structured approach to the history and examinations of a child with possible tic disorder and when investigations are indicated. Management is discussed under two categories of (a) Simple tics and (b) Tics with co-morbidities. Advice is given on who will benefit from psychology input and what to do when co-morbidities are noted. Indications for paediatric neurology and CAHMS referral are discussed. The Appendix includes community referral forms, the Yale tic questionnaire and some links to information for carers.

Conclusion The authors are hopeful this guideline has fulfilled the aims outlined. Consideration will be given to seeking feedback from users when it is formally adopted. Paediatricians from other Trusts may also find much of the guidance helpful though caution would be needed with the referral pathways which are different in different Trusts.

P149 IS VIRTUAL THE FUTURE OF OPD?

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10.1136/archdischild-2019-epa.504

Introduction The General Paediatric Outpatients Department at Our Lady's Children's Hospital Crumlin has a greater than two year waiting list for new routine appointments. Long waiting time is considered as one of the most concerning matters in the majority of health care organisations¹. A wait time of no more than 6 months for routine appointments is proposed². A virtual clinic was run by three General paediatricians from November 2017 to October 2018, with the aim to reassess and prioritise the 'long-waiters' on the waiting list. A Virtual clinic is a contact between the clinical team and the patient, without a face to face meeting, to plan clinical care with the use of telecommunication³.

Methods Parents of the longest waiting children were called by the paediatricians, after going through their referral letters. If parents were not contactable, their GPs were contacted. Progression of the symptoms, persistent concerns, any reviews in the meantime were recorded. Subsequently patients were either removed from the list with parental consent or remained on the list with or without prioritisation.

Results A total of 65 patients were reviewed via virtual clinics. 43 patients were subsequently removed from the list with parental consent. In 15 (23%) referring reason was resolved, 4 (6%) were seen by other hospitals and 2 (3%) were seen privately, while 7 (11%) were reviewed by other specialities. 22 patients remained on the waiting list. Among these 65, 41 (63%) parents were contactable, GPs were contacted in 9 (14%) cases while no one was contactable in 15 (23%) cases. Most common referral diagnoses were developmental concerns and gastrointestinal issues including abdominal pain, constipation and reflux, each contributing to 30% of the cohort. 10% were referred for recurrent UTIs, 3% with respiratory symptoms, 8% with seizures and headaches, while 18% were miscellaneous including eczema and fatigue.

Conclusion Virtual clinics can play an important role in dealing with the long waiting lists in paediatric population.

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P150 PRIME (PRETERM INFANTS NEED MILK EARLY); A QUALITY IMPROVEMENT INITIATIVE IN A TERTIARY NEONATAL UNIT

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10.1136/archdischild-2019-epa.505

Aim Maternal milk (MM) protects against necrotizing enterocolitis and sepsis. PRIME is a multi-disciplinary initiative to improve the early provision of MM for preterm infants and enhance outcomes. Our aim was to increase the number of high-risk infants receiving MM in the first day life in our tertiary neonatal unit.

Method We retrospectively reviewed time to first MM for infants born <32 weeks gestational age (GA) or with a birth weight (BW) <1500 g in 2016. We conducted a cross-sectional survey to evaluate the knowledge and attitudes of staff towards breast milk for preterm infants. Deficits in background knowledge and training informed a teaching programme. Education involved training sessions, development of guidelines, distribution of posters, and presentation at meetings. The first 5 infants per month born <32 weeks GA or BW <1500 g were included in the post-intervention analysis. The effect of the interventions were evaluated using a before and after study design. Time to first MM was our key performance indicator.

Results We reviewed 123 infants born in 2016 [Median (IQR) GA 29 (26, 31) weeks, BW 1140 (820, 1410) g]. Many infants didn't start feeds in 1st24 hours as MM was not available; median (IQR) time to 1st MM 35 (17, 55) hours, 34% of infants received MM in the 1st24 hours of life. Prospective data was collected from 25 infants, born May – October 2018, following interventions [Median (IQR) GA 30 (26, 31) weeks, BW 997 (890, 1560) g]. The median (IQR) time to 1st MM was 17 (8, 25) hours and 76% of infants received MM in the 1st24 hours.

Conclusion The initial results of this hospital-wide QI initiative are promising. The median time to first MM has halved in the 5 months since this initiative commenced. Further PDSA cycles are indicated to ensure ongoing improvement.

P151 ASSESSING THE USE OF THE ISBAR3 HANDOVER FRAMEWORK IN AN IRISH PAEDIATRIC HOSPITAL: A MEDICAL STUDENT PERSPECTIVE

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10.1136/archdischild-2019-epa.506

Intro Medical staff are routinely educated on the ISBAR₃ framework for clinical handover. This tool is implemented to encourage safer and more effective task transfer during clinical emergencies, referral to other specialties, transfer of hospital and wards.