treatment was extracted from digital health records. Patients sutured under GA were reviewed for contra-indications to Ketamine, determining the number potentially suitable for procedural sedation in retrospect. A literature search was used to identify healthcare costs of laceration closure under GA, versus the same procedure under Ketamine sedation. Admission cost per patient was gained by communication with relevant ward managers. Retrospective economic savings were calculated to ascertain the theoretical annual savings of introducing a Ketamine sedation list in the PED.

Results 234 patients were referred to OMFS for facial lacerations. 162 (69.2%) of these were deemed to require closure with sutures. 107 were able to tolerate closure under local anaesthetic while 55 required admission and suturing under GA. Of the children sutured under GA, 47 (85.5%) were deemed to be retrospectively suitable for Ketamine sedation and the remaining 8 (14.5%) had contra-indications. The cost saving of using Ketamine sedation over GA is £69 per patient and the admission cost per patient per day is £306. The retrospective theoretical annual healthcare saving was approximately £18,543.

Conclusion There is scope for introduction of a procedural Ketamine sedation list for paediatric facial lacerations that are currently being sutured under GA. This would reduce healthcare costs dramatically as well as optimising resources in the PED.

G244(P) TREATMENT OF FEVER IN CHILDREN WITH SICKLE CELL DISEASE

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10.1136/archdischild-2020-rcpch.211

Aims Fever is an important sign in children with sickle cell disease (SCD), often being the only indicator of serious and potentially life-threatening secondary bacterial infection. Treatment of febrile children with SCD in our Paediatric Emergency Department (PED) can be variable, including escalation of care of those who are unwell and pragmatic management of those who are well. We therefore audited the management of fever with SCD presenting to PED and developed guidance to aid management, particularly looking at whether ambulatory nursing teams can be utilised to manage 'low-risk' patients.

Methods We analysed the management of SCD children presenting to PED with fever over a one year period. Using these results, we developed guidance for febrile children with SCD, based on risk stratification.

Results 28 children with SCD presented between July 2018 – July 2019, of whom 22 were admitted and 6 discharged from PED. Diagnoses among these patients are displayed in table 1.

Antibiotic treatment was consistent in the management of fever due to acute chest syndrome, but was otherwise variable. One third of children discharged (2/6) received oral antibiotic treatment to complete at home. None of the discharged children were referred to the ambulatory nursing team for review. Subsequently we developed guidance to standardise clinical assessment, direct antibiotic choice, give clear risk-stratification criteria and advice on management of low-risk fevers of SCD children in the community.

Abstract G244(P) Table 1 Diagnoses among febrile children with SCD presenting to PED

Outcome	Diagnosis	Number
Admitted:	Acute chest syndrome	11
	Vaso-occlusive crisis: abdominal	7
	Vaso-occlusive crisis: limb	2
	Fever without obvious source	1
	Influenza	1
Discharged:	Upper respiratory tract infection	2
	Vaso-occlusive crisis: limb	3
	Peri-orbital cellulitis	1
		Total = 28

Conclusions Fever may indicate serious bacterial infection in children with SCD, requiring prompt and specific antibiotic treatment. Implementation of a guideline will help tailor treatment to the most likely cause of fever and risk-stratify these children accordingly. Utilisation of ambulatory nursing teams should be encouraged to promote admission avoidance and ensure low-risk children can be managed safely at home.

G245(P) ESTIMATING WEIGHT IN PAEDIATRIC TRAUMA PATIENTS – AN ONGOING CHALLENGE WITH A NEW SOLUTION

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10.1136/archdischild-2020-rcpch.212

The administration of drugs and fluid, most of which are given as the dose per kg of body weight, is a vital component in the management of the seriously injured child. Obtaining an accurate weight on arrival may not be immediately achievable because of instability, immobilisation and ongoing resuscitation.

The paediatric STAG (Scottish trauma audit group) data from * hospital was used to identify patients over 12 months. Clinical notes were reviewed to assess if weight was estimated or accurately measured.

56 paediatric trauma patients who met the STAG inclusion criteria presented to * over the 12 month period.

27/56 (48%) patients had an estimated weight on arrival; 5 were estimated using the 'old' APLS formula, 12 using the 'new' formulae and for the remaining 10 the method used was unclear.

Of those who initially had an estimated weight only 7/27 (26%) went on to have an accurate weight obtained at any time during their admission. In 5 patients, weight was underestimated (mean -12%) and in 2 patients, weight was overestimated (mean +19%). The weight estimation error ranged from negative 28% to positive 20%. Assessing the percentage error of estimated weight was challenging in this group of patients due to the small number on which an accurate weight was measured during this admission. Poor documentation may have been a contributing factor in some cases with the weight on a patient's drug kardex only being clearly identified as being an 'estimated' value in 66% of patients.