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 neuropsychology 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 although 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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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 organisations. A wait time of no more than 6 months for routine appointments is proposed. 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 telecommunication.

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 and after study design. Time to first MM was our key performance indicator.

Results A total of 65 patients were reviewed via virtual clinics. 43 patients were subsequently removed from the list with parental consent or remained on the list with or without prioritisation.

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

REFERENCES
Abstracts

P152 IMPLEMENTATION OF A BILIRUBIN MONITORING DOCUMENT IN THE NEONATAL ICU AND POSTNATAL WARD SETTING AT UNIVERSITY MATERNITY HOSPITAL LIMERICK

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Introduction Transcutaneous (TcB) and serum bilirubin (SBR) levels are often monitored during the neonatal period in order to decide if a newborn requires phototherapy. Other details, however, are required to assess the infant’s risk factors and threshold of treatment, Gestational age, ABO/Rh incompatibility and Direct Coombs test (DCT) are important amongst other risk factors to guide our management.

Aim To improve clarity and safety when recording TcB and SBR results by creating a one-page document encompassing all necessary pieces of information.

Method Our trial bilirubin monitoring document consisted of 3 sections. The first section is a standard Phototherapy nomogram followed by a section for details such as name, chart number, gestational age, date of birth, time of birth, DCT status and other risk factors. The third section consists of a table with columns for date, time of blood sample, age in hours, TcB, SBR, risk line, risk Zone and plan. Moreover, we included 8 rows for continual monitoring. Three months after implementation and education of this trial document, a survey was carried out amongst midwives and neonatal nurses in UMHL. Various questions were asked regarding the clarity and safety of the new document when compared with the old way of documenting. Feedback and comments were collected and analysed.

Results 24 individuals responded to the survey. Of these, 58% found the old way of documenting ‘unclear’ whereas 20% found it ‘very unclear’. 21% found the new document ‘clear’ and the remaining 79% found it ‘very clear’. 71% found the new document ‘easy to use’ and the remaining 29% found it ‘very easy to use’. 33% found the new document to be ‘safer’ and the remaining 67% found it ‘much safer’ to use when compared with the old way of documenting. Suggestions received included creating a column for the doctor’s signature next to the plan and also to include a line for the mother’s blood group in the second section.

Discussion Prior to implementation of this new document, all of these details were scattered throughout the chart making it difficult for another doctor to ascertain the information when it comes to interpreting a new bilirubin result for a particular newborn. Survey response was in favour of using our new document, due to its clarity, ease of use, enhanced safety and contingency of care. We plan to consider adding the suggested changes and finalising this document as a quality improvement initiative.

P153 AN AUDIT OF ADHERENCE TO NATIONAL GUIDELINES ON COMMUNICATION DURING CLINICAL HANDOVER IN THE UNIVERSITY HOSPITAL OF LIMERICK (UHL)

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Introduction Clinical handover is defined as ‘the transfer of professional responsibility and accountability for someone all aspects of care for a patient, to another person or professional group on a temporary or permanent basis.’ It has been identified as a high risk step in the patients hospital journey that can lead to delay in treatment and loss of trust and confidence amongst staff and patients.

Aim To assess the quality of clinical handover in UHL PD as recommended by the Communication (Clinical Handover) in Acute and Children’s Hospital Services, National Clinical Guideline No. 11 HSE (2015).

Methods A standardised proforma was used to assess the quality of our handover for all medically admitted patients in UHL PD. The audit team chose 10 randomised weekdays to collect information looking at the five aspects: suitability, patient safety, patient confidentiality, standardised communication tool (ISBAR), record keeping. A re-audit will be carried out after an education session to staff.

Results Handover was prioritised over other jobs 0% of the time. Staff had accurate up to date information 20% of the time. Room was inappropriate for handover, too small, not private. Clinical protected time but not adhered to. Handover policy clear. Handover timely in 80% of cases. Handover face to face, no read back, no ISBAR, no safety pause. 8–14 interruptions (late attendance, non-urgent bleeps)