DEVELOPMENT OF A CARE PATHWAY FOR CHILDREN WITH EDWARD’S SYNDROME

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66%, 95%, and 64% of cases respectively. Level of consciousness, motor activity, muscle tone, pupil size and reaction to light were similarly inadequately documented.

This quality improvement initiative aimed to educate doctors in a tertiary neonatal unit regarding the importance of systematic evaluation and documentation of neonatal encephalopathy using the Modified Sarnat Score.

Methods
An education session for all medical staff working in the neonatal unit was held, outlining the importance of appropriate use and documentation of the Sarnat Classification in clinical practice. Index cards were issued to all staff, describing the individual components of the score and those techniques necessary to elicit the relevant neurologic signs. A teaching video, demonstrating neurological assessment of a neonate using the Modified Sarnat Score, was recorded and uploaded to the official hospital website. Anonymous questionnaires were obtained to assess effectiveness of teaching.

Results
In total, 17 Healthcare Professionals attended the education session, with a mean of 8 years experience working in Paediatrics. 58% (n=10) had previously received education on the Sarnat Score. 47% (n=8) had used the Sarnat Score previously in clinical practice. Lack of formal training on the score was the main reason cited amongst those who had not used the score previously. 23% (n=4) correctly identified the individual components of the score prior to education. 12% (n=2) correctly scored ≥80% of the clinical scenarios provided. Following education, 71% (n=12) correctly scored ≥80% of the clinical scenarios provided. All staff (n=17) found the education session informative, and felt more confident using the Sarnat Score following the session. 58% (n=10) felt that further education on the Sarnat Score was required.

Conclusion
It is recognised that the neurological assessment of infants is challenging, particularly for inexperienced clinicians. The validated Sarnat classification system is a valuable resource in the clinical assessment of neonates with encephalopathy. This clinical tool provides physicians with a standardised approach to systematic neurological examination and documentation of pertinent neurological findings.

P179
PROMOTING AWARENESS OF CLEFT CARE: IMPROVING COLLABORATION & COMMUNICATION

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Background
Cleft lip and/or palate affects approximately 1 in 700 live births worldwide. 50% of the Irish cohort present as a cleft of the palate alone. Up to a third are not detected within the first 24 hours of life. Averages of 60% with lip involvement are diagnosed on antenatal scanning. Cleft Teams accept referrals upon diagnosis, collaborating and communicating with local services on a Hub & Spoke model to provide care. Delays in diagnosis and referral times can have a negative impact on the child and family. Some 400 syndromes are associated with clefting, most within the rare diseases category, and may not be diagnosed until months or years after birth.

Aims
• Promote awareness of how cleft care is organized in Ireland.
• Encourage enhanced collaboration & communication with local hospital and community based services to improve diagnosis rates and referral times.
• Highlight the need for on-going monitoring by key health care professionals (HCPs).

Methods
• Audits of timing of diagnosis demonstrated.
• Interventions planned by the Cleft Clinical Nurse Specialist (CNSp) detailed.
• Areas for improved working links are discussed.

Results
On-going audit demonstrates upward trends in diagnosis rates – 82% diagnosis in the 1st 24 hours of life for 2018 birth cohort with cleft palate only. Education sessions provided by the CNSp to HCPs have received positive feedback. Liaison with Public Health Nurses is proving successful for weight monitoring and cleft surgery planning.

Discussion
Although cleft is a specialist area of practice it affects on average 80 families a year in the Republic of Ireland. The Cleft CNSp has a role to educate and collaborate...
with maternity & community HCPs in highlighting the importance of prompt diagnosis and subsequent referral and management.

Conclusion On-going audit is important to identify trends/improvements. Continued education sessions for HCPs can assist with increasing awareness of cleft conditions, and the idea of ‘link nurses’ or ‘cleft champions’ could be considered. With a changing Model for Children’s Healthcare in Ireland further work is required with Neonatology, General Paediatrics, General Practitioners and Genetic teams to formulate more robust pathways for equal access to care and to assist potential syndromic diagnosis. In the interim the Cleft Team propose that each child has access to a named paediatrician locally for <5 years of age and that there is enhanced communication between HCPs involved in a child’s care.

**P180 QUALITY IMPROVEMENT PROJECT OF DISCHARGE SUMMARIES IN OUR LADY OF LOURDES IN DROGHEDA**

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Aims Quality improvement (QI) as a concept for clinical research has become more prevalent in recent years. Quality improvement is a focus on changing the way in which patient care is delivered. Central to this is developing a more rounded, patient-focused approach to the design and delivery of care. Discharge summaries are an important aspect of patient care and having the correct content is essential to communicate treatment plans with general practitioners.

Methods An regular review of discharge summaries on the paediatric ward was conducted in Our Lady of Lourdes Drogheda over a 4 week period. An initial 2 week review of charts was conducted and then an education session was carried out with NCHDs and results were explained. Five areas were considered for analysis, time to discharge summary completion (T2DSC), use of abbreviations (UOA), correct diagnosis documented (CD), correct follow up and referral (FU&R) and overall impression of discharge summary (OI). A sample of 20 random charts was used. The review was carried out again at two further points after a further education session to assess if there was an improvement.

Results

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<tr>
<th>All in Attendance (Consultant, Reg, SHO, SCBU Nurse)</th>
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Abstract P181 Table 1 Members of Neonatal Resuscitation Team present at ≤32/40 weeks gestation deliveries

The Paediatric Registrar was present at 26/27 (96%) of deliveries, a SCBU Nurse at 18/27 (66.6%), the Paediatric Consultant at 12/27 (44%) and the Paediatric SHO only documented at 9/27 (33.3%). Of note a paediatric consultant attended all 3 deliveries ≤26/40 and 6/7 deliveries between 26–30/40.

Conclusion In our small cohort, there was wide variation with no consistent practice. Resuscitation documentation needs improving. A SCBU Nurse and Paediatric Registrar were the commonest resuscitation team. Deciding on a gestational cut off and defining high-risk deliveries would be helpful in establishing a standardised protocol for when a consultant paediatrician should be in attendance at a delivery.