infants admitted to the unit on their first feed, during their admission, and on discharge.

We report the evolution of the type of feed received by the infants during their unit stay. Correlation between gestational age, birth weight, and type of feed on the first feed, and that on of discharge was also detailed.

Unit IT patient data revealed 150 cases. 37 of whom were re-admissions, 3 were kept NPO, leaving 110 patients in total.

Comparison of the type of first feed versus the type of feed on discharge, reveals a significant drop in the amount of exclusively formula fed infants going from 69% to 47%.

50% were discharged home on formula, 8% of those formula fed on discharge were fed some mother’s milk during their unit stay. 20% of infants who received formula on first feeds were receiving exclusive breastmilk on discharge. 25% infants were discharged on combined mother’s milk and formula feeding.

The amount of infants receiving mother’s milk exclusively remains consistent from the time of their first feed to when they are discharged from the unit (26% compared to 27%). Of the 29 infants who were given mother’s milk on their first feed, 59% were fed exclusive mother’s milk on discharge. A relatively small (14%) number of these were receiving all exclusive mother’s milk feeds throughout their admission, and on discharge.

Infants who received breastmilk only or formula only as their first feed and were discharged on combined feed, the infants who were fed formula on their first feed make the bulk of that increase in the combined feed category on discharge.

Out of the 36 infants with a birth weight under 2000 g who received formula as their first feed, 3 infants received regular formula feeds thereafter. The other 33 infants (91.67) received preterm formula regardless of their gestational age. This compliance rate of the nutritional guideline needs further improvement.

Overall we see the benefits of the unit’s nutritional guideline to promote mothers expressing milk and establish direct breastfeeding in the moderate to late preterm infants. Antenatal lactation support is important in optimizing the breastfeeding rates further in this patient group.

**P204** PRECISION ENTAILS PERFECTION: DO WE NEED BLOOD FORMS?

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**Introduction** In Temple Street Children’s University Hospital, we care for more than 150,000 Children per year, leading to numerous blood forms received by the Phlebotomy Department.

**Aim**

- To raise awareness among medical staff regarding the importance of accuracy in blood form request
- To evaluate the current performance compared to the standard set by the hospital

**Methods** This is a 6-week prospective study during which data is collected to evaluate the current performance of accuracy. PDSA cycle was adopted for all three points of data collection. All data was anonymised, collated and analyzed on Excel.

**Result** During the first two weeks of the study, an audit was carried out and there was 32.76% of blood forms filled incorrectly. A verbal reminder during monday handover and grand rounds were given to all NCHDs for the next two weeks and 31.97% of forms were filled incorrectly. For the last 2 weeks of study, an ID card size reminder was distributed to all NCHDs. All NCHDs feedback agreed that the card was useful. Unfortunately there were still no improvements found.

**Conclusion** This study showed no improvement despite verbal and visual reminders. This often increase errors and more workload for phlebotomist and laboratory staff. In the future, computerized blood order through an electronic platform that codes to a bar-coded blood stickers might be an option to increase work productivity and eliminate errors.

**P206** AUDIT OF COMPLIANCE TO GUIDELINES OF DOWN SYNDROME(DS) MANAGEMENT IN NICU OF UNIVERSITY MATERNITY HOSPITAL LIMERICK(UMLH)

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**Background** Children with Down syndrome have multiple malformations because of the presence of extra genetic material
from chromosome 21(1). The guidelines is designed to help the pediatrician to care for children with Down syndrome and their families(1).

**Objective** To assess compliance to guidelines for management of Down Syndrome babies admitted in NICU of UMHL in 2017.

**Methodology** Retrospective study on DS babies admitted to NICU of UMHL in 2017 by collecting data from hospital inpatient enquiry system (HIPE) of UMHL. Different variables were studied including admission examination, cardiac assessment, DS centile chart, karyotype request, Guthrie card, full blood count (FBC), cardio referral, typed discharge letter, ophthalmology assessment, hearing assessment, medical social worker (MSW) referral, physiotherapy referral, early intervention team (EIT) referral, information leaflet to parents, DS registry consent and follow up.

