Abstract G257 Table 1

TRY-CPAP outcomes		HCW				
		RA	IN-O ₂	CPAP	ECPAP	Total
Paediatrician	RA	0	1	0	0	0
	IN-O ₂	1	29	2	1	33
	CPAP	0	0	15	1	17
	ECPAP	0	0	0	7	7
	Total	2	28	18	9	57

HCW=Health Care Worker, RA=Room Air, IN-O₂=intranasal oxygen, ECPAP=Early CPAP

G258 EPILEPSY IN WESTERN UGANDA: USING SATELLITE CLINICS TO REMOVE BARRIERS TO SEEKING CARE

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Aims Epilepsy affects three times as many children in African countries compared to higher income settings. Unfortunately, epilepsy clinics in Africa countries are poorly attended even when there is free provision of care. To reduce this treatment gap we introduced low cost rural epilepsy clinics in Western Uganda. The aim of this study was to evaluate their effectiveness.

Methods Pre-intervention attendance and follow-up at hospital based clinics was audited for three month periods. The intervention involved a new guideline written by the medical, pharmaceutical and community rehabilitation staff at the regional hospital, providing information about the locally available medications, how to start medication and monitor side effects. In addition, clinics local to the hospital were introduced and then satellite clinics in four rural locations were introduced. The cost of these extra clinics, attendance and follow-up at the clinics were audited over nine months post intervention and re-audited six years after the intervention. Cost analyses excluded medication costs as medications were provided by the government to the hospital and community clinics without charge. Clinic costs did not change depending on patient attendance.

Results One patient attended the hospital clinic each month. Post intervention, at the clinics local to the hospital a median of 8 patients (range 2–12) attended per month with 100% attending for follow up at the booked time; the cost per clinic was £15. At the satellite rural clinics, there was a median of 42 (range 15 to 56) patients per clinic with 70% of patients attending follow up appointments; the cost per clinic was £34. The hospital based clinic ceased to exist. Six years post intervention the attendance at the satellite clinics was a median of 47 patients (range 25 to 85) per clinic; the cost per clinic remained £34. Satellite clinic attendance post intervention was significantly higher than locally held clinics ($p=0.004$).

Conclusion Rural epilepsy clinics away from the hospital were associated with higher attendance which was sustained six years post intervention. This was achieved at relatively low cost.

G259 DELIVERING NURSE-LED EMERGENCY PAEDIATRIC CARE IN SIERRA LEONEAN HOSPITALS: THE EFFECT ON QUALITY OF CARE AND MORTALITY

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Aims To assess the impact of a national programme in paediatric secondary care, to introduce ETAT protocols and train nursing staff to lead emergency management.

Methods Within a wider strategy to reduce child mortality, the Sierra Leone Ministry of Health and Sanitation engaged WHO and RCPCH to introduce WHO Emergency Triage Assessment and Treatment (ETAT) protocols to all district hospitals. Two clinical mentors (one Sierra Leonean, one UK/international) were placed at each hospital for six months, and delivered a three-month teaching programme with a written and practical examination, as well as hands-on clinical mentorship. Upon passing the examination, nurses were awarded the right to assess, prescribe for, and treat emergency paediatric cases.

The mentors collected treatment data each day on children admitted the previous day, and followed each child to record their discharge outcome. This programme monitoring data was analysed to identify compliance with clinical protocols, and to calculate mortality rates. The programme delivery period was split into seven four-week blocks, and compliance rates and mortality rates were calculated for each four-week period.

Results We analysed monitoring data from three regional hospitals in the first phase of roll-out (table 1). The combined mortality rate across the three hospitals fell from 15% in the first four-week period, to 4% in the final period. This fall was accompanied by improvements in key areas of compliance with WHO ETAT standards.

Abstract G259 Table 1

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Admissions	452	481	555	539	646	638	412
Deaths	66	73	63	64	51	39	18
	(15%)	(15%)	(11%)	(12%)	(8%)	(6%)	(4%)
Oxygen for severe respiratory distress	52/86	117/	117/	125/	156/	256/	93/101
	(60%)	151	162	169	216	264	(93%)
		(77%)	(72%)	(74%)	(72%)	(97%)	
Antibiotics correctly prescribed	116/	304/	426/	452/	462/	536/	354/
	390	436	517	512	544	623	398
	(30%)	(70%)	(82%)	(88%)	(85%)	(86%)	(89%)
Dextrose for hypoglycaemia	38/55	63/79	104/	131/	95/112	122/	48/56
	(69%)	(80%)	120	152	(85%)	133	(86%)
			(87%)	(86%)		(92%)	

Conclusion This study suggests that implementation of ETAT protocols and delivery of improved quality of care and decreased mortality may be achievable with an effective and cost-efficient nurse-led model for emergency paediatric care in low-resource settings.