Conclusions We are proud to say that, Clinical Pearls has been widely accepted by the team and department. This team initiative has become an integral part of departmental educational activity, to improve patient care, safety and promote reflective practice.

‘Most people seem to want tremendous improvement, instantly. But you’ll probably find it’s the little things you do that eventually add up to big results.’ - Joel Weldon

We are hoping to continue Clinical Pearls beyond the pandemic and promote it across the region to take this initiative forward.

British Association of General Paediatrics

848 AUDIT ON DOCTORS’ DOCUMENTATION OF OVERWEIGHT AND OBESITY IN CHILDREN ATTENDING GENERAL CHILDREN’S OUTPATIENTS’ CLINICS IN MALTA

Amanda Fenech, Thea Dimech, Marie Claire Grech, Simon Attard Montalto. *Mater Dei Hospital*

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Background Childhood obesity is a global epidemic and Malta is no exception. Despite local awareness, not all children seen at the general hospital’s children’s outpatients (COP) have their height and weight measured. In the latest Health Behavior in School Children (HBSC) report, Malta has the highest percentage of overweight and obese children in 11, 13 and 15-year-old youths. Consequently, these children are likely to progress into overweight and obese adults, with an increased risk of developing non-communicable diseases such as hypertension, diabetes and other complications at a younger age.

Objectives The aim of clinicians is to manage children holistically and, therefore, this should include appropriate weight assessment and management. This study was designed to gauge the prevalence of doctors’ documentation of overweight and obesity with or without appropriate advice and referral, in children attending general Children’s Outpatients. The NICE guideline on Obesity: identification, assessment and management (CG189), was used as the criterion to which we compare our local practice.

Methods The NICE guideline on obesity was used to define overweight and obesity and WHO Growth Standards for 0–5 years and the 2007 WHO child growth reference charts for 5–19 years were used. A cross-sectional study was conducted over 10 weeks between January and March 2020. Data on age, gender, weight, height, percentiles/BMI, doctor grade, presenting complaint, appointment frequency and previous anthropometric documentation were collected from clinical notes. All children attending general COP, between 2–15 years of age and free from chronic medical illnesses affecting BMI were included.

Results In 418 patients, weight and height were documented in 64.8% and 58.1% respectively, while percentiles were documented in 17.0%. Furthermore, BMI was documented in just 1.2% of cases, and 32% no anthropometric measurements documented whatsoever. Moreover, 29.7% of children who were previously flagged up as obese/overweight were not followed-up, and only 12% who were documented as obese, were investigated, albeit incompletely. Only 7% of known

overweight children had dietary advice documented in their notes.

Conclusions COP’s services are not attaining the standard as per current guidelines, which suggest that all children should be screened for obesity opportunistically. We recommend the distribution of a dietary guidelines leaflet to parents, with additional advice on 60 minutes of daily moderate-to-vigorous physical activity (MVPA), limiting screen time to less than one hour a day, adequate sleep and healthy nutrition and beverage choice. Furthermore, continuous medical education for doctors will help when giving sustainable advice during follow ups. This audit stresses the urgent need of a child obesity clinic in Malta. Within a child obesity clinic, professional help may be provided with multi-disciplinary input, for effective management programmes of childhood obesity, including the use of FDA-approved pharmacotherapy and bariatric surgery. Only this will help prevent children with obesity to grow into obese adults with all the social, physical, mental and economic implications associated with it.

Young People’s Health Special Interest Group

849 EQUIPPING THE TEAM TO MEET THE NEEDS OF YOUNG PEOPLE IN THE PAEDIATRIC EMERGENCY DEPARTMENT: HEEADSSS AND BEYOND

¹Gayle Appleby, ²Meriam Ghobrial, ²Lauren Williams, ²Ella Farina, ²Felicity Mitchell, ²Sarah Davies. ¹Lewisham and Greenwich NHS Trust; ²Chelsea and Westminster Hospital

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Background Even before the coronavirus pandemic young people were increasingly attending Paediatric Emergency Departments (PED). A spectrum exists regarding the pandemic’s impact on adolescents. All have experienced disruption to education, some additional worries or concerns for family or friends and others have attended PED with new and/or worsening mental health difficulties.

Objectives In response to the increasing numbers and needs of adolescent patients attending PED we created a program to upskill the PED team to help them provide the best care for this patient group. To identify which young people required additional support and/or signposting to resources we aimed to undertake a HEEADSSS (Home, Education, Eating, Activities, Drugs, Sex, Suicide, Safety) screening assessment on all 12–15 years old attending PED.

