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.

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**GP92**

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

Elaine Fitzgerald, Claire Fagan, Grainne Bauer, Sharon Ryan, Charlotte O’Dwyer, Sarah Maidment*, Clara Murtagh. CM®Temple street, Dublin, Ireland

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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-dependent 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;

  - **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.

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**GP93**

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

Nimantha Michael Gamage, Patricia Byrne*, Caroline McGrath. Liaison Child Psychiatry, Tallaght University Hospital, Dublin, Ireland

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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.