passed away due to primary disease progression. The mainstay of our analysis was to look at factors associated with delay in decannulation among children and the associated morbidity.

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DEVELOPMENT OF A BRONCHIOLITIS ASSESSMENT TOOL IN TWO BUSY UK DISTRICT GENERAL HOSPITALS: 'BRONCHIOLITIS-MADE-EASY'

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Background/Aim Bronchiolitis is one of the commonest causes of hospital presentations during the winter period. It poses a great deal of strain on the health care staff and resources. A targeted assessment tool is thought to provide a prompt and optimal assessment to limit unwarranted investigations and hospital admissions. The acute assessment of children with a clinical diagnosis of bronchiolitis was initially audited with subsequent re-audit using the assessment pro forma.

Methods Children admitted with bronchiolitis between November 2017 and January 2018 in one hospital site were randomly selected. Medical notes were reviewed to evaluate the clinical assessments and treatment(s) offered in comparison with NICE guidance. A pilot study was subsequently performed to assess the use of the new assessment pro forma by medical students and junior doctors.

Results Thirty medical notes were randomly selected for the audit. History of apnoea was inquired in 7 of 20 infants aged 3 months and below. Oral intake was clearly documented in only 36.7% (11/30). Neonatal events were clearly documented in 96.7% (29/30). Documentation of exposure to passive smoking occurred in 23.3% (7/30). Only 50% had documented assessment of hydration status and femoral pulses. Blood tests were requested in 13 infants with clinical indications documented in 7. Sixty-five percent (11/17) had no documented clinical indication for chest radiograph. Inappropriate treatments (bronchodilators, steroids, antibiotics) were initiated in 30% of infants. The pilot study involved 15 volunteers (medical students and junior doctors) on the use of the assessment pro forma in the 2 hospital sites. Analyses of the pro forma demonstrated 100% compliance in all parameters re-audited.

Conclusion The new pro forma has demonstrated its usefulness in targeted assessment of children with suspected bronchiolitis. Well-focused history and examination will safely stratify children to be managed in the community or hospital. The feedbacks received from its use were excellent.

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LYMPHADENOPATHY REFERRALS TO A GENERAL PAEDIATRIC DEPARTMENT

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The aim of the study The aim of the audit was to determine if patients referred with lymphadenopathy need to wait for a General Paediatric outpatient appointment or if instead they could be reassured with normal investigations prior to attending the clinic, with the aim of providing a guideline for community management in some cases.

Method Lymphadenopathy is a common cause of presentation at GPs and a cause of concern for parents. We analysed a number of tertiary referrals to the General Paediatric Department in OLCHC to determine what and if any investigations should be performed for these patients and how we might improve the patient experience for these cases. Between September 2017 and January 2019, General Paediatric Triage Clinic received 12 referrals of patients with lymphadenopathy from GPs. Less than 50% of referral letters included information about the size, mobility, consistency or tenderness of the concerning lymphatic nodule. None of the referral letters included blood test results or any other investigations. All referrals were asked to attend for blood tests including FBC, U+E, CRP, Urate, LDH. Depending on the results, further investigations were ordered or patients were discharged.

Results 8 (66%) patients attended phlebotomy for blood tests. 50% of blood tests performed were normal, of these 2 patients were discharged from Triage Clinic and 2 patients remained on waiting list. 4 patients had abnormal blood results, 3 had a neck ultrasound performed, all of which were normal. 2 were subsequently discharged from Triage Clinic, 1 remained on waiting list. 1 patient was seen in Paediatric OPD and was discharged based on reassuring clinical examination without any further investigations. 4 patients did not attend for blood tests, 3 were discharged from Triage Clinic after not responding to multiple notifications. 1 remains on waiting list awaiting response to second notification.

Recommendations Developing a clinical guideline for lymphadenopathy with clinical examination and investigation criteria warranting referral to General Paediatric clinic which will empower GPs to perform appropriate investigations including the ultrasound prior referring patients on, therefore reducing the waiting times in our outpatient clinic.

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KEEPING CHILDREN SAFE FROM MEDICATION HARM: THE MEDSIQ JOURNEY

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Background In 2015 the UK Royal College of Paediatrics and Child Health (RCPCH) launched www.medsiq.org, an innovative website for sharing resources and quality improvement projects relating to paediatric medication safety. MedsIQ was founded in response to increasing awareness that children and young people are frequently harmed by errors in their medication. Children are 3 times more likely than adults to be harmed by medication errors and it has been shown that up to 15% of inpatient prescriptions have errors on them (1).

