Abstracts

G302(P) OBESITY – WHY DO CLINICIANS STILL TURN A "BLIND EYE"
L Ek, T Waterfield, R Shahid, C Lander, N Nathwani. Paediatrics, Luton and Dunstable Hospital, Luton, UK
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Approximately 3 in 10 children aged 2–15 years are overweight or obese. This is concerning because weight problems in childhood often continue into adulthood. NICE guidance states that healthcare professionals should ‘aim to create a supportive environment that helps a child who is overweight or who has obesity, and their family, make lifestyle changes’.

Aims
1. Determine the prevalence of obesity amongst paediatric outpatients
2. Audit practice against NICE guidance
3. Collect qualitative data on clinician attitudes towards obesity

Methods
This prospective audit assessed the weight, BMI, ethnicity and outcome of patients presenting to the paediatric outpatient department (POD) over a 10 week period. Patients were audited from all clinical specialties using the POD.

Overweight and obese children were identified as having a weight above the 91st and 98th centiles respectively and underweight children a BMI below the 0.4th centile on the appropriate RCPCH Body Mass Index (BMI) charts and growth charts. The only exclusion criteria were children under 2 and over 16 years of age. Qualitative data was collected via structured interviews with clinicians working in the POD.

Results
569 children were audited of which 407 met the inclusion criteria. The cohort’s demographics were as expected for the area. The prevalence of overweight and obese children from this cohort was 14% and 11% respectively. Of those identified as either overweight or obese only 2% and 34% respectively were offered an intervention. Interventions included; advice, investigations, or referral. Interestingly all underweight children were investigated and given follow up support. Qualitative data from structured interviews demonstrated that clinicians were aware of obesity as a health issue but failed to act for a variety of reasons including a lack of time and for fear of damaging the doctor-patient relationship.

Analysis
Clinicians are not complying with NICE guidelines for a range of reasons including; time constraints, a lack of training and concerns over damaging the doctor-patient relationship. We are currently training an obesity nurse specialist to support clinicians during outpatient clinics and to offer additional training and educational support with a view to changing clinician attitudes towards obesity.

G303(P) AWARENESS OF HEALTHCARE PROFESSIONALS ABOUT THE POSSIBILITY OF SUBSTANDARD MEDICINES
T Almuzaini, I Choonara, H Sammons. Academic Division of Child Health, University of Nottingham, Derbyshire Children’s Hospital, Derby, UK
10.1136/archdischild-2015-308599.280

Aims
The number of reports per year by the MHRA of substandard medicines is rising. The aim of this study was to examine healthcare professionals’ (HCPs) willingness to consider and report defective medicines. To gauge their awareness of reporting systems designed for HCPs to report defective medicines, issues related to medicine quality and the official online pharmacy logo (as the marker of legitimate online pharmacies).

Methods
This pilot study involved HCPs (paediatric doctors, pharmacists, and children’s nurses) and used self-administered questionnaires containing case scenarios derived from actual reported incidents. An invitation letter and questionnaire were sent to each doctor and nurse working at Derbyshire Children’s Hospital, as well as pharmacist members of the Nottinghamshire and Derbyshire Local Pharmacy Forum.

Results
30 doctors (60% response rate), 31 pharmacists (2.7%), and 47 nurses (42%) responded, a total of 108 HCPs. Only 27 HCPs (23% doctors, 39% pharmacists, and 17% nurses) considered the possibility of manufacturer error when a medicine’s defect was obscure (fentanyl transdermal system with manufacturer error causing excessive release of the medicine). Most HCPs (77%, 74%, and 66%) responded that they would report such an incident via the Yellow Card Scheme, established to gather reports of adverse drug reactions. Most HCPs (100%, 87%, and 81%) agreed with the statement that ‘medicines in the UK are manufactured to a high standard’, though more than one-third (40%, 39%, and 30%) believed that poor-quality medicines existed in the medicine supply chain in the UK. However, only 5% of HCPs were aware of the defective medicines reporting system and few (7%, 16%, and 6%) were aware of the official online pharmacy logo.
Conclusions HCPs’ awareness of the possibility of defective medicines was low. The vast majority were unaware of the defective medicines reporting system and of the official logo of registered online pharmacies in the UK. Findings suggest a need to increase HCPs’ awareness of these measures.

