Conclusions The majority of children referred with suspicion of ‘papilledema’ raised by an optometrist or junior-ophthalmology doctors, do not have significant pathology on review by specialist. Increased referrals for suspicious optic-discs but with normal examination, results in unnecessary imaging and also causes high levels of anxiety for the family. We, therefore like to suggest a pathway where in, there is a joint neurology and paediatric ophthalmologist clinic, where all the child referred as ‘papilledema’ can be assessed and if confirmed as true papilledema, then we would consider imaging and further tests including LP for CSF opening pressure measurement. Further follow-up will depend on the aetiology of papilledema. A more robust prospective audit will have to be implemented so as to collect more data and evaluate said guideline in the future.

Paediatric Special Interest Group: British Society of Haematology

1039 IMPROVING PAEDIATRIC SICKLE CELL DISEASE PATIENTS’ TRANSITION VIA ENHANCED HEALTH LITERACY USING AN ADOLESCENT-GUIDED BESPOKE ANIMATED VIDEO INTERVENTION

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Background Transition from paediatric to adult healthcare in patients with sickle cell disease (SCD) is widely acknowledged as a high-risk period with increased use of emergency services as well as higher morbidity and mortality. Consequently, the COVID-19 pandemic is likely to have confounded transitional processes via the subsequent disruption of healthcare practices which includes redeployment of specialist nurses, reduction in clinics and complicated waiting processes due to social distancing. One influencing factor determining the success of transition is health literacy. This is recognised as the ability of individuals to obtain, process and apply information to promote and maintain good health. Disease specific knowledge is an integral part of health literacy and contributes to empowerment of individuals with regard to their condition. It is particularly pertinent during the COVID-19 era for historically disadvantaged patients with SCD, where heightened anxiety and healthcare disruption can both contribute to diminishing that empowerment.

Objectives This project centred on ameliorating health literacy in 14–15-year-olds with SCD, by improving their knowledge of the aetiology, pathophysiology and complications of their condition along with the transition process, resources and contacts available to them. Congruent to their learning, the patients were also motivated to develop their self-management of SCD.

Methods Utilising an interventional pre- and post-methodology, this convenience sample was surveyed prior to and after watching a researcher-developed, age-appropriate SCD educational video, constructed via web-based animation software. The survey questioned participants to rate their confidence in the knowledge of a variety of SCD and transition-based topics between 1–5 using a Likert scale, where 1 = very confident and 5 = not confident at all. The survey also contained gender specific questions relating to sexual health complications of SCD, including understanding priapism and dysmenorrhea. Inclusion criteria comprised a participant age of 14–15 and a diagnosis of SCD.

Results Findings from the pre-intervention survey indicated that 47.8% of Likert scale selections were ‘very confident’ and ‘confident’ and the post-intervention survey indicated that 84.6% were ‘very confident’ and ‘confident’, representing a 36.8% proportional increase in participant confidence of SCD knowledge and transitional competence. Survey findings also yielded a 90% proportional increase of boys and an 80% proportional increase of girls selecting ‘very confident’ and ‘confident’ on the respective gender specific questions, between pre- and post-intervention surveys.

Conclusions The correlation between health literacy and prognosis in paediatric populations with long term conditions, most notably SCD, is just beginning to surface. These results are promising indications that the interventional video holds substantial educational value for SCD transitional patients. Further research should include enhancing the video’s quality to cater for different adolescent age groups whilst expanding the geographical recruitment and thus, sample size.

The social restrictions of COVID-19 have engendered innovative and adaptive healthcare delivery to patients and this study’s educational video contributes to that catalogue of creativity. Like health literacy, the effects of the pandemic on SCD are yet to be fully understood and with optimism, this study will encourage further research in improving SCD transition.

British Association of Perinatal Medicine and Neonatal Society

1040 AUDIT: DOCUMENTATION OF GLUCOSE INFUSION RATE IN HYPERGLYCAEMIC PRETERMS OF BIRTHWEIGHT LESS THAN 1 KG IN A NICU

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Background Hyperglycaemia is common in preterms of less than 1kg due to immature glucose regulation and iatrogenic causes like IV fluids and medications. The treatment of hyperglycaemia includes decreasing the glucose infusion rate(GIR), and failing this, using insulin.

Insulin use requires frequent blood sampling to monitor blood glucose. Studies have highlighted the psychological effects of repeated bloodtaking on premature infants’ neurodevelopment. It is imperative to ensure effective treatment of hyperglycaemia early on by reducing the GIR in order to avoid having to start insulin. We audited the insulin prescription charts to check if GIR was documented on first starting insulin between 01/01/2020 and 22/02/21.

