No department had a psychosocial screening tool embedded in the admission document.

158/231(69%) had less than half of the eight domains completed. The median was 1.5 (range 0–8). Home and education/employment were most frequently asked (37–42%). Eating/exercise, drugs, safety, sexual activity and other activities were the least frequently asked (14–27%). The proportion of those with a concern identified when asked ranged from 18%–39%.

However, in self-harm, depression and suicide, only 85/231 (37%) were asked, with concern identified in 87%.

78 patients were admitted for mental health; 28(39%) had less than half the domains completed (median 5, range 0–8). Drug use 46/78(59%), safety and sexual activity (both 38/78 (49%)) were inconsistently documented in this group, with concerns identified in 20–26% of those asked.

90/231(39%) were referred to CAMHS, social care, counselling, online or other support services. 16/77(21%) patients with a concern documented in at least one domain were not referred onwards.

Conclusions This study demonstrates poor implementation of the HEEADSSS tool on admission, across a wide geographical area. Increased utilisation of a psychosocial screening tool would provide more opportunities to CYP to discuss their psychosocial health and receive appropriate support, in line with national guidance standards. Further work is underway addressing barriers to using HEEADSSS, considering electronic or embedded tools and signposting to relevant services.

British Association of General Paediatrics

1057

SLEEP DISTURBANCES IN SCHOOL-GOING CHILDREN WITH AUTISM SPECTRUM DISORDER AT A MALAYSIAN TERTIARY HOSPITAL

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10.1136/archdischild-2021-rcpch.364

Background Children with autism spectrum disorder (ASD) have a variety of co-morbid medical problems, including sleep disturbances. Prevalence of sleep disorders has been reported to be higher in this group as compared to the general population. Identifying sleep problems in children with ASD may help increase awareness and improve the overall quality of care for them.

Objectives The aim of this study was to determine the prevalence of sleep problems and associated factors in a group of Malaysian children aged 6 to 16 years, with ASD.

Methods This is a cross-sectional study at the Child Development Centre of UKM Medical Centre (UKM MC) on ASD children aged 6–16 years. Demographic data was obtained and the Sleep Disturbances Scale for Children (SDSC) questionnaire was completed by the main caregiver. Logistic regression analysis was used to determine factors related to higher total SDSC scores.

Results A total of 128 patients were recruited (111 boys) with a median age of 8 years 3 months (IQR: 2 years 10 months). Forty-seven (36.7%) of them obtained total SDSC scores in the pathological range with 19 (14.8%) scoring high for

overall disturbances and 28 (21.9%) for at least one subtype of sleep disorders: 25 (19.5%) DIMS, 18 (14.1%) SBD, 10 (7.8%) DOES, 5 (3.9%) DOA, 6 (4.7%) SWTD, and 3 (2.3%) SHY. More than half of the children (57.8%) were reported to have sufficient sleep duration of 8–11 hours, but longer sleep latency of at least 15 minutes (82.8%). Half of the ASD children also had co-morbidities in which one-third (34.4%) had attention-deficit hyperactivity disorder (ADHD). Using logistic regression analysis, four factors were significantly associated with higher total SDSC scores; female gender ($p = 0.016$), older age group (11–16 years old) ($p = 0.039$), shorter sleep length ($p = 0.043$) and longer sleep latency ($p < 0.001$).

Conclusions The prevalence of sleep disturbances is high among Malaysian children with ASD, especially DIMS. Female gender, older age group, shorter sleep length and longer sleep latency were found to be associated with the sleep disturbances. Evaluation of sleep problems should form part of the comprehensive care of children with ASD.

Abbreviations: DA, disorders of arousal; DIMS, disorders of initiating and maintaining sleep; DOES, disorders of excessive somnolence; SBD, sleep breathing disorders; SDSC, Sleep Disturbance Scale for Children; SHY, sleep hyperhidrosis; SWTD, sleep-wake transition disorders.

British Association of Perinatal Medicine and Neonatal Society

1059

NON-OCCLUSIVE MESENTERIC ISCHAEMIA (NOMI) IN NEONATES: A DEVASTATING DISEASE

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10.1136/archdischild-2021-rcpch.365

Background NOMI is an acute mesenteric circulatory disorder characterized by non-organic occlusion of blood vessels. It is an acute neonatal surgical emergency associated with high mortality.

Methods To describe three cases of neonates with NOMI requiring laparotomy and surgical intervention.

