders were introduced for all paediatric outpatient appointments from February 2014 in our District General Hospital setting.

Aim We aimed to evaluate the DNA rate at the paediatric outpatients after implementation of telephone reminders.

Methods Using our hospital outpatient database, DNA rates were reviewed for 6 months (Feb–July 2013) and compared with the DNA rates for similar duration in 2014 (before and after the introduction of reminders). For Feb–July 2014 period, comparison was also made for patients who confirmed attendance during reminders versus those left a voice message and those who didn’t receive a call or did not answer.

Results Total number of patients in 6 months (2013) were 4156 (2674 follow-up (F/U), 1482 New) and 4732 (3100 F/U, 1632 New) in 2014 (Figure 1). Overall DNA rate for both F/U and New appointments in 2014 was 11.4% (post intervention), which was 5.1% (p value < 0.0001) lower than the total DNA rate in 2013 (16.5%). Although reduction was noticed in both F/U and New appointments but it was only statistically significant in follow up (6.9%, p value <0.0001) compared to new appointment (1.7%, p value 0.1470).

DNA rate was lowest at 3.4% in the patients who answered and confirmed the appointment. Patients confirming attendance were less likely to DNA compared to those patients who had voice messages (10.98% DNA, p value 0.0041) or not answering phone/not called (13.65% DNA, p value 0.0001).

Conclusion Our results endorse the usefulness of telephone reminders and validates that confirmation of clinic appointment