International Child Health Group

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NOT ONLY SURVIVING BUT ALSO THRIVING: AN EXPERIENCE OF CLINICAL CARE FOR PAEDIATRIC CHRONIC PATIENTS IN A LIMITED-RESOURCE HEALTH CENTRE IN ETHIOPIA

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Background Mortality in children under 5 years of age is decreasing thanks to WHO's Sustainable Development Goals (SDG) 2015 program. As a result, chronic paediatric diseases are becoming a growing burden in developing countries. The new SDG 2030 recommend implementing international policies to ensure children not only survive, but also thrive throughout their life. However, management of acute diseases still dominates the scene. 'Let Children have Health' Clinic is a paediatric health centre in Meki, a city in Ethiopia's Oromia region, where on average 100 children are reviewed every day with an unidentified number of patients on chronic treatment. **Objectives** We aim to share our experience setting up a clinical service for paediatric chronic patients in a low-resource setting.

Methods Local medical records were reviewed: many chronic patients were found to be receiving incorrect management and follow-up. A specific weekly chronic patient clinic was set up in January 2020. It was run by a designated health officer with the support of a paediatrician. A logbook was started to keep record of patients seen and to book follow-up appointments, encouraging regular attendance and improving continuity of care. Furthermore, guidelines commonly followed in clinic (MSF, WHO and Ethiopian National guidelines) were reviewed, highlighting a lack of resources for the diagnosis and management of chronic paediatric patients and the urgent need of some guidance.

Results In order to provide local staff with a structured approach to most common chronic conditions, an integrated chronic patient guideline was developed. The guideline covers relevant clinical presentation, diagnosis and treatment of each condition based on local availability of laboratory or radiological tests and drug treatments. This document was written by paediatricians working in the field, based on European guidelines and the Oxford Handbook of Tropical Medicine. However, a pragmatic approach was the main focus: diagnoses are reached with simple investigations available at the clinic. Further diagnostic procedures which would require costly laboratory tests or referral to a tertiary centre are listed but are not classified as necessary unless diagnosis remains uncertain. Recommended treatments are based on WHO essential medications or alternatively, drugs that are available at the clinic with no extra cost to patients. Based on the logbook record from January 2020 to March 2021, 135 children were identified to have a chronic condition requiring regular treatment and clinic appointments. The majority of patients had cardiac diseases (51%), followed by neurological conditions (29%) and diabetes (9%). A small number of thyroid, rheumatological, respiratory, nephrology and psychiatric conditions were also identified. 1158

dedicated chronic patient visits were performed over this period, averaging 22 visits per week.

Conclusions Chronic diseases are becoming a significant burden for lower income countries, traditionally more focused on short term goals and acute pathology. In order to deliver high quality care to this ever-growing groups of patients, local healthcare workers require access to dedicated chronic patient training, guidelines and resources. We successfully implemented a chronic patient clinic and provided our Ethiopian colleagues in Meki with the tools to independently manage long-term conditions in children with locally available resources.

Quality Improvement and Patient Safety

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WORKING TOWARDS A GREENER NHS: IMPROVING HOW WE PROVIDE DISCHARGE INFORMATION TO FAMILIES

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Background When paediatric patients are discharged, the written and verbal information given to parents is inconsistent. This leads to increased parental anxiety and potential for either inappropriate re-attendance or delayed attendance due to lack of understanding. Written information is easily lost or forgotten, and printing large volumes of paper leaflets has a negative environmental impact that is unnecessary.

Objectives We want to direct parents to appropriate online information at discharge that can be accessed on the parents' phone using QR codes, which will be displayed as a poster in clinical areas. This will dramatically reduce the hospitals carbon footprint while providing consistent discharge information.

Methods To gather information about current practice we retrospectively audited admissions over a two week period. Following introduction of the QR codes we will contact parents and audit whether they received any discharge information. We will also seek feedback about the accessibility of the QR codes, and provide teaching sessions for staff about how to access them. These QR codes are dynamic, meaning we can collect useful audit data, which will help plan the focus for ongoing educational interventions.

Results In two weeks, 542 patients seen in our ED; we randomly selected 42 patients and were able to access records for 33. Out of these 33 patients we were able to contact 20 families to ask about their experience.

In 100% of cases clinicians have documented that either verbal or written advice had been given. 90% were documented receiving 'red flag advice', 18% documented as receiving written advice was 82% were documented as receiving verbal advice only.

Of the 33 families we contacted we were able to speak to 20. Of these families 15% did not remember if they were given written advice, 80% reported no written advice was given and 5% remembered receiving written advice (in this case a head injury advice leaflet). Within our cohort there were 4 patients identified as having 'wheeze' – 2 of these families were successfully contacted and both stated they had not received a weaning plan despite this being documented in the medical notes.