appropriately. Silver nitrate was previously the first line of treatment of this condition in our local hospital. However, it is associated with various problems which include burns to the surrounding skin and need to be applied by a trained health professional.

Salt treatment was introduced to our local hospital as the first line treatment for umbilical granulomas. Salt is thought to be effective due to its desiccant properties. The salt is applied and monitored by our outreach nursing team after the diagnosis is confirmed. Salt is applied to the area for 30 minutes after it has been cleaned. Further application of salt is done by the parents twice daily after they have been trained. On the 4th day of treatment, the granuloma is assessed by the team at home. No further treatment is required if it has resolved completely. In cases of treatment failure, further treatment with polyurethane and silver nitrate is considered as per local policy.

Objectives A retrospective audit was undertaken to demonstrate the effectiveness of salt therapy as the first line of treatment for umbilical granulomas.

Methods A review of the case notes of the infants treated for umbilical granuloma between January 2019 and November 2020 in our trust was done. A proforma was created reviewing what treatment the infants received.

Results A total of 6 infants received salt treatment as the first line of treatment for their umbilical granulomas during the review period. The umbilical granulomas resolved completely with salt treatment after a 3 day course of salt application. No infant during our study period required second line treatment.

Conclusions Our audit has demonstrated that salt treatment is an effective, environmentally friendly, inexpensive and easily available first line treatment for umbilical granulomas with no reported side effects.

British Association of Perinatal Medicine and Neonatal Society

1173 DOES TRANSPORT TIME TO OFFSITE MICROBIOLOGY AFFECT TIME TO POSITIVITY OF BLOOD CULTURES IN INFANTS SCREENED FOR EARLY ONSET SEPSIS? Edward Donald James Broad, Norfolk and Norwich University Hospital

Background Screening babies for early onset sepsis represents a high proportion of neonatal antibiotics use. Due to historical concerns about the delays in transportation of blood cultures from our District General Hospital to off-site microbiology services, antibiotics are currently continued until the automatically generated report of ‘no growth’ appears 36 hours after incubation begins in the microbiology lab. Consequently, it was predicted that babies were having multiple doses of unnecessary antibiotics, and a prolonged stay, without ascertaining whether there was a significant delay in reporting of positive blood cultures caused by transport off-site.

Objectives To determine whether the transport time to offsite microbiology affects the Time To Positivity in blood cultures sent from a District General Hospital NICU.

Methods Blood culture data from 1/1/2015–13/05/2020 was obtained, and analysed for indication for antibiotics, CRP values, bacteria isolated, whether the bacteria was clinically considered a contaminant, and time elapsed from culture being taken and antibiotics commenced to phone call to NICU informing them of a positive result. Finally, NICE guidelines for discontinuation of antibiotics at 36 hours (well baby, low initial suspicion of sepsis, reassuring CRP trend) was retrospectively applied to the true positive blood cultures taken for early onset sepsis, to ascertain if any neonates would have inappropriately had their antibiotics stopped due to transport time to offsite microbiology.

Results 2113 blood cultures were sent over the 5 year period studied, of which 37 were positive, 14 were considered ‘true positives’, and 6 were true positives from infants screened for early onset sepsis. 5/6 (83%) flagged as positive at 36 hours from being taken, and 6/6 flagged at 48hrs from being taken. The single outlier was a baby who was intubated, cooled and transferred to a tertiary centre. Both CRP values in this child were >10. In early onset sepsis screening, the negative predictive value of a negative culture having further growth after 36hrs was 99.8%.

Conclusions If the NICE guidance for discontinuing antibiotics in early onset sepsis were followed, and antibiotics were stopped 36 hours after commencing in well appearing babies with a low initial suspicion of sepsis, with two CRP levels less than 10, and with blood cultures that have not flagged as positive by 36 hours from starting antibiotics, there would have been zero cases of missed bacteraemia in five years. The concerns about the impact of transport time are unwarranted, and lead to poor antimicrobial stewardship practices. Based on previously gathered data on the number of inappropriate extra antibiotic doses given to these babies, in a centre with 2500 live births/year, this has the potential to save £1700/year in drug costs alone, and could reduce the length of stay by 12–24 hours for 116 low risk babies per year.

Quality Improvement and Patient Safety

1175 SOCIAL DISTANCING IN THE SEMINAR ROOM OF A CHILDREN’S HOSPITAL – A PROSPECTIVE QI ANALYSIS OF PRACTICES AND RECOMMENDATIONS

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Background SARS-CoV-2 can be spread when people have close sustained contact. This means spending more than 15 minutes within two metres of a covid-positive person as it spreads through droplets from sneezes and cough. To that effect, Public Health England recommends social distancing, that is, maintaining a distance of at least 2 metres between people of different households. In cases where a 2m distance is not possible, additional measures such as a wearing a face covering and having adequate ventilation should be ensured.

