Methodology There was a retrospective review of all patients reviewed in clinic in the last 3 months with Cerebral Palsy less than 18 years old. The radiology system 'NiMIS' was used to check for evidence of imaging and clinic letter was reviewed for evidence of clinical examination. The patients were classified according to their GMFCS group and results documented as 'Yes' 'No' if compliant to one or both guidelines and 'Don't know' if the images were not available on NIMIS.

Results 12 patients were included in this re-audit with the overall compliance being 90%. GMFCS 1 included 3 patients all meeting the surveillance guidelines. GMFCS 2 included 3 patients with 100% compliance. GMFCS 3 included 2 patients with 50% compliance. GMFCS 4 had no patients. GMFCS 5 included 4 patients with 100% compliance and Hemiplegic Gait Group included 1 patient with 100% compliance.

Conclusion We are now above the standard set for compliance to these guidelines. The re-audit was over a shorter time with fewer patients, however it does suggest an initial positive change. The plan will be to re-audit again in six months and a years' time to ensure that this level of compliance is maintained.

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P145 PAEDIATRIC POCKET GUIDES: ADAPTATION OF AN EXISTING LOCAL IRISH RESOURCE TO OVERCOME CHALLENGES TO CLINICAL GUIDELINE IMPLEMENTATION IN A LIMITED RESOURCE PAEDIATRIC ONCOLOGY SETTING IN TANZANIA

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We adapted an existing pocket guide to provide an easily accessible solution to support implementation of paediatric oncology guidelines for staff of the Paediatric Oncology Unit at Muhimbili National Hospital, Tanzania.

Background In 2018, a team of Irish Children's Nurses were invited to support the provision of the first 8-week Paediatric Oncology Nursing Course in Muhimbili National Hospital. Support was provided in the classroom, through clinical mentorship on the ward and the development of the Paediatric Pocket Guide (PPG).

A detailed, locally appropriate Supportive Care Handbook had been developed for nurses and doctors working in the Paediatric Oncology Unit. However, the printed guidelines were expensive to print, bulky to routinely carry and regularly 'disappeared' from the ward. Rapid staff turnover (interns change every week!) also made dissemination difficult. Due to hospital IT issues the document was not available on ward computers. The lack of accessibility was felt to be a contributing factor to the lack of adherence to clinical protocols and guidelines. Gaps in knowledge and understanding of complex oncology issues have a direct impact on the provision of safe consistent care and survival of children treated on Upendo

Children's oncology ward. Similar challenges were noted with the implementation of a tailored Paediatric Early Warning System (PEWS) on the ward.

Intervention Two versions (nursing and medical) of a summary pocket-sized paediatric oncology guideline resources were developed and printed on water-resistant cards. All staff attending specific education sessions were given a personal copy. Three months following the introduction of the Paediatric Pocket Guide an evaluation survey was completed. The findings were overwhelmingly positive

- 100% of staff find it very useful
- 100% of staff say their knowledge of oncology guidelines has improved and helps them follow the guidelines
- 67% strongly agree and 33% agree that patients are safer following the introduction of the PPG
- Examples were given of when the pocket guide was used in clinical practice and suggestions for improvement

Learning The PPGs have led to improved adherence by ward staff to oncology protocols and guidelines and improved awareness and implementation of the PEWS.

Creating locally relevant clinical guidelines is essential but consideration must also be given to how this information will be imparted to staff. The lightweight but cheap and durable pocket-guides have bridged this very significant gap between knowledge generation and clinical application. They also prompt guidelines to be regularly reviewed and updated with each new printed edition.

P146 AN AUDIT OF MANAGEMENT OF FEVER IN INFANTS YOUNGER THAN THREE MONTHS ON A GENERAL PAEDIATRIC WARD

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Introduction Fever is a common presentation in paediatrics. Infants <3 months presenting with fever should be managed on an inpatient basis due to the increased risk of serious bacterial infection (SBI), with infants <1 month always considered high risk for SBI. The local guideline in Cavan General Hospital for the management of these infants is based on NICE guidelines. A previous audit revealed poor compliance. We aim to determine if compliance has improved.

Aim To determine compliance with guidelines for the management of fever in infants younger than 3 months.

Methods 38 infants younger than 3 month were admitted to the paediatrics ward in Cavan General Hospital with fever between January 1st2018 and December 31st2018. Charts were reviewed retrospectively using set criteria to determine compliance, and identify areas where improvement was necessary.

Results 37 charts were reviewed. One chart could not be located at the time of the study. Of 37 patients, 9 were less than one month of age, and 28 were between 1 – 3 months. All patients had blood tests done, though not all had a venous blood gas performed as per protocol. One patient only had an FBC done, with no U&E or CRP. All but two patients had a urine sample checked.

