make the study suitable for paediatric implementation included using ‘Monkey’ - a cartoon character with varying facial expressions. For example, ‘Monkey’ was linked to a Likert scale, facilitating children to independently respond to questions. Information sheets containing details of the study were handed to parents/carers on the day of their child’s procedure. Posters in recovery and business cards to take home displaying the website URL were used to boost response rate. Satisfaction rates were calculated based on patient and parent/carer response to the adapted FFT. Answers to qualitative questions were manually analysed in a thematic approach to identify recurring themes.

**Results** 22 questionnaires were completed by parents, with 13 patient sections being completed, over 8 months. Parental and patient satisfaction rates were high, at 100% and 92% respectively. Attentive, informative and friendly staff were the main justifications for their positive feedback. Suggestions for improvement were limited, with no dominant themes being detected.

**Conclusion** There were overwhelmingly high satisfaction rates from both the parent and patient perspective, with minimal suggestions for improvements. To strengthen conclusions further data needs collecting. The acceptability by both patients and parents/carers means the resources created in this study have potential to be used across multiple departments and multiple paediatric centers.

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**G155(P) PROLONGED JAUNDICE CLINIC: ARE WE DOING TOO MANY TESTS?**

**Background** Prolonged jaundice is common and in the majority of cases is benign and self-resolves. The prolonged jaundice screen aims to rule out serious causes of prolonged jaundice, such as biliary atresia. In our prolonged jaundice clinic (PJC) we test for FBC, blood film, G6PD, TFTs, LFTs, split bilirubin and urine MC&S. Babies are often being brought back for repeat tests due to insufficient bloods or incidental findings. The process is time consuming, resource consuming and anecdotally resulted in poor patient satisfaction.

**Aim** We aimed to reduce the number of investigations and potentially unnecessary repeat tests being carried out in the PJC.

**Method** A retrospective review was conducted of babies seen in the PJC over 13 months. We collected data on investigation results, repeat tests (and reasons for these) and what pathologies were ultimately picked up.

**Results** 212 patients were seen in the PJC in the study period. 14% had a bilirubin result greater than 200 mmol/L. 1 baby had a conjugated bilirubin above 25 mmol or greater than 10% of total bilirubin. Despite this, 68 babies (32%) had at least one repeat test carried out, with some having multiple repeats. A total of 156 repeat tests were carried out. Out of the 212 babies seen 6 babies (2.8%) with pathology were detected: 1 autoimmune neutropenia, 3 G6PD deficiency, 1 intra-hepatic jaundice and 1 e coli UTI requiring treatment with oral antibiotics only.

**Conclusion** There was a wide variation in how results were interpreted and hence the reasons for repeating/not repeating tests. A large number of babies did not have high bilirubin results but were having repeat tests done for either insufficient bloods or incidental findings in other parts of the screen.

**Plan** We have written a new guideline and proposed a 2 tier investigation pathway with all babies having ‘tier 1’ investigations (FBC and split bilirubin) when initially seen in PJC, but only those with abnormalities in this initial screen going on to have ‘tier 2’ investigations (repeat tier 1 investigations in addition to reticulocytes, film, group and DAT, LFTs and urine MC&S).