Objectives The objective of this audit was to look at social distancing measures among healthcare professionals during the morning paediatric handover in the seminar room at our Hospital and to identify areas of improvement so as to prevent the spread of the infection among hospital.

Methods A daily head count was carried out at the morning handover in the seminar room from 1st November 2020 to
15th January 2021. This included doctors, medical students and physician associates. Given the size of the seminar room, the infection control team recommends that the total number of people in the room should not exceed 15 at any given time.

**Results** The recommended total number of people was exceeded on 25 discrete days (54.3%) in that period time. Moreover, chairs spaced 2m apart to ensure safe distancing were moved closer by the healthcare professionals on a daily basis. This increases the risk of spread amongst the staff. After communicating the results with all the stakeholders and staff at UHL Children’s hospital, some positive changes were noticed.

Display of the poster within the seminar room and on the entrance door to the seminar room, marking the distance on the floor, communicating the results with staff and regular reminder about the need of adherence to PHE guidance helped the practice of social distancing. Since implementing this change, total number of people reduced to 9 on an average with maximum of 11 over 2 weeks period.

**Conclusions** Social distancing measures should be better adhered to reduce the risk of person to person transmission in a hospital setting. Participants were advised to limit the number of staff to one to two each from every ward to help minimise the number of attendees in the seminar room. Staff are being encouraged to leave after handing over jobs from their specific wards. Strict adherence to guidance with regular reminders during handovers about its implementation and reviewing PDSA cycles are key to sustain this improvement.

**British Association for Community Child Health**

**1176 OUTPATIENT CLINICS – WHAT DO FAMILIES VALUE?**

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**Background** Gloucestershire Hospitals NHS Foundation Trust Community Paediatrics service has reviewed the patient experience of outpatient clinics to guide the remodelling of this service. The department comprises eight consultants across two sites, serving a population of 630,000. The NHS Long Term Plan aims to reduce face-to-face appointments by one third through embracing technology. The COVID-19 pandemic has accelerated the introduction of remote clinics via telephone or video appointments in this division. Having never been routinely used, this represented a significant change in practice. Data was required regarding the aspects of the outpatient environment valued by families, to plan the organisation of future services.

**Objectives** To understand the patient experience of using central hospital and peripheral community clinics, and remote clinics to direct development of the service.

**Methods** Community paediatric patients and families were invited to complete a survey examining preferences on location, facilities, virtual vs face-to-face appointments and MDT working.

**Results** 1990 surveys were distributed and 265 were completed, representing a 13% return. 87% of respondents stated their child had ADHD or Autism, or a learning disability.

**Appointment preferences** 58% of respondents reported that proximity to home was the most important factor in determining clinic location of choice; time out of school to attend appointments was frequently mentioned. Parking and appointments at the same site as other facilities such as radiology and blood testing was mentioned in 43% and 27% of answers respectively. 20% of wheelchair users reference accessibility in addition to the factors above.

**Virtual Appointments** 70% of those who had attended a video appointment stated they were happy for appointments to be run in this way, compared to 39% of those who had not. 55% of those who had attended a telephone appointment stated they were happy about appointments being run in this format, compared to 40% of those who had not.

Patient reported advantages of virtual appointments included convenience and reduced travel time. A lack of physical examination, technical problems and a reduction in child engagement in the appointment were concerns mentioned by respondents.

**MDT working** 80% of respondents had not attended a multi-disciplinary clinic. 87% of those who had attended reported it to be helpful.

**Conclusions** The majority of respondents identified their child as having ADHD or autism, or learning difficulties. The NHS Long Term Plan and RCPCH State of Child Health Reports highlight the need for greater focus on the needs of these young people.

Proximity to home and parking remain the most important factors in determining preferred clinic location. The number of patients who were happy to have video appointments was higher in those who had experienced these already, suggesting they were more successful than expected. A smaller difference was seen for telephone appointments. MDT working was popular amongst those who had experienced this.

Both remote appointments and MDT working are modalities of consultation that should be considered when developing the Community Paediatrics service, using models of working that are closer to that outlined in the NHS Long Term Plan.

**Quality Improvement and Patient Safety**

**1178 APPLICATION OF NICE BRONCHIOLITIS FLUID THRESHOLDS TO INFANTS ADMITTED WITH ACUTE BRONCHIOLITIS**

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**Background** Feeding support is the most common reason for bronchiolitis hospital admission. NICE bronchiolitis guidelines recommend an assessment of hydration status (including >12 hours since last wet nappy) and feed volume thresholds (<50% or <75%), taking into account risk factors (prematurity, congenital heart disease, < 3 months of age). There are no data to support these recommendations.