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

1,2Jean Donnelly, 1,3Suzanne Kelleher*. 1Our Lady’s Children’s Hospital Crumlin, Dublin, Ireland; 2Trinity College Dublin, Dublin, Ireland; 3Royal College of Surgeons Ireland, Dublin, Ireland

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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

1Amy P Worrall*, 1Eleanor Gallagher, 2Maeve O'Reilly, 3Mary Devins, 1School of Medicine, Trinity College Dublin, Dublin, Ireland; 2Our Lady’s Children’s Hospital Crumlin, Dublin, Ireland

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

Karen Dennehy*. St Luke’s Hospital and Our Lady’s Children’s Hospital Crumlin, Dublin, Ireland

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Background Buprenorphine is a synthetic opioid analgesic, its primary therapeutic actions being analgesia and sedation.
Buprenorphine’s analgesic effect is due to partial agonist activity at mu-opioid receptors (ORs), and has very strong receptor affinity. It’s also a kappa-OR antagonist. The unique activity of the drug as a partial agonist/antagonist at varying receptor sites, means that above a certain dose, employing other opioid receptor agonists as breakthrough (BT) analgesia, may perceivably be ineffective. Studies have looked at effectiveness of morphine sulphate and other mu agonists for episodic BT pain in patients receiving transdermal (TD) buprenorphine. With typical clinical doses, it is possible to use morphine sulphate or other mu agonists without loss of analgesia. Antagonism is felt to only be a concern at very high doses. The usual doses in practice, as cited by the Palliative Care Formulary (PCF), range from 10–40 mcg/hour. Evidence suggests the phenomenon may become relevant at doses exceeding approximately 66 mcg/hour.

This is poorly studied in children to date.

Aims
- The study aim was to ascertain, of children under review by Specialist Palliative Care (SPC) in a Paediatric Hospital, who were prescribed TD buprenorphine as their background analgesia: what dose(s) were used; BT analgesia; whether above cut-off dose cited, BT analgesia changed.
- With respect to our paediatric population on the higher doses of buprenorphine, to determine if there was loss of analgesic benefit with use of opioid agonist BT.

Methods
- SPC brainstorming session.
- Literature review.
- Liaising with in–house pharmacist in relation to local prescribing trends, Meeting with SPC pharmacist.
- Data generated from pharmacy records detailing patients in question.
- Demographics collected/kardexes studied.
- Chart review with on doses above 65 mcg/hr.
- Data was collected including PRN opiate choice/dose/changes to PRN opioid corresponding with up–titration of the buprenorphine, other non–opioid analgesics/pain scores.

Results
Of 15 patients, one buprenorphine dose exceeded named cut-off dose. Oxycodeone was breakthrough analgesic, from which he derived benefit. He had experienced opioid induced hyperalgesia on TD fentanyl, prompting rotation to buprenorphine.

Conclusions
This study revealed one patient on agonists where they may not be advisable. He suffered no ill consequence. The review, albeit small patient numbers, was an insight into our prescribing in relation to buprenorphine. It may remind us to consider the mode of activity of commonly used medications in our practice, explain why in some instances, the BT medication of choice is not proving effective.

P176 BLOOD CULTURE IN CHILDHOOD COMMUNITY-ACQUIRED PNEUMONIA- WHEN SHOULD WE DO IT?
Badin Ramly, Animitra Das, Juliette Lucey, Navdeep Kaur Brar*. University Hospital Waterford, Waterford, Ireland
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Introduction
It is recommended that blood cultures are collected from those with moderate to severe community-acquired pneumonia (CAP). Positivity of blood culture in childhood CAP is often quoted as <10%7 and blood cultures are considered to be of limited utility as the organisms are rarely identified. Also, positive results often do not alter the choice of management. Streptococcus pneumoniae is cultured in the blood in <5% of cases of pneumococcal CAP cases. Thus, this study is done to prove that we should not routinely be doing blood cultures in all children with CAP as it is more likely to cause an unnecessary burden to the care of the children.

Methods
The total numbers of blood culture collected from paediatric age group patients were obtained from microbiology laboratory quality officer, and they were subdivided into those taken in the emergency department, paediatric assessment unit and also the general paediatric ward. Positive results were looked at, and the diagnoses were extracted from the patients’ charts to see any of those were diagnosed as community-acquired pneumonia.

Results
In total, from 1st January 2018 till 31st December 2018, there were 934 blood cultures taken from paediatric age group patients. There were 398 (42%) taken in general paediatric ward, 215 (3%) taken in paediatric assessment unit and 321 (34.4%) taken in the emergency department. However, there were only 40 (4.5%) positive blood cultures out of 934 samples sent. Eleven out of 40 (27.5%) positive cultures were treated as true positive cultures. Only one out of the eleven patients was diagnosed with Streptococcus pneumonia CAP sepsis, and the patient has a background history of Trisomy 21. Most of the positive cultures were contaminants, and two were from patients diagnosed with CAP.

Conclusion
Blood cultures should not be routinely taken from patients diagnosed with community-acquired pneumonia as there is a high prevalence of viral respiratory infection in children, and the probability of false-positive blood cultures that may lead to unnecessary repeat cultures, hospitalisation and parental distress. Special considerations should be taken into account when deciding to collect blood cultures from patients diagnosed with CAP such as from children with long-standing comorbidities that may complicate the course of the illness or children who presented with evidence of sepsis or complicated illness. More importantly, guidelines on when blood culture is necessary and when it should be repeated are crucial in ensuring a better quality of care.

P177 THE MODIFIED SARNAT SCORE IN THE ASSESSMENT OF NEONATAL ENCEPHALOPATHY: A QUALITY IMPROVEMENT INITIATIVE
Bronwyn Power*, Julie McGinley, John F Murphy. The National Maternity Hospital, Holles Street, Dublin, Ireland
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Introduction
‘Neurophobia’, the fear of clinical neurology by physicians, is widely acknowledged in the literature. The Sarnat Score is essential for the clinical designation of the severity of encephalopathy in neonatal patients. A recent review of therapeutic hypothermia cases (n=140) in the Republic of Ireland (2016–2017), highlighted incomplete documentation of the Sarnat Score in neonates with encephalopathy. On the first day of treatment, posture, tendon reflexes, tonic neck and moro reflexes were undocumented for 70%,...