engagement and recovery within medical treatment plans. Stimulants (e.g. methylphenidate) are first line licensed medications for ADHD, and selective norepinephrine reuptake inhibitors (e.g. atomoxetine) and alpha-2A adrenergic receptor agonists (e.g. guanfacine) are second line. At least 85% of children respond to stimulants, and only require alternative medications due to poor tolerance profiles.

European Union member states classify narcotics according to United Nation conventions, and stimulant medications are classified as controlled drugs. This means that they have strict prescribing rules, which if not adhered to results in delayed dispensing, continued impairment, and increased demands on already stretched clinical resources. In Ireland ADHD is treated by tertiary mental health services, however in many European countries, paediatricians take a lead role in ADHD treatment.

Aim This study examines the knowledge of trainee doctors in Ireland of the prescribing restrictions of stimulant medications, and the alternative non controlled medications used to treat ADHD.

Method A questionnaire was designed to capture the current knowledge and prescribing habits of Irish trainee doctors on the 4 commonly used ADHD medications i.e. methylphenidate based, amphetamine based, atomoxetine and guanfacine. The percentage of correct answers were calculated, and Chi squared testing used.

Results 47 questionnaires were completed and returned with a response rate of 57.5%. The majority of doctors knew that stimulants were controlled and how to prescribe these, however only one third of doctors distinguished correctly that the other 2 drug classes were not controlled, and similarly did not know how to prescribe them.

Conclusion There is a knowledge gap amongst trainee doctors around prescribing for ADHD. Mainly for the non-controlled medication options, but also on specific points around prescribing the controlled stimulant medications. We hope that this identified gap in knowledge can be filled with targeted teaching; supporting doctors to become informed, competent and comfortable in prescribing for this common childhood illness.

P171

ANTENATAL CORTICOSTEROID THERAPY: TO DETERMINE THE LEVEL OF ADHERENCE TO PROTOCOL IN PRETERM NEONATES

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Background and aim Institute of Obstetricians and Gynaecologists (RCPI) guideline for preterm prelabour rupture of the membranes (PPROM) recommends the administration of antenatal corticosteroids for women who are 24 to 36 weeks pregnant with anticipated preterm labour. It reduces the risks of respiratory distress syndrome, intraventricular haemorrhage and necrotizing enterocolitis. Recommended steroid is 12 mg of intramuscular Betamethasone given 24 hours apart and at least 24 hours before delivery. This study determined the level of adherence to the guidelines.

Methodology Mothers who presented in preterm prelabour rupture of membranes between 1/1/2015 and 31/12/2018 were incorporated into this study. Mothers were evaluated for

maternal age, parity, body mass index, ethnicity and demographic distribution. Babies were evaluated for gender, gestational age, weight, corticosteroid type and time of administration prior to delivery, number of doses, type of respiratory support, comorbidities and length of hospital stay. Data was recorded on a collection sheet.

Results 103 mothers with PPRM were eligible to receive antenatal steroids, of whom 44(43%) received recommended treatment and 59(57%) received incomplete or no treatment. Out of infants who received complete course of antenatal steroids, 7(16%) required surfactant and intubation, 3 (7%) required CPAP and surfactant, 16(36.4%) required only CPAP, 1 (2%) required high flow oxygen and 17(38.6%) did not need any respiratory support. Of the 59 infants who had an incomplete course or no steroids, 12(20%) required surfactant and intubation, 4(6.8%) required surfactant and CPAP, 20 (34%) required CPAP, 1 (2%) required low flow oxygen and 22(37.2%) did not require any support. Of those who received complete treatment, 26 were early preterm (28-<34 weeks) and 20 were late preterm (34-34+5 weeks). Of those who received incomplete or no treatment, 28 were early preterm and 29 were late preterm. The mean gestational age for infants who received complete treatment was 30 ± 2 weeks, and for those who received incomplete treatment was 32 ± 2 weeks. Of the 103 mothers, 88(85.4%) were Irish and 15 (14.6%) were Non-Irish.

Conclusion It was found that adherence to guideline is satisfactory. Imminent preterm delivery prevented 100% adherence to the protocol. This is a risk reduction strategy and parents should be made aware of the possible outcomes.

P172

TRENDS IN PAEDIATRIC MORBIDITY AND MORTALITY AT UNIVERSITY HOSPITAL LIMERICK

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Background Morbidity and Mortality (M+M) meetings are an important strand of good clinical governance in institutions committed to maintaining and improving the quality of patient care. In 2015, the Department of Paediatrics, UHL made a decision to establish a Paediatric M + M. The meetings were designed to allow structured presentation of complicated Paediatric cases in a multidisciplinary forum to facilitate open discussion in order to identify areas of improvement. Since then, meetings have been held at quarterly intervals between 1300 and 1400 hrs on the last Friday of 'term'. Morbidity is defined as cases requiring transfer to a tertiary hospital and mortality as all cases of children who died under Paediatric care. To date 10 M + M meetings have been held.

