

**G180(P) SUDDEN UNEXPECTED DEATH IN INFANCY AND CHILDHOOD – SIMULATION TRAINING TO IMPROVE CONFIDENCE AND UNDERSTANDING OF THE SUDIC INVESTIGATION**

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**Introduction** Paediatricians play a vital role in managing the multi-agency investigative process following a sudden unexpected death in infancy or childhood (SUDIC). Inadequate SUDIC investigation has devastating consequences for families and professionals.

The low incidence of SUDIC and shortened training time result in reduced exposure. The Kennedy Report highlighted the need for improvement of training. Despite these recommendations a lack of experience and awareness of the multi-professional roles exists amongst senior trainees.

Simulation-based education has been used effectively to bridge the gap between knowledge and clinical experience. We developed a one day course for senior paediatric trainees and consultants using high fidelity simulation and experiential learning.

**Methods** Key events of a SUDIC case and investigation were simulated including:

- Resuscitation
- Breaking bad news
- Post-mortem examination and investigations
- Death scene examination
- Rapid response meeting
- Report writing
- Parent experiences

Content and scenarios were mapped to the Postgraduate RCPCH Curriculum for General Paediatrics and Community Child Health, and delivered by SUDIC specialists within paediatrics and police.

Outcomes assessed included qualitative pre- and post-course confidence and self-reported skills performing key aspects of SUDIC management.

**Results** Seven SUDIC simulation courses have been delivered to date (2016–2017), with 8–15 candidates in each. Significant improvement was seen between pre- and post-course Likert scores for confidence and skills in all key aspects; including confidence explaining the process to parents (increased from 14.3% to 90.9%) and practical skills e.g. performing skin biopsy (from 17.9% to 87.9%). Free text feedback comments were overwhelmingly positive – referencing much improved understanding of the investigative process.

**Conclusion** Simulation training improved confidence and perceived ability to manage key aspects of SUDIC – an area where self-reported confidence and skills are low due to little clinical exposure. This may ultimately improve the quality of SUDIC investigations and experiences for families.

This course is funded for all trainees within our deanery. It has the potential to be delivered nationally and could be adopted for multi-professional SUDIC training for health, social care and police.

**G181(P) EXPLORING COMPLEMENTARY FEEDING PRACTICES (CFP), CONCERNS AND DRIVERS IN THE BRITISH BANGLADESHI POPULATION, TO OPTIMISE INFANT NUTRITION AND LIFELONG WELLBEING**

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**Aims** To explore complementary feeding practices (CFP), concerns and drivers in Bangladeshi communities to inform the adaptation of a female volunteer-led participatory learning and action cycle based intervention to optimise infant (6–24 month) nutrition and prevent long term conditions such as obesity and diabetes.

**Methods** The NEON (Nurture Early for Optimal Nutrition) study utilised collaborative participatory approaches, working with trained community researchers. A snowballing technique was used to achieve a purposive sample of Bangladeshi mothers, fathers and pregnant women living in the UK >3 or <3 years and grandparents, community members, key informants and health professionals with experience or professional interests in CFP in the UK health context. Qualitative topic guides were informed by the literature and guided by a socio-ecological framework. Semi-structured interviews (45) and focus group discussions (12) were conducted in homes and community spaces by a trained Bangladeshi community facilitator and the researcher. Data were analysed using Framework methodology in NVivo.

**Results** Families reported diverse methods use to feed infants aged 6–24 months, including: cup, beaker, spoon, syringe and ‘modified bottle’, and styles of feeding, including: distraction feeding, ‘force’ feeding, messy eating and responsive feeding. Common practices included mixed breast and bottle-feeding, or switching to bottle to facilitate early weaning. Some preferred formula that is thickened or advertised as for hungry babies and the early introduction of cow’s milk. Hand feeding was common as a tradition, for ease and a show of love. Respondents described a range of concerns and worries related to complementary feeding: early weaning, filling the belly, fussy eaters, understanding good growth and development, health in childhood (including obesity and dental caries), health in adulthood (including chronic diseases), overfeeding, safety and unhealthy food preparation. Societal views that ‘a chubby baby is a healthy baby’ were linked with parental concerns about ‘filling the belly’ and professional concerns for ‘overfeeding’.

**Conclusion** Long-term health can be influenced by optimal infant nutrition. Interventions need to recognise the socio-cultural drivers of CFP practices to develop targeted and acceptable programmes.