Objectives

- To assess the documentation of GIR on starting insulin sliding scales in hyperglycaemic preterms of birthweight less than 1kg.
- To assess how documentation of GIR affects number of times blood is taken.
- To explore ways to improve documentation and thereby help to reduce number of bloods taken.
Methods I identified babies of birthweight less than 1kg on BadgerNet. Their discharge summaries showed whether they received insulin. Their prescription charts were reviewed for whether GIR was documented on prescribing insulin. The total number of bloods taken in the first 24 hours of starting insulin and whether the baby had an arterial line were noted. Findings were presented on 24/02/21 to the neonatal team and we discussed and suggested possible changes to improve documentation of GIR.

Results The number of babies less than 1kg birthweight identified as having received insulin on the unit was 13. 54% of them had their GIR documented the first time insulin was started whilst 46% did not. 69% of them had an arterial line whilst 31% did not. 56% of babies with arterial line had their GIR documented whilst 44% did not. 75% of babies without arterial line had their GIR documented whilst 25% did not.

The average number of times blood was taken in all the babies in the audit was 6.5. The average number of times blood was taken in babies with an arterial line was 5 whereas it was 8.8 in those without arterial line.

The number of times blood was taken from babies whose GIR was not documented was 2% higher than those whose GIR had been documented.

Conclusions The majority of babies had their GIR documented but there is big room for improvement. Documentation of GIR may be associated with a reduction in the number of times blood is taken.

Recommendations 1. Place the formula for GIR on the second side of the insulin prescription chart where the GIR is written to make it easier to see.

2. Calculate GIR using our e-handover system which allows for IV fluids to be prescribed on it and also shows GIR of the total fluids prescribed.

3. Consider speaking to pharmacy if GIR is raised and ask for a bespoke TPN bag with less glucose.

4. Nursing staff could prompt medical staff to write the GIR on insulin charts before giving insulin.

5. Present findings to the new cohort of trainees starting in March 2021, highlighting the importance of calculating the GIR and acting on it before starting insulin.

British Association of Perinatal Medicine and Neonatal Society

1041 AUDIT ASSESSING ANTIBIOTIC ADMINISTRATION FOR SUSPECTED EARLY-ONSET NEONATAL SEPSIS ON THE POSTNATAL WARDS IN ADDENBROOKE’S HOSPITAL, UK

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Background Neonatal sepsis is a systemic infection in newborns and a significant cause of morbidity and mortality. Early signs of sepsis are often non-specific; hence it’s essential to identify risk factors and commence treatment as soon as possible, to optimise outcomes.

Following the results of a previous audit in Addenbrooke’s Hospital in 2018 and with the COVID-19 pandemic; from September 2020 there has been a change in the practice in our neonatal unit. Instead of transferring babies to NICU for cannulation and antibiotics administration, midwives have been trained to administer antibiotics on the postnatal wards. This minimises COVID exposure and aimed to reduce the time taken to administer antibiotics.

Objectives Following the recent change in practice, the aim of our audit was to assess the time taken for antibiotics to be administered after the decision has been made to treat and explore the reasons behind any delay in antibiotic administration on postnatal wards. Our set standard was that 100% of babies with early onset neonatal sepsis should have antibiotics administered within one hour of decision made to treat, as per the NICE guidelines.

Methods Retrospectively we identified neonates on the postnatal ward that were >35 weeks gestation, >1.8 Kg, born in September 2020 and November 2020 that underwent a partial septic screen. We obtained the following data: gender, mode of delivery, decision time to screen, time taken for antibiotics to be prescribed, duration for antibiotics to be administered and reasons for a delay in performing the septic screen or administering the antibiotics.

We also sent an online questionnaire to doctors working at the hospital to help determine potential reasons behind antibiotic administration delay.

Results Out of 100 babies analysed, 15% of the babies requiring treatment received antibiotics within the hour from decision time.

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<thead>
<tr>
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<th>Median (Minutes)</th>
<th>Range (Minutes)</th>
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<tbody>
<tr>
<td>Time taken for antibiotics to be administered after decision to treat</td>
<td>106</td>
<td>17–553</td>
</tr>
<tr>
<td>Time taken for antibiotics to be prescribed after decision to treat</td>
<td>59.5</td>
<td>0–249</td>
</tr>
<tr>
<td>Time taken for antibiotics to be administered after prescription</td>
<td>41</td>
<td>0–425</td>
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There was no significant difference between results from September and November 2020.

The questionnaire revealed that reasons for delay included; delay in communication of risk factors between midwifery to neonatal team, neonatal team being busy with emergencies/clinical duties, poor stocking of cannulation trolleys and assumption that medical team had administered the antibiotics.

Conclusions We did not meet the NICE guideline standard in administering antibiotics for suspected neonatal sepsis. However, implementing this change helped to minimise separating babies from mothers and reduced the risk of COVID 19 exposure.

We identified issues resulting in delay of antibiotic administration and presented this to the neonatal and midwifery team. We introduced a sepsis cannulation box and also a template on the electronic patient record system (EPIC smart phrase) which highlights babies requiring treatment to midwives, along with the subsequent steps to follow. We also recommended that doctors prescribe antibiotics prior to cannulation and most importantly we raised awareness of the NICE guidelines to the multidisciplinary team.