Methods An online questionnaire generated baseline data around staff confidence using HEEADSSS and managing

Abstract 849 Table 1

	Confidence levels	Extremely	Very	Somewhat	Not so	Not at all
How confident are you using the HEEADSSS assessment tool?	Pre N =26		2	10	8	6
	Post N=16	4	6	6		

Abstract 849 Table 2

Weeks ->	Pre				Adolescent Month				Post				Frequency
HEEADSSS questions asked per interaction					1 HEEADSSS	2 CAMHS	3 Sexual health	4 Gangs/ CSE					
1	20	23	19	9	20	14	5	6	16	17	15	13	35%
2	12	22	22	13	22	16	5	7	10	10	12	20	33%
3	4	4	5	14	4	3	3	2	3	7	7	9	13%
4	2	3		1	1	3	2	3	3	4	2	4	5%
5	2	1	2		3	2	1	1		1	2	2	3%
6					2	1	1	1	1		2	1	2%
7	1		1		1			1	1	1	3	1	2%
8		1	1	1	2	1	1		3	5	5	3	4%

scenarios. This needs assessment generated ideas for an 'adolescent awareness month', whereby each week corresponded to a new theme with multi-modal teaching occurring each week. The survey was repeated to ascertain confidence levels post intervention. Data on the number of HEEADSSS screenings carried out was obtained from electronic records, pre, during and post this month.

Results The needs assessment showed an improved confidence in using the HEEADSSS tool after adolescent month (table 1). The post survey feedback demonstrated improved confidence in caring for those requiring Child and Adolescent Mental Health (CAMHS) input and how to approach talking about sex. It also identified areas where further teaching was required.

There were 783 potential encounters to undertake a HEEADSSS assessment; in 1/3 of presentations no HEEADSSS questions were asked. In most interactions 1–2 questions were asked (table 2). An increase in the number of HEEADSSS questions asked was seen and sustained (table 2). The most common questions asked were home and/or education, with eating and safety most commonly missed.

Conclusions This project helped promote a culture of awareness around adolescents and their requirements. An increased in confidence levels in approaching and managing their needs was reported post interventions. However, there is still more work to do in this area to translate this confidence into regular practice.

British Society of Paediatric Endocrinology and Diabetes

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MANAGEMENT OF CONGENITAL ADRENAL HYPERPLASIA IN A PAEDIATRIC ENDOCRINOLOGY CENTER OVER THE PAST 20 YEARS

¹Antony Fu, ²Eunice Wong, ²Eunice Wong. ¹Department of Paediatrics and Adolescent Medicine; ²Tuen Mun Hospital

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Background Congenital adrenal hyperplasia (CAH) is a group of autosomal recessive disorders in adrenal cortical steroidogenesis. It is the commonest cause of genital ambiguity in newborn and primary adrenal insufficiency during childhood. The most common form of CAH is owing to

steroid 21-Hydroxylase deficiency (21-OHD). Affected individuals have to receive lifelong corticosteroid replacement. It can be fatal if left untreated. Patients often suffer from the long-term complications resulting from either overtreatment or undertreatment. There are many different daily schedules of steroid replacement therapies and formulations, yet there is no unified approach in clinical practice with regard to the clinical management of CAH, with temporal and geographical variation despite existent international guidelines.

Objectives

- To describe the clinical characteristics and medical management of a local cohort of classic CAH patients
- To examine the delivery of corticosteroid replacement in the treatment of children and adolescents with classic CAH due to 21-OHD

Methods

Design and setting

Retrospective chart review of 23 patients with classic CAH due to 21-OHD who were longitudinally followed up in a local paediatric endocrinology center over the past 20 years.

Main outcome measures

Outcome variables of interest include demographics, clinical characterization of CAH subtypes (salt-wasting SW and simple virilizing SV), laboratory investigations at diagnosis and on monitoring, genetic testing (karyotyping and genotyping), treatment including type of glucocorticoid replacement, glucocorticoid daily schedules and dose levels, CAH-associated complications and details of genital surgery undertaken.

Results Among our 23 patients with classic CAH, 12 were females (52.2%). All except one patient were Chinese (95.7%). 11 were salt wasting (SW) subtype (47.8%) and 12 were simple virilizing (SV). There were 8 patients with SW CAH were male (72.7%) and 9 patients with SV CAH were female (75%). The mean age of diagnosis in SW CAH (0.66 month) was younger than in SV CAH (3.14 years). Their initial presentations are presented in figure 1.

The most popular glucocorticoid remained Hydrocortisone but recently more patients were put on Prednisolone. There showed a gentle decline in the mean total daily hydrocortisone (or equivalent) dose throughout the years. Glucocorticoid was prescribed from 2–3 times a day to more often 4 times a day recently (if not on Prednisolone) (figure 2).