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.

Conclusions There is a discrepancy between what the clinician documents about giving advice and what the family remembers. We clearly need to find a better way to give families information that they will remember and they can rely on. We hope that the impact of our change will not only be to educate and empower parents to manage their child's condition, but also open parents up to other available resources which they can access the next time their child is unwell, and therefore reduce the number of inappropriate A+E attendances. We have traditionally always given parents written information leaflets, but as technology changes and advances, we need to consider different ways of giving parents information that can also reduce our carbon footprint. We anticipate that this intervention will provide easier access for staff and patients to relevant patient centred information, thereby improving patient and parent education, reducing anxiety and as a consequence reducing the number of inappropriate re-attendances to hospital.

Quality Improvement and Patient Safety

1079 IMPLEMENTATION OF COMMUNICATION STRATEGY TO IMPROVE INFORMATION DISTRIBUTION AND PATIENT CARE DURING THE COVID-19 PANDEMIC

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Background This project was undertaken at a large tertiary teaching hospital involving members of the multi-professional team involved in patient care during the COVID-19 pandemic. Early on, we realised that much of our information distribution relied on emails and face-to-face meetings. With rapidly changing guidelines and recommendations, quantity of information to distribute became overwhelming. Staff were receiving multiple, daily trust-wide and department-specific emails. There was huge information overload, resulting in miscommunication.

Objectives 1. To provide up-to-date information that has been appraised for accuracy, relevance and importance

2. Increase effectiveness in information distribution - identify relevant recipients, timely distribution, minimising information overload, and creating a repository for reference

Methods Our QI methodology is based on the model for improvement framework and PDSA cycles.

PDSA cycle 1: Identifying stakeholders, and a preferred method of communication

- Stakeholders were identified and engaged.
- Baseline data was taken from the trust's internal communication survey data
- We agreed on a trial information distribution via an intranet page

PDSA cycle 2: Implementation of the Covid-19 intranet page

- Paediatric Consultant led the design of the webpage, including content, location and structure.
- The webpage was reviewed using Dalhousie university criteria.
- Informal feedback was regularly sought from stakeholders to upkeep the webpage. A formal survey was could not be completed at 3 months due to staff redeployment.

PDSA cycle 3: Improving awareness of the intranet page - in progress.

- The intranet page was advertised in induction for new staff and disseminated in the monthly staff bulletin.
- Survey was performed at 6 months to collect quantitative and qualitative data to assess staff use and satisfaction

Results PDSA cycle 1: We identified staff bulletins, emails, intranet and team meetings as staff's preferred methods of communication. 51% of respondents reporting using the intranet daily, and a further 29% using every few days. 90% rated the intranet as a useful resource.

PDSA cycle 3: Survey data showed that 75% reported accessed the website, with 61% of these using it on a weekly basis. It was mostly accessed for information for staff, PPE guidance and testing policies. The website was rated highly for accuracy, ease of access, useful and up-to-date information. All topics were rated useful and respondents were highly likely to recommend it to other colleagues. Qualitative responses were assessed with word clouds. The 3 main words were as follows: key successes - easy, organised, relevant; areas for improvement: awareness, reminders, layout. Of the 25% that did not use the webpage, all cited lack of awareness as the reason.

Conclusions These were unprecedented times with rapidly changing guidelines. Creation and distribution of easily accessible up-to-date information to colleagues was increasingly important. Creating a central point of reference worked well for a large hospital where the staff base changes regularly and already have saturated email inboxes. Ensuring that information was aimed at all members of the MDT provided streamlined and unified information.

British Society for the History of Paediatrics and Child Health (ePoster presentations only)

1081 LEGG-CALVE-PERTHES DISEASE: A TRANSATLANTIC EFFORT

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Background Legg-Calves-Perthes (LCP) disease, or Perthes' disease, has been present since prehistoric times, with paleopaethologists identifying what is believed to be the most ancient case in 6th to 3rd Century BC Italy. Nevertheless, it was over two millennia later in the early 20th Century that LCP was named and its aetiology investigated. The historical development of LCP represents only a part of the wider development in paediatric orthopaedics occurring at the time, a period revolutionised by Rontgen's discovery of X-rays in 1895.

Objectives A historical overview of Legg-Calves-Perthes disease.

Methods Literature review.

Results Early research of paediatric hip conditions centred on direct visualisation under anaesthesia, biopsy and clinical assessment. Rokitsky, an 18th century pathologist, is now believed to have incorrectly ascribed some early cases of LCP as hip infection and tuberculosis, both conditions predominant at the time. The lack of radiographic imaging provided a