P2  CHAPERONS FOR CHILD PROTECTION MEDICAL EXAMINATIONS: A MISSING LINK?

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10.1136/archdischild-2019-epa.358

Abstracts

Background Child protection medical examinations should be undertaken in the presence of a chaperone. This as a good practice recommendation is clearly stated in the Child Protection companion.

Aim We undertook an audit of Child Protection medical examination reports to see if our practice meets the standards set by RCPCPCH in Child Protection companion.

Method Child protection companion’s model report was chosen as the standard to compare our practices. Hospital-based electronic patient records system (clinical portal) was used to review the reports by a single auditor. Twenty-eight reports were randomly selected. These children undertook Child Protection medical examination at a District General Hospital over a period of 14 months from January 2017 to February 2018.

Demographics Three-fourth of the reports were by boys & one-fourth were girls. Fifteen percent were under 1 year old, sixty percent were between 1 &5 years old and twenty-five percent were over 5 years old.

Timeliness Three-fourth of the reports were typed within 72 hours of CP medical examination.

Quality All (100%) the reports stated the source of information and recommendations made after assessment. Over three-fourth reports stated informed consent was taken; included a brief introduction of the author and information about the growth centiles.

Two-third reports established that child’s concerns were recorded. Reference to the evidence-based literature was made in fifteen percent of the reports.

Only seven percent of the reports stated use of Chaperones and amendments in the report after peer review meeting. Three percent of the reports stated both the time and date of referral.

Recommendations Our audit highlighted that Chaperones is an underused entity in child protection medical examinations. Chaperons are not only supposed to provide assurance to the child and family but also offers clinicians with an extra layer of protection in case of a complaint.

Thus we strongly advocate using Chaperon’s in all cases of Child Protection Medicals unless declined by the child/family. In that case, this should be clearly documented. There is also a pressing need to improve the quality of overall documentation.
Paediatric Burns Unit at Our Lady's Children’s Hospital in Crumlin, on admissions to the unit with burns ≥20% TBSA. We look at their mechanism of injury (scald vs. flame), TBSA as %, and length of hospital stay, as well as long term outcomes where available.

P5 FACTORS ASSOCIATED WITH COMPLIANCE WITH NUT/SEED REINTRODUCTION FOLLOWING A NEGATIVE FOOD CHALLENGE – A COHORT REVIEW FROM A SPECIALIST PEDIATRIC ALLERGY UNIT

Introduction Selective nut/seed eating has become standard practice in allergy units across Europe, with studies suggesting there is potential for patients allergic to one nut or seed to incorporate others into their diet. To minimize cross-contamination risk, our unit guidelines provide standards for ‘safe selective nut/seed eating’ however the compliance rate with such guidelines is unknown. The aim of the current study is to assess patient compliance with nut/seed reintroduction, and examine the factors predictive of full compliance.

Methods Eligible patients who had a negative food challenge to a nut/seed in the preceding 2 and 12 months at a single paediatric allergy unit were identified from an institutional database, and followed up via a telephone interviewer-administered questionnaire in June 2018. Patient compliance with nut/seed reintroduction advice in four domains including frequency of eating (i.e. ≥2 times/week), type of food consumed (i.e. whole/ground from single nut/seed pack), age-appropriate portion size, location of eating (i.e. in the home only) was assessed; ‘full’ compliance denotes compliance with all four domains combined. Data were collected on patient recall of support/information, barriers to compliance, and parental perceptions of the reintroduction experience.

Results From 141 eligible patients, 100 (70.9%) consenting participants were successfully followed up at either 2 (54%) or 12 (46%) months post-challenge; median age was 3.8 years. Only 17% (n = 17) of the sample fully complied with all four domains combined. The highest compliance rate was in the ‘location’ domain (70%); 39% of patients complied with recommended ‘portion size’. The most prevalent reason for not eating the nut/seed as frequently as recommended included ‘the child not liking the taste of the food’ (n = 24; 41.1%). Fifty five percent (n = 55) of parents reported to receiving hospital literature on nut/seed reintroduction; 15% spoke with a dietitian regarding nut/seed reintroduction advice. Parental agreement with the statement ‘my child likes eating this food’ was independently associated with full compliance with nut/seed reintroduction advice (aOR 3.6, 95% CI 1.55–20.8, P = 0.009).

Conclusion This study demonstrates that compliance with local guidelines on nut/seed reintroduction is poor. There is a need to ensure that all patients receive optimal support/information on the day of the food challenge. More thorough assessment prior to the challenge of whether patients and their families are suitable for, and committed to selective nut/seed eating, may result in improved compliance.