**Standard** Medical management guidelines for DS developed by The National Children’s Hospital, Tallaght, Dublin and updated on 30th Sep 2009.

**Results** Total 10 babies listed with DS admitted in NICU in 2017. 40%(n=4) were excluded because of normal karyotype and referral to other hospital. Study was conducted on remaining 60%(n=6) babies which showed 100% compliance to guidelines for cardiac assessment, karyotype request, FBC, cardio referral, EIT referral, information leaflet to parents and follow up. 17%(n=1) failed to comply with guidelines for admission examination, DS centile chart, Guthrie card, typed discharge letter, ophthalmology assessment, hearing assessment, and physiotherapy referral. MSW referral was not sent in 67%(n=4) and failed to get DS registry consent in 100%(n=6) babies.

**Conclusion** Medical social worker referral and consent for DS registry were the most deficient aspects of its management. Further, compliance is also required in admission examination, DS centile chart, Guthrie card, typed discharge letter, ophthalmology assessment, hearing assessment, and physiotherapy referral.

REFERENCES


**Abstracts**

**P207 A CASE FOR A CHECKLIST!**

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10.1136/archdischild-2019-epa.562

**Introduction** Referrals to hospital specialty clinics and communication between clinicians can be varied in quality, with many clinicians omitting relevant clinical details from their communications. Pro-formas and check lists are one way this practice can be improved. Current evidence suggests these tools can be beneficial. The aim of this study was to investigate whether a pro-forma would standardise communication between clinicians and primary care practitioners (PCPs) with an overarching aim of minimising the amount of relevant information omitted.

**Methods** A retrospective audit of 17 letters dictated from the paediatric consultant back to PCPs were analysed to see which relevant clinical details were omitted from the communications.

**Results** A total of 143 symptoms that may have been relevant to the history were omitted from the communication. The most common relevant symptoms omitted from the communications were: Urinary symptoms (16), headache (13), irritability (13) and weight loss (12).

**Discussion** Numerous symptoms that may have been clinically relevant are missed from communications between clinicians. Even if the symptoms aren’t present, it is important to include relevant negatives. A pro-forma may eradicate these omissions and lead to a more complete clinical summary. Perhaps designing a pro-forma may help to show improvement in the quality of communication and referrals to a specialty paediatric clinic. Improvement in communication between clinicians may help to provide the best possible outcomes for patients. We have suggested a model for further use in the department.

**P208 CLINICAL AUDIT: ARE DOCTORS TREATING ASTHMA APPROPRIATELY?**


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**Background** Asthma is still causing significant morbidity and mortality worldwide, only minimal improvement has been seen in the key outcomes over the last decade despite increasing treatment costs. Ireland has one of the highest rates of asthma in the world. Current estimates suggest that the prevalence of doctor-diagnosed asthma in children in Ireland is 21.5%. Physician’s role in asthma management and care is imperative, proper control of the disease depends on the doctor’s ability and experience in recognizing symptoms and defining the severity level as recommended by international guidelines.

**Objectives**

- To look at the demographic characteristics of children admitted due to asthma in St Luke’s General hospital.
- To assess whether acute asthma management of children in St Luke’s General hospital was in line with the hospital guidelines.
- To evaluate whether the patients’ asthma had been appropriately classified according to the guidelines.
- To assess whether the patients were appropriately treated according to their classification.
- To suggest areas that require improvement in the management of acute asthma in St Luke’s hospital.

**Guidelines** The management of acute asthma in St Luke’s General hospital is guided by the BTS/SIGN guidelines.

**Methods** This was a retrospective review. Children admitted due to acute asthma to St Luke’s Hospital were identified from the HIPE department.

Over the time period Jan 2018 to Dec 2018 (n=44).

**Charts were retrieved and reviewed**

**Results and Discussion Pending**

REFERENCES


3. Respiratory Health of the Nation 2018, Irish thoracic society