Of 37 infants, 16 had a lumbar puncture performed, with a further three having attempted lumbar puncture. In the < 1 month old group, who should be considered as high risk for SBI, only 5 of 9 infants had a lumbar puncture performed. Additionally, a number of lumbar punctures were delayed, with one lumbar puncture delayed by 4 days.

Regarding treatment, 26 infants received parenteral antibiotics; 16 of these infants received 'triple antibiotic therapy' consisting of amoxicillin, gentamicin and cefotaxime. Additionally, 6 infants who were treated with antibiotics due to concerns regarding sepsis did not have a lumbar puncture.

Conclusions This audit shows that while we are compliant with investigations such as blood tests, and urine sampling in most cases, compliance with guidance regarding lumbar puncture and antibiotic treatment is still poor, and the audit revealed significant variation in these areas, suggesting greater education regarding guidelines is required.

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THE DEVELOPMENT OF THE DOWN SYNDROME HEALTH SURVEILLANCE CLINIC

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The problem Down syndrome (DS) is the most prevalent chromosomal abnormality accounting for 8% of all registered cases in Europe. One baby with DS is born out of every 444 live births in Ireland. Recent decades have seen a substantial increase in the life expectancy of children with DS. The implementation of medical guidelines with preventative health care programmes have helped to improve life expectancy and quality of life.

Aim The development of a multidisciplinary one stop clinic to provide health surveillance for children with Down Syndrome to improve adherence to guidelines outlined by the Down Syndrome Medical Interest Group UK and Ireland (DSMIG).

Making a case for change

In 2015, an audit of adherence to medical guidelines outlined by DSMIG was performed comparing children attending a disability-based service in comparison with a hospital-based service. Compliance to guidelines was higher in the hospital-based clinic. An interprofessional group performed a root cause analysis and subsequently developed a dedicated multidisciplinary DS Health Surveillance Clinic (DSHSC) amalgamating the clinic run in the disability service with children attending hospital-based general paediatric clinics.

Improvements seen The DSHSC occurs twice monthly and caters for 207 children with DS. Families are reviewed by the medical team and DS Clinical nurse specialist and rotate through audiology and phlebotomy as required. A clinical proforma has lead to significant improvement in assessing for symptoms of obstructive sleep apnoea, coeliac disease, atlantoaxial instability and arthropathy associated with DS as well as developmental assessment. Compliance to national

guidelines improved on re-audit of 58 patients attending the DSHSC chosen at random of similar demographics.

In conjunction with re-auditing of adherence to guidelines, parental questionnaire was distributed at random to families attending the clinic. Parental satisfaction was 100% (n=24) good to excellent on a 5-point Likert scale. Sixty-six percent (n=16/24) had a wait-time of less than 30 minutes. Additional dietetic and play therapy support was reported to enhance the clinic experience by 58% (n=14/24) and 79% (n=19/24), respectively, of respondents.

Conclusion The DSHSC provides parents with a 'one stop' clinic with access to medical and nursing support, phlebotomy and audiology. The co-ordination of same day appointments reducing time missing from school and work, and sharing of information. The use of a clinical proforma reduces the cognitive burden of medical staff in reviewing children and improves adherence to guidelines. We aim to continue to run health promotion projects, such as immunization education, through the clinic.

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A GUIDELINE FOR THE SECONDARY CARE MANAGEMENT OF TICS IN CHILDREN IN THE BELFAST TRUST

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Background Tic Disorder is a common problem that affects 1:1000 children. Tics can either be an isolated phenomenon, causing minimal stress or can be functionally significant causing interference with day to day life.

Within the Belfast trust many children are referred by General Practitioners to general paediatricians in the Royal Belfast Hospital for Sick Children because of concerns about tics. It was noted after discussion with the general paediatric team that investigations, management and referral patterns differed among general paediatricians.

Aims The authors therefore concluded it would be helpful to develop a guideline to

1. encourage a consistent investigation and management approach for Tic disorder and
2. clarify referral pathways from Belfast Trust general paediatrics to psychology, neurology and community based services including Child & Adult Mental Health Services (CAHMS)

Methodology In 2018, a small working group was established in RBHSC, consisting of two general paediatricians, one consultant paediatric neurologist, the lead paediatric psychologist and a paediatric trainee. An initial draft, based on information and evidence from current medical literature, was produced. It was subsequently amended several times after working group meetings and regular email correspondence. Belfast Trust Community paediatricians and the CAHMS lead were consulted, with particular attention to the referral pathways. The wider general paediatric medical team was asked to review the final draft. Help was obtained from a quality improvement manager to ensure the guideline met Trust quality and formatting standards.

Results The guideline is now complete and awaiting final approval from the Belfast Trust. It contains advice on