**G182(P) USE OF AN ECLECTIC APPROACH IN AUTISM SPECTRUM DISORDER; A DEVELOPING COUNTRY PERSPECTIVE**

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**Aim** To see the effect of an eclectic approach in management of ASD in a resource constrained set up.

**Material and method** A total number of 70 children were enrolled after parental consent. Parental Questionnaire, Functional Behaviour Analysis (FBA), Childhood Autism Rating Scale II (CARS II), Portage Early Education Programme (PEEP) were administered in addition to clinical diagnosis of autism based on DSM V (APA 2013). Children below 2.5 years and above 5 years along with children with cerebral palsy and Syndromes were excluded from the study. An Eclectic Approach included Applied Behaviour Analysis (ABA), Functional Behaviour Analysis, Speech And Language Therapy and Picture Exchange Communication System (PECS), Developmental therapy, Occupational and Sensory Integration Therapy, Social Skills Training and parents as partners. Statistical Analysis was done using SPSS 21 (Frequencies, Pearson correlation).

### Results

**Abstract G182(P) Table 1** Age of diagnosis & duration of therapy

n=70	Mean (months)	+SD	Min (months)	Max (months)
Chronological Age	40.77	9.87	30	60
Duration of Therapy	19.2	7.07	12	36

**Abstract G182(P) Table 2** Correlation between CARS & developmental profile

Developmental profile skill areas	CARS correlation (p value)
Cognition	0.430 (0.000)
Socialisation	0.194 (0.107)
Language	0.308 (0.010)
Self Help	0.101 (0.406)
Motor	0.137 (0.256)

**Abstract G182(P) Table 3** Correlation between duration of therapy & developmental profile

Developmental profile skill areas	Duration of therapy correlation (p value)
Cognition	0.311 (0.009)
Socialisation	0.269 (0.024)
Language	0.383 (0.001)
Self Help	0.080 (0.510)
Motor	0.304 (0.011)

Males were more affected than females and mean age of diagnosis was 3.4 years. Improvement was seen both in Behavioural and Developmental Profile. Longer duration of therapy lead to better outcome in language, cognition and socialisation.

**Conclusion** An Eclectic Approach is a useful intervention in children with ASD in a low resource country.

### G183(P) A NOVEL WAY TO SCORE THE AUTISM SPECTRUM QUOTIENT QUESTIONNAIRES AND CHILDHOOD AUTISM SPECTRUM TESTS

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**Aims** The incidence of autism in the UK is predicted at 0.1%; 1 00 000 children and 7 00 000 adults. Diagnosis of Autism Spectrum Disorder (ASD) varies regionally though national standards are outlined; NICE Clinical guideline (CG128) and Quality standard (QS51).

The use of questionnaires to assess for Autism Spectrum Disorder (ASD) in community child health services, is common practice. Questionnaires are sent to both parents and caregivers and the school. Returned questionnaires are then hand scored by clinicians. Questionnaire scores alongside history, clinical examination and multidisciplinary assessment are used to inform diagnoses.

The Autism Spectrum Quotient: Children's Version (AQ-Child) and Adolescent's Version (AQ-Adol) and Childhood Asperger Syndrome Test (CAST) have been widely used in the NHS for 10 and 15 years, respectively. The AQ includes 50, 4 point Likert scale questions and the CAST includes 39 binary yes/no questions. Scoring questionnaires can take several minutes each and is usually done by comparing answers to an A4 paper score sheet. In order to improve cost effectiveness and ultimately service delivery we explored ways to score questionnaires more efficiency.

**Methods** Relevant published literature on the method of scoring AQ-Child, AQ-Adol and CAST questionnaires was sought from Ovid MEDLINE 1946–2017. Search criteria included; English language and studies specifically detailing the scoring of the AQ-Child, AQ-Adol and CAST. Unpublished data on local practice was also sought from international search engines; Google, Bing and Yahoo.

We devised specifically sized acetates which are made to be placed over the completed AQ-Child, AQ-Adol and CAST questionnaires to enable scoring.

**Results** No published or unpublished data was found to evidence any methods of scoring the AQ-Child, AQ-Adol and CAST questionnaires away from the conventional score sheets. Our locally designed and produced acetates when placed above the AQ-Child, AQ-Adol and CAST questionnaires significantly reduced scoring time.

**Conclusion** Our designs for scoring the AQ-Child, AQ-Adol and CAST questionnaires are entirely novel and unique. Locally, they have significantly increased efficiency and cost effectiveness.

As pressures on our services continue to increase this is a welcome step in improving service delivery and patient care.