G304(P) RCPCH BEST PRACTICE GUIDELINE TO NEWBORN EXAMINATION TO REDUCE THE PREVALENCE OF DELAYED DETECTION OF CLEFT PALATE (CP)

Introduction The UK prevalence of Cleft Palate (CP) without cleft lip is 1 in 1,750 live births. Half of CP have associated malformations and syndromes. The prevalence of delayed detection in the first 24 h after birth is 30%, 16% more than 72 h, 7% under three months of age, 3% under year and 2% over one year old. Potentially unnecessary delay in appropriate management, parental distress, and litigation occur. Strong circumstantial evidence suggests the method of palate examination as the cause.

Aim Develop recommendations for optimal examination of the palate during routine newborn examination to ensure early detection of CP.

Methods A consensus guidelines group was led by the RCPCH, including parent groups and key professional stakeholders. The RCPCH standards for development of clinical guidelines in paediatrics and child health were followed. A systematic review with methodological advice from the RCPCH clinical standards team was undertaken. Where there was limited evidence to support recommendations for practice a Delphi consensus method was carried out. When Delphi consensus was not reached, recommendations were based on working group consensus.

Results
1. Examination of the newborn baby’s hard and soft palate should be carried out by visual inspection and recorded in the Child Health Record.
2. Use a torch and method of depressing the tongue to visualise the whole palate.
3. Parents should be informed if the whole palate (including the full length of the soft palate) has not been visualised.
4. Failure to visually inspect the whole palate at first attempt should be followed by repeat visual examination within 24 h.

Conclusion Trusts should provide training on the correct method of visual inspection of the palate to all healthcare professionals required to carry out newborn examinations.


G305(P) REFERRAL AND INVESTIGATION OF PAEDIATRIC URINARY TRACT INFECTIONS IN A GENERAL PRACTICE SETTING – ARE WE GETTING IT RIGHT?

Introduction Urinary Tract Infection (UTI) is a common bacterial infection. Natural history in children has changed over the last 30–50 years due to antibiotics and improvements in healthcare. There remains uncertainty about the most appropriate and effective way to manage UTIs in children including whether or not investigations, follow-up and prophylaxis are justified. The correct timeframe during which these should occur depends on presentation and age of the child.

Aims NICE clinical guideline 54 is often confusing due to the complex nature of follow up and the range of investigations required depending on presentation and age. The guideline can be quite challenging to follow in a busy general practice environment. The aim is to assess current management in terms of referral and further investigations and suggest any necessary improvements to facilitate this process.

Method Retrospective audit looking at management of patients under 16 years old presenting to an inner city general practice from September 2010–14 with suspected UTI. Culture positive UTIs were identified and patients who fulfilled the NICE criteria for referral were highlighted. Referrals were categorised as appropriate, inappropriate or missed. Grade of clinician who made referral was recorded.

Conclusion There remains uncertainty about the most appropriate and effective way to manage UTIs in children including whether or not investigations, follow-up and prophylaxis are justified. The guideline can be quite challenging to follow in a busy general practice environment. The aim is to assess current management in terms of referral and further investigations and suggest any necessary improvements to facilitate this process.

Abstract 305(P) Figure 1

Investigation of Children With Urinary Tract Infection

Based on NICE Clinical Guideline 54

< 6 months old

2, 3, 4

5, 6

7, 8

< 6 months old

9, 10, 11

12, 13

14

< 6 months old

US during acute infection

DMUA in 4-6 months following acute infection

MCUG

6 months–3 years

US during acute infection

DMUA 4-6 months following acute infection

Has the child responded well to treatment with suitable antibiotics within 48 hours?

Does the child have any of the following physical features?

Seriously ill

Painful or severe

Abdominal or bladder mass

Rash and/or diarrhoea

Septicemia

Infection with non-C shape organisms

< 6 months old

US during acute infection

DMUA in 4-6 months following acute infection

MCUG

6 months–3 years

US not referred within 6 weeks

DMUA 4-6 months following acute infection

Consider MCUG if:

Dilation or ultrasound

Nephroureteral joint

Non-C shape infection

Family history of VUR

> 3 years

US within 6 weeks

Does the child need further management?

Acute pyelonephritis (upper UTI)

Bacteriuria: B fever > 38°C

A positive urine culture

Acute pyelonephritis (lower UTI)

Bacteriuria: B fever > 38°C

A positive urine culture

Acute pyelonephritis (both upper and lower UTI)

Bacteriuria: B fever > 38°C

A positive urine culture

Abstract 305(P) Figure 1

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US during acute infection

DMUA in 4-6 months following acute infection

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Bacteriuria: B fever > 38°C

A positive urine culture

Acute pyelonephritis (both upper and lower UTI)

Bacteriuria: B fever > 38°C

A positive urine culture