Aims Our aim was to review the recent trends in Paediatric Morbidity and Mortality in our region

Methods Medical charts, Emergency Department notes and transfer letters are reviewed to ascertain the presentation, initial assessments, management and mode of transfer etc of patients deemed to meet the criteria for our M + M. The Tertiary centres are contacted to clarify outcomes. This data is then structured into a PowerPoint presentation by two Paediatric Trainees assigned to the task and presented to the Department at the M + M meeting facilitating discussion on 'human factors' and 'systems failures' when identified.

Confidentiality and a 'no blame' ethos are key principles when reviewing cases where shortcomings are identified. The information obtained during each M + M meeting is then stored in its PowerPoint format in a confidential file held by our Administrative Head of Department.

Data collected for each of the meetings was reviewed by the authors and collated

Results The number of cases discussed at each meeting ranged from 24- 42 with a mean of 30. Interestingly there was no seasonal variation in total numbers of transfers or deaths. A wide variety of pathologies were seen. The number of deaths over each three month period remained markedly consistent both in terms of numbers at four and causes- expected deaths due to life limiting illness, accidents, suicide, sepsis and SIDS .

Conclusion We established a Paediatric M + M meeting to review complicated cases and deaths at our busy Regional Centre. Our study suggests that findings in relation to Paediatric serious illness and death have remained consistent in our catchment area since our successful initiative with no obvious trends.

P173 ACT BEST ACTIVE CLINICAL TRIAGING BEFORE EVALUATION EXPEDITES TREATMENT

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Aim To improve patient safety while on an OPD waiting list, by implementing an active triaging process

Method The traditional triage process for referrals was passive, subjective and varied amongst consultants resulting in the majority of children being waitlisted. All new referrals to General Paediatrics were reviewed in a Triage Assessment clinic by two consultants, who jointly reviewed each referral in conjunction with any additional patient information available e.g. previous attendances, investigations etc. They were then waitlisted or deflected back to the GP or to other more appropriate services. Patient 'activities' were performed as appropriate, including radiology, phlebotomy or providing treatment algorithms to GP/parents. A record was kept of all investigations.

Results All data was collected for analysis including number of referrals, triage outcome, reason for referral, activities performed. Analysis of data allowed us to determine the change in triage outcomes. During the initial 16 months of the project 1900 referrals were assessed. Of these, 1203 (63%) were waitlisted, 580 (31%) were deflected/rejected and 114 (6%) were 'Out of Catchment'. Of those waitlisted 830 (69%) were routine, 313 (26%) were soon and 59 (5%) were urgent. Overall, 1109 activities were recorded including sending letters to GPs (588) and parents (105), ordering radiologic investigations (135), phoning GPs (46) or parents (119) for further information. The project has decreased by 37% those waitlisted for OPD appointments.

Conclusion The waiting list should decrease the waiting list by 13.6 months year on year as 694 less new patient appointments were needed over the first 16 months.

The impact on patients was that six serious illnesses were detected early who otherwise would have been delayed in their diagnoses and management with serious consequences.

Patient care from the first point of contact with the hospital is now vastly improved from a patient safety perspective.

GPs have welcomed direct responsive engagement with hospital consultants. This project is projected to be rolled out nationally. Expanding this project beyond our own department will prove challenging as it's a new way of working.

P174 A STUDY OF END OF LIFE CARE ALGORITHMS FOLLOWING THE DEATH OF A CHILD IN A TERTIARY PAEDIATRIC HOSPITAL

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Aims Prompt communication with all professionals involved in the care of a child who has died is essential. To aid this, Our Lady's Children's Hospital Crumlin (OLCHC), has developed a pan departmental algorithm to provide guidance. The 'When a Child Dies (WACD) Algorithm' provides a guided checklist for staff to ensure all stakeholders are informed of the death, and that tasks related to the care of the child and family following a death are completed. This research aimed to audit the activation and completion of the WACD algorithms.

Methods A retrospective study was conducted in a 324-bed in OLCHC. The deaths of 251 children from 2015-2016 were included. Demographic information, diagnoses, disease status, end of life care, place of death and algorithm completion was investigated. The audit was conducted against standards from current institutional guidelines.

Results Of the 251 paediatric deaths audited, 43% died in OLCHC, 11% died in another hospital or hospice, 3% were unaccounted for, and 42% died at home. The most common departments were Cardiology and Haematology/Oncology, accounting for 26.3% and 21.5% of deaths respectively. 17% (43) had the appropriate WACD fully completed, 48% (120) were partially completed and 35% (88) of cases had no WACD forms completed.

Conclusions Departments that more commonly encounter paediatric deaths were more consistent in completion of the WACD algorithm. There is a need to disseminate information and knowledge of the algorithms, especially in departments with a low frequency of childhood deaths. This would ensure that primary care teams, GPs, referring hospitals and any other relevant healthcare professionals are informed on the death of their patient. It also ensures that families are met by the on-call team, the chaplain, and that follow-up with their primary consultant is arranged for the family.

P175 REVIEW OF BREAKTHROUGH ANALGESIA PRESCRIBED USING TRANSDERMAL BUPENORPHINE AS THEIR BACKGROUND OPIOID, IN CHILDREN UNDER REVIEW BY PALLIATIVE MEDICINE IN AN INPATIENT SETTING

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Background Buprenorphine is a synthetic opioid analgesic, its primary therapeutic actions being analgesia and sedation.