pancreatic and nutritional status, LFT result (normal, clinically insignificant, or clinically significant based on Royal Brompton Care of Children with CF guideline), referral to a hepatologist and timing of next US.

Results Between 2012 and 2017, 31 CF patients had a US at age 5 years. 22 patients (71.0%) had no sonographic evidence of CFLD at time of first screening US. The remaining 9 patients (29.0%) displayed only mild evidence of CFLD. One patient (3.1%) was commenced on ursodeoxycholic acid. Two patients (6.2%) were referred to a hepatologist. Follow up US was conducted an average of approximately 2 years following initial US. Mild clinically insignificant LFT derangement was common (74.1%) but, all patients who had completely normal LFT results had no US evidence of disease.

Conclusions These results suggest that US conducted at age 5 rarely alters clinical management. Although US is a non-invasive investigation, CF patients already have a high treatment burden and given US at 5 years is highly unlikely to change management, it is unnecessary (especially in those with normal LFT's). Further investigation is needed to determine the optimal age to commence US screening for CFLD.

GP92

THE EXPERIENCE OF A DAILY HOSPITAL WIDE OPERATIONAL HUDDLE AT TEMPLE STREET CHILDREN'S UNIVERSITY HOSPITAL

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The increasing complexity of healthcare delivery makes care co-ordination and maintaining safety a continuous challenge. Adverse events persist at a rate of 10.7% and half of such events being preventable (Stockwell *et al.* 2018)

The daily co-ordination of organisational needs results in a significant amount of information exchange across departments and individuals. This can affect the ability to plan and manage thus contributing to patient safety risk. Inter-dependant complex processes need a significant amount of information exchange and miscommunications could occur.

- What was the initiative taken?

A daily operational huddle to discuss key issues and plan ahead was piloted in 2014. The change was sustained and the huddle continuously improved and is now fully embedded.

- How was the change implemented?

Evidence from other organisations was reviewed. A format was designed and piloted amongst nursing staff initially. One representative from each department attended daily. Feedback and lessons learned were incorporated over time and the process expanded to include multiple departments. A pro forma whiteboard and huddle room was introduced in 2016.

- What problems were encountered with the process of change and how were these overcome?

Concerns regarding time to attend were initially expressed by frontline staff. Resolved by discussing benefits, visibility of teamwork in action through sharing resources and agreeing solutions. Additionally, it was agreed that attending the huddle reduced interruptions by phone calls.

A survey of huddle participants revealed the following results;

Question	Answer
1 In the last week I have been made aware of a risk via the huddle	52% agreed
2 Information about the outcome of past risks is provided at the huddle	64% agreed
3 I am comfortable sharing an incident or risk from my department at the huddle	86% Agreed
4 The huddle is useful for me in my role	95% Agreed
5 I have learned new things at the huddle	92% Agreed
6 I am comfortable giving my report at the	95% Agreed

Abstract GP92 Table 1 Percentage of huddles where key categories were discussed

Area	Total	% all huddles
PEWS	36	40%
Family Concerns	12	13%
Stepped down from ICU	47	52%
Patients with multiple teams involved	9	10%
High risk therapies	49	54%
Watchers	37	41%
Good catch Identified	4	4%
Clear Leader	74	82%

- How did this improve patient/client care?

A daily forum now exists for planning, problem solving, identification of risks, sharing of lessons learned, sharing of resources and mass communication.

GP93

EATING DISORDERS- A DESCRIPTIVE STUDY OF YOUNG PATIENTS WHO PRESENTED TO THE TALLAGHT UNIVERSITY HOSPITAL FOR ACUTE INTERVENTIONS AND MEDICAL STABILIZATION

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Aim Anorexia Nervosa (AN) is a serious disorder with life-threatening physical and psychological complications. Adolescents with AN have a standard mortality ratio 10 times of peers, primarily through physical complications. This study was carried out to investigate presentations of young patients under 16 years with restrictive eating disorders to Tallaght University Hospital, and evaluate standards of assessments and clinical practise compared to current best practice, the Junior MARSIPAN Guidelines (RCPsych, 2015).

Method A retrospective case study was conducted on all young patients (under 16) referred to the Liaison Child Psychiatry service with restrictive eating disorders between January 2014 and December 2018. Data from all available clinical records was examined. Baseline demographic variables, pathways of care, presenting symptoms and medical interventions were recorded. Clinical records were examined for evidence of recorded information regarding parameters of the JMARSIPAN risk assessment guidelines at admission and discharge.