

services, research identifying reasoning behind caregiver choices, their understanding of healthcare options and the provision of further education and health information represent worthwhile steps in tackling this issue.

G107(P) THE DEVELOPMENT OF A CONSULTANT PAEDIATRICIAN PHONE-LINE FOR GENERAL PRACTITIONERS

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Aims Ambulatory paediatric services have changed significantly over the last year at our hospital. One of these changes has been the development of a consultant-manned phone line, whereby general practitioners (GPs) can speak directly to a consultant paediatrician between 0800–2300 on weekdays and 0800–2000 at weekends. The aim was to optimise patient care by facilitating timely communication with the most appropriate hospital based paediatrician. This enables acutely unwell children and outpatient referrals to be directed appropriately, reducing paediatric emergency department (PED) attendances and it also serves to strengthen links between primary and secondary care.

Methods Activity data for the first five months was analysed. The consultants complete a proforma for each phone call with a predefined data set. This includes the general demographics of the caller and the patient in question, as well as information about the outcomes of calls.

Results 167 calls from GPs have been taken since the phone-line began and 59 of these have been recorded onto proformas. 29% were from GPs asking for management advice and potential referral of outpatient problems, whereas 68% were from GPs asking about the acute management of an unwell child in the GP surgery. There were a variety of different outcomes from the calls, directing the unwell child to the most appropriate practitioner (Figure 1). Consultants taking the phone calls recorded that 33 ED attendances and 2 admissions had been prevented following calls from GPs.

Conclusion The phone-line has been very successful, reducing PED attendances and improving pathways of outpatient referrals. Not only does this service comply with 'Facing the Future' standards, as it is consultant delivered and available at times of peak activity, but it is also in accordance with the NHS Mandate, keeping children out of hospital, in the community wherever possible. The service is in its infancy, but thus far has been instrumental in the development of ambulatory paediatric services at our hospital. It provides excellent quality of care for local children and enhances our links with local GPs.

G108(P) IN PAEDIATRIC CARDIOPULMONARY ARREST ARE SUPRAGLOTTIC AIRWAY DEVICES (SAD) ADEQUATE FOR OXYGENATING AND VENTILATING?

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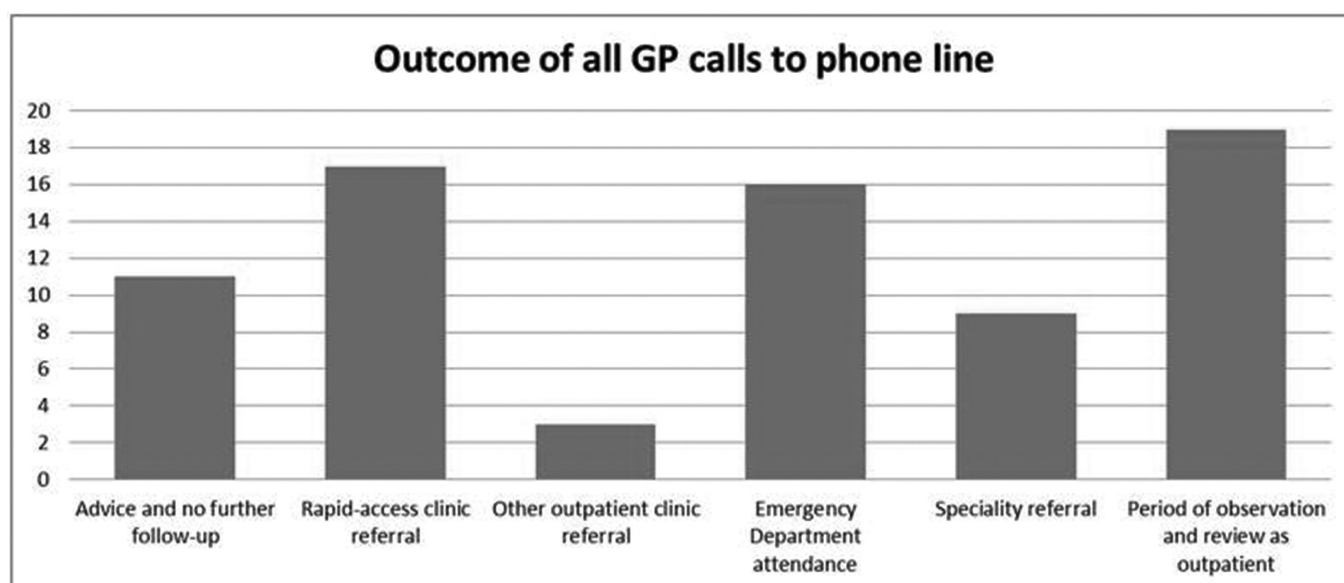
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Clinical scenario A two year old has a witnessed cardiopulmonary arrest whilst in your Emergency Department. You are able to ventilate the child using a bag valve mask (BVM) and oral pharyngeal airway, but notice his stomach is becoming inflated. In cardiac arrest in adults you know that a LMA or iGel is now the advised airway to use (ALS guidelines 2011), but you wonder if this could apply to children as well.

Search parameters MEDLINE (1950-present) and EMBASE (1980 to present) [(exp ventilation) AND (exp ped* OR paed* OR child) AND (exp arrest)] LIMIT: English.

Search outcomes 327 papers, 6 of which were relevant. A further two papers were found from the reference of one of the original search articles.

Comments No paper looks specifically at using a SAD in a paediatric arrest, all the cases have been in mannequins or in anaesthetised children, simulating arrest. Hypoxia, which is often the cause, is a very important factor to overcome in paediatric arrest. By using a SAD one can undertake uninterrupted chest compressions and ventilation. The comparison with BVM and intubation in the prehospital setting shows that neurological



Abstract G107(P) Figure 1 The outcomes of all phone calls from GPs to the phone-line