the NICE bronchiolitis guidelines (NG9) which now recommends isotonic fluids.

Aim To investigate patterns of IV fluid administration and analyse plasma sodium measurements in children with bronchiolitis admitted to a busy paediatric unit.

Methods Audit of all infants with bronchiolitis, on IV fluids between November 2016 and January 2017. The audit protocol was derived from NICE guidance (NG9).

Results Thirty-two out of 237 patients admitted with bronchiolitis received IV fluids (13.5%). Data was available for twenty-nine infants. The median age was 7 weeks and the majority were male (n=20). The most common pathogen isolated was RSV in 85.7% of cases.

Seventeen (58.6%) infants received isotonic fluids however, 16 (55.2%) received hypotonic or a mixture of hypotonic and isotonic solutions. Two infants were hyponatraemic on admission (sodium 121 mmol/L and 129 mmol/L respectively), however none developed iatrogenic hyponatraemia. There was a single case of hypernatraemia in the isotonic fluids group (sodium 147 mmol/L). There was no significant difference in change in sodium between those receiving purely hypotonic or isotonic solutions. Moreover, there was no association observed between rate of IV infusion (boluses not included) and change in sodium however, there was a significant association with duration of intravenous fluids ($p=0.012$). Two infants had large variations in plasma sodium of 10 and 12 mmol/L respectively.

Conclusions Significant changes in plasma sodium can occur whilst children are receiving IV fluids. This highlights the importance of regular electrolyte monitoring and regular assessment of the need for on-going fluid administration.

G139(P) AWARDS FOR EXCELLENCE IN PAEDIATRICS: A TRAINEES' PERSPECTIVE IN IMPROVING MORALE

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10.1136/archdischild-2018-rcpch.135

Background and aims The paediatric team at Milton Keynes University Hospital has a monthly Award for Excellence, where all staff could nominate any other member of staff for excellence at work. We hoped that this would improve team morale by giving opportunity to celebrate the nominated staff and to make staff feel more appreciated.

We analysed the awards over last 12 months to review junior doctors' role in nominating and receiving nominations.

Method Review of nominations for the last 12 months. Designation of staff who filled the nominations and those that were nominated was collected along the reasons for nomination.

Results 54 members of staff were nominated for the Excellence award in the last 12 months. Most of the nominations were by consultants (42%) and nurses (33%). Wide ranges of professionals were recommended for these awards but the most common were nurses (44%) and junior doctors (26%).

The reasons for nominations were varied and included good communication, hard work, great leadership, compassion and feedback from patients. Informal feedback from few of the award-winning trainees showed that these awards were appreciated and encouraged motivation.

Conclusions Awards for excellence in paediatric is an important way to appreciate staff that have made a significant positive impact on patient care and teamwork. While the junior doctors were the second most nominated group to receive awards, it is important to notice that they did not nominate any individuals in the last 12 months. One of the reasons might be that they were not aware of these awards and efforts will be made to include this in their future induction sessions. We feel that empowering trainees to nominate staff for these awards will help feel part of the team and receiving these awards will increase their morale. Learning from excellence (Greatix), an online positive feedback tool has recently been launched in our Trust and paediatric nominations will be monitored in the future.

G140(P) GASTROSCHISIS: A 9 YEAR SINGLE CENTRE EXPERIENCE

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10.1136/archdischild-2018-rcpch.136

Aims To describe the outcomes of all babies with gastroschisis managed over a 9 year period at a single surgical unit.

Methods Retrospective study of all infants with gastroschisis, repaired between Jan 2007 to Jan 2016. They were analysed according to Simple vs Complex Gastroschisis and the Simple group subdivided into Primary vs Staged Closure.

Results We identified 56 babies. There were 45 simple and 10 complex cases. One baby was excluded with a closed gastroschisis. 26 babies with Simple Gastroschisis had primary and 19 had staged closure.

No deaths were noted. No significant differences in operative complications and unplanned re-operations were demonstrated. The median length of stay, time to full feeds and parenteral nutrition duration was not significantly different between simple and complex gastroschisis groups.

There was a significant difference in days to first feed and parenteral nutrition duration in Simple Gastroschisis managed with Primary closure and Staged closure (table 1).

Abstract G140(P) Table 1

	Simple, staged	Simple, primary	Mean diff	P value
Days to first feed	9.5	18	8 (3–17)	<0.001
Days to full feed	21	31	8 (0–24)	0.04
Day of parenteral nutrition	21	33	11 (2–21)	0.01

Conclusions

- Simple vs Complex Gastroschisis:
 - There was a higher but non significant risk of operative complications in the complex group.
 - No statistically significant difference between the simple and complex groups. A sizable proportion of complex patients were excluded as they did not achieve outcome or were transferred to other units.
- Primary vs Staged closure in Simple Gastroschisis:
 - No statistically significant difference in operative complications between primary and staged groups.