Infants require a full physical examination within 72 h of birth and again between 6–8 weeks of age. NICE Clinical Guideline CG37 titled ‘Routine postnatal care of women and their babies’ specifies a 43-part list of expected examination points. We wanted to determine the proportion of infants attending for their 8-week baby check at a local General Practice, who had adequate documentation of examination findings in the electronic health records (EHR). The audit also aimed to determine if practice could be improved using an online template.

A retrospective audit assessing documentation of examination findings for the 8-week check was performed on 20 patients attending the practice during a four-month period. 100% babies at the 6–8 week check should have all 43 criteria entered into the EHR. Each patient was given a score relating to the number of criteria documented. We then created a unique, easily identifiable ‘8-week baby check’ electronic template for use with the EHR and doctors in the practice were trained in its use. Subsequent re-audit on a sample of 20 patients completed the audit cycle.

The initial audit showed overall percentage documentation was 22%, well below the 100% standard. Best recorded were 100% reflex, heart sounds and hips, entered for 11 of 20 patients. 0 of 20 patients records commented on hands, feet, nose, ears, neck or presence of dysmorphism. 8 patients had only ‘8-week check OK’ entered into the EHR. Re–audit once the electronic template was in place showed a 73% improvement in documentation, with all 43 criteria being entered for at least 95% of the children.

The initial audit highlighted inadequate documentation of examination findings in the EHR at the 6–8 week newborn check. A well-designed intervention was shown to significantly improve practice thus maintaining medico-legally sound patient care. A well-designed intervention was shown to significantly improve practice thus maintaining medico-legally sound patient care. Re–audit once the electronic template was in place showed a 73% improvement in documentation, with all 43 criteria being entered for at least 95% of the children.

Aims/objectives We examined pre bedtime/bedtime activities and sleep hygiene practices in special needs /non special needs children with sleep difficulties and explored level of pre-bedtime exposure to artificial lights from modern electronic media including computers, cell phones and digital television.

Methods Sleep hygiene surveys were conducted separately in carers of children with special needs-ADHD (6–18 years), pre-school children with Autism Spectrum disorder (3–5 years) and a non special needs population of 500 primary school children in a socially deprived area from periods June 2013 to March 2014.

Results Children in both special needs and non-special needs populations kept some form of electronic media in their bedrooms (26%) and played with these or watched television within ½–2 h (44%) before bedtime. Electronic device exposure was highest in the ADHD group (54%). Majority (68%) of carers in the ADHD cohort reported some improvement in sleep onset difficulties when they followed advice regarding switching electronic media off at least an hour before bedtime.

Conclusions There is an urgent need for Health and Educational Professionals to educate families about the role of modern electronic media/TV on the sleep cycle of children when conducting sleep education/hygiene.

There should be more public health awareness and research about the impact of modern electronic media and artificial lights on sleep in children with/without special needs and neurodevelopment disorders.

Outcome Following surveys, sleep tools have been developed to enable health and educational professionals conduct a more effective sleep interview and hygiene. Tools have been widely circulated to GPs, Health professionals and over 200 mental health Leads in schools. They have also been circulated on the National Child Trust UK website (NCTUK).

Introduction Sleep onset difficulties may be worsened by exposure to artificial lights from modern electronic media with wave-lengths similar to day light, potentially inhibiting the action of the sleep hormone melatonin responsible for sleep-wake cycle. A lot of current sleep hygiene advice for patients/families lack specific advice about the role of artificial lights in suppressing natural melatonin production.

Aims Disrupted sleep is commonly treated with melatonin, especially in children with Neurodevelopmental disorders. (BNF for Children 2014/2015). We surveyed melatonin prescription practices amongst Community Paediatricians in the East of England.

Methods In May 2014 we sent out an online survey to all Community Paediatricians in the East of England.

Results 17 responses in total were received from all over the region.

All Paediatricians prescribe melatonin to children with Neurodevelopmental disorders, Neurodisability (73%), Visual impairment (73%), Intellectual disability (67%) and to Children with Chronic Fatigue Syndrome (20%) and behaviour difficulties (20%). Sleep advice is given by all clinicians and promoted through leaflets (56%), referral to Specialist Sleep clinics (38%) and support from other professionals (School Nurses, 13%, Occupational Therapists, 6%, Intellectual Disability Services, 19% and Family workers, 13%). On average clinicians felt sleep hygiene should be tried for 3 months (range 1–6 months) before melatonin is started. Most (59%) clinicians do not routinely
assess impairment of function before prescribing melatonin. The main preparation of melatonin prescribed is tablets (94%), followed by liquid (59%) then capsules (41%). Mostly (65%) slow release medication is given. The minimum dose of melatonin prescribed is 2 mg (range 0.5 mg–3 mg), maximum dose range (4–12 mg).

Practice varies in how often children are reviewed. Some (35%) review in the first 3–4 months, others 6 monthly (29%). Most (94%) clinicians offer at least yearly reviews. Routine trials off melatonin are offered by 65%. On average children stay 26 months on melatonin before withdrawal (range 6–120 months).

In comments Paediatrician gave views regarding the management of disrupted sleep, the need for good sleep hygiene support, which patient groups melatonin is best suited for and management of melatonin treatment.

Conclusions This survey has highlighted variability amongst Community Paediatrians in the East of England in certain areas of melatonin prescribing, possibly due to lack of uniform standards. With these results we are therefore creating a generic regional algorithm for initiating melatonin in children with disrupted sleep pattern which may form a platform for developing a melatonin prescription and sleep guideline for individual Organisations.

**Abstract G430(P) Figure 1 Current pathway**

**G430(P) IS IT POSSIBLE TO HAVE HIGH STANDARDS PRACTICAL PATHWAY FOR AUTISM SPECTRUM DISORDER?**

A Tarhini. Community Paediatrics, Shropshire Community Health NHS Trust, Shrewsbury, UK

10.1136/archdischild-2015-308599.384

**Aims** Public awareness of Autism Spectrum Disorder (ASD) is increasing, as well as the demand for assessment. The implementation of high standards and practical pathway for assessment and diagnosis can be a challenge for many trusts including our trust. The aim was to reconstruct the current pathway by the trust to produce a practical pathway for assessment and diagnosis of ASD that meet the high standards of NICE guidelines and following the DSM-V criteria.

**Methods** Firstly the strengths and weaknesses of the current pathway have been identified. Secondly set up the essential elements of the future pathway defined by DSM-V criteria and NICE guidelines for ASD assessment and diagnosis. An estimated time scale was calculated based on clinic and administration time required.

**Results** Three essential elements for the assessment have been identified: A) comprehensive meeting with paediatrician, B) multisource observational reports and C) direct assessment. It was possible to incorporate in each step some elements of the NICE guidelines and DSM-V criteria to cover all the essential elements and criteria. Finally, a set of recommendations and suggested pathway for the assessment and diagnosis of ASD was produced. The estimated time to make a definitive outcome about ASD is possible within 240 min of clinician’s direct clinical and administration work.

See Figures 1 and 2

**Conclusion** It is essential for trusts to have a high standards and practical pathway for ASD diagnosis and assessment in line with NICE guidelines and DSM-V criteria. The current pathway was not satisfactory and a suggested practical pathway has been produced to meet the high standards of practice.

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