Results Three neonates with NOMI are described, all requiring laparotomy and bowel resection for extensive bowel ischaemia. Baby A was a 1900g 34 weeks infant with Trisomy 21, a large patent ductus arteriosus and duodenal stenosis which was surgically corrected on day 2. He developed abdominal distension on day 11 and underwent emergency laparotomy. Baby B was a 3600g term male infant with transposition of great arteries requiring an early balloon atrial septostomy with prostaglandin infusion while awaiting corrective surgery. He developed abdominal distension on day 11 and had extensive bowel ischaemia requiring resection. Both babies A and B developed multiple complications post-operatively and succumbed on day 38 and 66 respectively. Baby C was a 3200g term male infant with Tetralogy of Fallot and severe pulmonary stenosis requiring prostaglandin infusion. He developed abdominal distension on day 8 requiring surgical resection for extensive bowel ischaemia and stoma creation. The stoma was successfully closed following feeding establishment. He remains well at this time of writing.

Conclusions Although the mainstay of management in NOMI is reduction of spasm and improving perfusion of the mesenteric artery using vasodilators, the identification of at-risk neonates remains a challenge. In our case series, the NOMI had progressed extensively requiring laparotomy and bowel resection. The risk of mortality is high and a timely diagnostic laparotomy with excision of irreversibly necrotized intestine can be lifesaving.

Quality Improvement and Patient Safety

1060

MEDICAL EMERGENCY COVER AT A TIER 4 INPATIENT CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

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10.1136/archdischild-2021-rcpch.366

Background The inpatient tier 4 CAMHS unit provides care for children and young people with serious and complex mental health problems across four lodges. A patient safety risk was identified; in an emergency locating a doctor during normal working hours could be challenging. Doctors did not carry a bleep, could be working in a variety of different clinical areas or a doctor may not be assigned to each lodge every day. It was recognised patients may become acutely unwell or injured and a doctor should be in attendance promptly to undertake assessment and treatment.

Objectives

Aims

- A baton emergency medic blick (similar to a bleep) to be held during normal working hours.
- In an emergency a 'double blick' should indicate there is an emergency and a doctor should attend.

Objectives

1. Is a baton medic emergency blick an effective way of ensuring a doctor attends in an emergency?
2. Does the blick inappropriately impact a clinicians normal working?
3. What emergencies occur onsite and do staff feel confident/competent managing them?

Methods A medic emergency blick rota was designed assigning a non-consultant grade CAMHS doctor to carry the blick Monday to Friday during normal working hours.

Data was collected prospectively over a four month period. For every 'double blick' a proforma was completed collecting data on the emergency and what the outcome was.

Results 4 events were recorded, 2 were clinical events, 1 was a test and 1 a technical problem.

Conclusions In answer to the objectives:

(1) The medical emergency blick was effective in ensuring a medic attends in an emergency during normal working hours.

(2) There were 4 blicks during the data collection period which was confirmed with the team excluding the possibility of missing data. It was agreed by clinicians that carrying the blick does not inappropriately disrupt normal working.

(3) Of the emergencies that occurred medics felt competent and confident to manage them.

(4) The team agreed following the trial period that the medic emergency blick was a safe and effective way to ensure a doctor attends in an emergency and that it should continue. It was identified at feedback there were occasions during the trial where the blick was not collected and this was not recognised or escalated. A safety net plan was therefore agreed to prevent this happening in the future. The intention is to audit in 6 months to ensure continued compliance and explore frequency and nature of double blicks.

The project is limited by the small amount of data, however this is reflective of the clinical situation.

Quality Improvement and Patient Safety

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'TURNING OVER A NEW LEAF': IMPROVING THE QUALITY AND QUANTITY OF LEARNING FROM EXCELLENCE NOMINATIONS

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10.1136/archdischild-2021-rcpch.367

Background The Learning from Excellence initiative, previously piloted at Birmingham Children's Hospital,¹ aims to promote the recognition and celebration of positive clinical practice, and share these learning points to optimise patient care and foster a supportive, resilient working environment. Results from the pilot indicated that about 90% of staff agreed that Learning from Excellence increases staff morale and the quality of patient care.¹ Learning from Excellence initiatives have since been introduced across many NHS Trusts, including the Paediatric department at Great Western Hospital, Swindon, where the 'LeaFE' nomination process began in 2017.

Objectives This quality improvement project aimed to improve the quality and quantity of 'LeaFE' nominations made in the

Date/ time	Lodge	Was a medic required?	Activity before the blick	Summary of case	Input	Outcome	Competent/ confident to manage
8/10/20							
14:15	G	Yes	Telephone appointment, 2 minutes to close conversation. Unsure initially whether to attend.	Acute exacerbation of asthma	Examination, instructions to support workers and nurses. Applied oxygen and debrief after.	Hospital transfer.	Yes
15/1/21							
12:35	S	Yes	Meeting in the seminar room, easy to attend.	Patient removed dressing and had profuse bleeding.	Examination and referral.	Hospital transfer.	Yes