What is MedsIQ? Medication safety is a complex issue and innovative approaches to combat the problem are needed. Part of the answer lies with the medical community; most clinical teams have tried to tackle the problem; by auditing prescribing standards or having pharmacists on ward rounds, through to more innovative drug calculator apps, e-prescribing tools and Druggles (a safety huddle focusing on medication errors). The MedsIQ platform has been developed to allow people to share their ideas. Submitted projects and resources are peer-reviewed and shared online. Alongside the website, there is a Champions' Network – a community of practice in improving paediatric medication safety, who participate in webinars and

face-to-face events to enable deeper discussion of shared challenges and solutions.

Impact Since launching in 2015 the website has had more than 70 resources, over 1100 registered users and a growing community of Champions. To maintain the wider network there are bi-monthly webinars to discuss diverse medication safety topics. These webinars have raised safety issues that have gone on to shape national strategy via the RCPCH. They are accessed frequently on YouTube. There have been a series of well-attended MedsIQ events hosted at the RCPCH to bring clinicians, families and researchers together to discuss medication safety. Through these events MedsIQ has been able to work closely with families and the public to support safe administration of medicines within the community.

Where next? In direct response to topics raised at MedsIQ events and webinars, the MedsIQ team are working closely with their partners, Wellchild and Medicines for Children, to help develop a new app to support families to manage medications in the home environment. This app is due to launch in March 2019.

Following the success of MedsIQ, the RCPCH is launching QI central, a website that extends the MedsIQ concept to all areas of paediatric Quality Improvement. This website launches in March 2019.

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RADIOGRAPHIC ABNORMALITIES IN CHILDREN HOSPITALIZED WITH ACUTE ASTHMA

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Introduction Acute asthma exacerbation is a common cause of children admissions. Chest x-ray is not part of routine acute asthma management, but may be performed in some cases. A chest radiograph should be performed if there is subcutaneous emphysema, persistent unilateral sign, or in life threatening asthma (Emergency Paediatrics asthma Guideline-RCPI-HSE).

Aim To find out the outcome of the chest x-rays in children admitted with acute asthma, and its contribution in the management plan.

Methods

- A retrospective chart review.
- Inclusion criteria: Children 5–16 years admitted with acute asthma, had chest x-ray.
- Place: Paediatrics ward, Our Lady of Lourdes Hospital, Drogheda.
- Period: the year 2017.
- Sample size: 28 children.

Results

- Two third of children included in the audit were males, one third were females.
- One third of patients were admitted in September, the rest were admitted in the other months.
- About three quarter of x-rays were performed during the evening and night shifts.
- Two third of x-rays were performed within 3 hours of ED attendance.

- Half were indicated by poor response to initial treatment (increased respiratory effort, oxygen requirement).
- Around one third of the x-rays showed elements of infection. Antibiotics were prescribed to two third of patients.
- Two third of the patients had previous x-rays.

Discussion

- Chest x-rays may be beneficial in some cases where presence of another lung pathology can have negative effect on the response to asthma treatment.
- Two third of children were unnecessarily exposed to radiation. Two third received antibiotics in the absence of evidence of infection, this has impact on patients safety.

Recommendations

- Adherence to HSE guideline in acute asthma management.
- Minimize unnecessary investigation in acute asthma.
- Patient safety should be a priority when taking management decisions.

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ADMISSION RATES TO NICU FROM ASSISTED DELIVERIES

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Aim Our aim was to determine admission rates to the neonatal ICU from operative vaginal deliveries (OVDs) as well as elective and emergency Caesarean sections (C/S). By completing this audit we aimed to establish the need for Paediatric SHO presence at the above deliveries.

Methods Our study period was the month of February 2018. We excluded all births under 35 weeks gestation who would qualify for an automatic admission to the NICU. Our study population included any infants born by either elective/emergency CS and OVDs. We obtained our data set from Medical records and isolated our study population. Using the electronic medical record we determined the mode of delivery, reason for same and if an admission to NICU was required within in the first 4 hours of life.

Results In the study period there were 561 live births. 213 infants were delivered by either C/S or OVD. There were 77 OVDs and 136 C/S, which could be further broken down into 69 Emergency C/S and 67 Elective. Of the OVDs 16 patients were admitted to the NICU giving an overall admission rate of 22%. Interestingly both C/S populations showed the same number of admissions; 10 per group.

Conclusion As Neonatal SHO's we are required to attend all C/S as well as OVDs. The above data shows no difference between the admission rates of infants born by emergency versus elective C/S. However, the admission rate of infants born by OVD is 1 in 5. From this audit it could be determined that there is a continued need for Paediatric assistance at above deliveries however there is the need for further investigation into the timing and reason for above admissions. Going forward we would like to compare the above figures with admission rates to NICU from Spontaneous Vaginal Deliveries.