positively impact on ACEs. The future health of the nation rests on our collective response to the findings of the ACEs study.

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FROM DOORWAY TO DISCHARGE: A MULTI-DISCIPLINARY QUALITY IMPROVEMENT INNOVATION TO IMPROVE THE CAMHS PATIENT JOURNEY

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Background Mental health problems are increasingly common among children and young people (CYP) with 1 in 8 reporting symptoms.¹ Our service experienced 3 presentations per week within 2016 which further increased by 60% this year. From doorway to discharge each patient will see 7 different healthcare professionals. This may result in frustration at perceived lack of communication between staff, lack of knowledge² and need to repeat their story.

Aims

- Create a multi-disciplinary mental health pro-forma for CYP presenting to hospital with mental health difficulties.
- Assist staff to complete appropriate, informed assessments.
- Improve patient experience by reducing need for story repetition.

Methods Plan: 2 independent retrospective case-note analyses of 27 presentations to the Emergency Department (ED) over a 4 month period of patients aged between 14 and 15, and 24 admissions to the ward over a 3 month period of patients aged under 16.

Do: Implemented a pro-forma encompassing the patient journey including key aspects identified for improvement from data analysis; risk assessment, safeguarding, physical and mental state examination (MSE).

Study: Second data-analysis followed a 6 week pilot period. A further retrospective case-note analysis of 19 admissions to the ward via the ED.

Abstract G74 Figure 1 Page 1 and 2 of the paediatric mental health admission document

Results Within ED there was improvement regarding risk assessment (92.9% vs 10%), safeguarding (100% vs 52.9%) and MSE (92.9% vs 51.9%).

Ward data demonstrated a lack of engagement with the pro-forma, no change to those fully completing risk assessment (0%) and deterioration in MSE (57% vs 35.7%) and physical examination (70% vs 57.1%).

Discussion and future direction

The mental health pro-forma resulted in clear improvement in outcomes within ED assessments across many aspects. These improvements may be replicated on the wards by increasing staff engagement with the pro-forma. Suggestions to achieve this aim, as well as other improvements, make up the 'act' aspect of our PDSA cycle:

- Multi-disciplinary education on mental health presentations and use of pro-forma.
- Pro-forma colour coding according to discipline for clearer access.
- Patient experience analysis.

Further data analysis is planned for early 2018.

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PRESCRIBING AMOXICILLIN FOR BABIES UP TO 3 MONTHS OF AGE: DEFINITELY TIME FOR CHANGE

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Background and objectives In the United Kingdom, the National Institute of Health and Care Excellence (NICE) guidelines recommend that amoxicillin is prescribed for suspected sepsis or meningitis in infants under 3 months of age to cover for *Listeria monocytogenes* infection. However, this infection is rare, particularly outside the neonatal period. We evaluate current evidence and propose that routine amoxicillin use be limited to infants under 1 month of age, as is currently practiced in other countries.

Methods We critically evaluate the need for this practice by reviewing current literature, NICE guidelines and the literature cited within. Epidemiological data from the last decade was gathered and analysed from Public Health England. Data was collected over a 12 month period regarding the prescription of intravenous amoxicillin in infants under 3 months of age at Chelsea and Westminster Hospital, London.

Results

- Over the last decade, only 120 cases of confirmed listeria were reported in infants throughout England and Wales. 97.5% (n=117) presented within the first month, and the remaining after 3 months of age. Thus routine intravenous amoxicillin treatment for those between 1–3 months of age was futile.
- Extrapolating data over 12 months from our own hospital to represent national figures, 9316 infants aged between 1–3 months might have received at least 24 hours of intravenous amoxicillin. This equates to at least 28,000 excessive doses of intravenous amoxicillin.
- NICE guideline evidence is out-dated and unconvincing. Changing current recommendations would result in significant time, resource and financial savings for hospitals, contribute to a reduction in antibiotic resistance and promote antibiotic stewardship.

Conclusion Given the above evidence, reducing the routine age for empirical amoxicillin use in suspected sepsis and/or meningitis from 3 months to 1 month is appropriate and overdue.