with chronic headache, and 3/35 (9%) were diagnosed with non-specific headache. None were diagnosed with tension-type headache.

15/35 (44%) had a head MRI, which was normal in all.

Only 5/35 (14%) patients were recommended a headache diary. 3/8 (38%) with migraine and one patient whose headache was not classified were given du-to-therapy consisting of a triptan and NSAID. A further 2/8 (25%) with migraine, and two patients whose headaches were not classified, were prescribed a triptan. Five patients without a headache diagnosis, three with chronic headache, one with migraine, one with secondary headache, one with non-specific headache were treated with NSAIDs only. 3/8 (38%) patients with migraines, six with undiagnosed headache, and one with chronic headache were given pizotifen prophylaxis.

Advice about Medication Overuse Headache was documented in six patients.

9/35 (26%), including 4/8 (50%) patients with migraine, four with unclassified headache, and one with non-specific headache were discharged after the initial consult. 2/35 (6%), including one patient with secondary headache, and one non-specific headache were referred to tertiary care after initial consult.

The mean follow-up period after initial consult was nine months. 1/8 (13%) patients with migraine, and seven patients with unclassified headache were discharged after the first follow-up; 1/8 (13%) with migraine, two with unclassified headache, and two patients with chronic headache were discharged after the second follow-up. One patient with unclassified headache was discharged after the third follow-up. Six patients did not have their headaches discussed in subsequent visits and three patients are still being followed-up. Two patients have been lost to follow up.

15/22 (68%) evaluable, who had a follow-up, experienced an improvement in their symptoms.

Conclusions There was a good attempt at describing headaches, but many patients were not given a specific diagnosis as recommended by NICE. Also, fewer patients should have undergone brain imaging, more should have had advice about using headache diaries, and Medication Overuse Headache.

We recommend a template to help diagnose and manage headaches in the clinic and a remote follow-up system for patients after discharge.

REFERENCE
1. https://www.nice.org.uk/guidance/qs42

Child Protection Special Interest Group

1333 BARRIERS TO IDENTIFICATION AND REPORTING OF CHILD ABUSE CASES AT THE EMERGENCY DEPARTMENT, KHARTOUM, SUDAN

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Background Early diagnosis and intervention of Child Abuse is crucial where it prevents approximately one in three children from suffering subsequent abuse. Family and Child Protection Units (FCPU) in Sudan frequently receive cases of abuse. Nevertheless, it is observed that a number of children victims in the community never make it to any FCPU, therefore never get appropriate management. On the other hand, the emergency department (ED) acts as the main entry of crisis-based health care visits, thus it is assumed to be the first encounter with a health care service for the abused child and therefore the main opportunity for such cases to be identified and managed, yet it is believed that in Khartoum a number of children come to the casualty with signs of abuse disguised in the form of related or unrelated medical complaints, but they tend to be missed or neglected.

Objectives The objectives of the study were to determine knowledge of medical personnel about the common child abuse signs at presentation to the ED, identify reasons behind not reporting, measures they take when identifying such cases and if there is any relationship between received training and the ability to detect and report the cases.

Methods The study was conducted in December 2017 in a hospital setting, in a descriptive exploratory cross-sectional study-design. Stratified sampling was used, where three main public hospitals were chosen via simple random sampling from a list of public hospitals in Khartoum State. Furthermore, proportionate number of medical personnel was taken from each ED in each of the three hospitals, from whom data was collected using a semi-structured questionnaire derived from a previous study by Intima Alrimawi et al, in 2014.

Data analysis was done to obtain the frequencies and descriptive statistics, and Chi-square statistical test was carried out to analyze the relationship between the different variables.

Results In order for medical personnel to consider reporting, suspicion of a child abuse must precede, unfortunately only 31.1% of them have had previous training and thus knowledge on the presentation of suspected cases. The majority of those with previous training were always able to detect signs of child abuse. Furthermore, a significant relationship was found between receiving training and the ability to identify a case of child abuse (P-value=0.000), but no impact on the actual attitude of reporting the cases.

It was also found that most of the medical personnel do not consider reporting of child abuse cases, but they would take a detailed history to screen the case without knowing the next step (64.9%). In more than half, the main reasons that impeded them from reporting was to avoid getting in troubles with the victims’ family by getting sued for considering such a stigmatizing finding. Only 4.5% attributed it to the absence of a clear protocol and reporting system for such cases.

Conclusions The study revealed a low level of knowledge on detection of child abuse cases, and further, lack of supporting law and protocol to deal with such sensitive cases to allow doctors to confidently report them.

Young People’s Health Special Interest Group

1334 VIRTUAL REALITY HOSPITAL: DEVELOPING A PATIENT CENTRED VIRTUAL ENVIRONMENT TO REDUCE PREPROCEDURAL ANXIETY IN CHILDREN AND YOUNG PEOPLE

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Background Anxiety is a common experience among Children and Young People (CYP) attending hospital for a procedure
under general anaesthetic, some of whom require anxiolytic medication. Methods to reduce anxiety, such as hospital tours, have not been possible during the COVID-19 pandemic prompting us to reimagine how these can be delivered.

Use of Virtual Reality (VR) in Paediatrics has largely focused on distraction during a procedure but VR can be effectively used preoperatively to reduce anxiety. Preadmission use of VR to reduce anxiety has also demonstrated a potential health economic benefit.

We describe progress in developing a VR environment to simulate hospital tours in a Paediatric Hospital in the United Kingdom.

**Objectives**
Improve the patient experience by reducing preprocedural anxiety in CYP attending for a planned procedure under general anaesthetic, using VR technology to simulate a tour of an anaesthetic room.

The VR environment must be accessible and interactive for CYP aged 8–21 years using a smartphone or device and VR headset at home, the content and design of which is informed by the experience and opinions of CYP at every stage of development.

**Methods**
Initial input of CYP was sought at a Young People’s Forum. Discussions informing both the content and design were facilitated by healthcare professionals and involved CYP aged 10–18 years.

A VR developer then created a digitally rendered anaesthetic room to produce a minimum viable product (MVP) using ‘Autodesk Maya’ and ‘Unity’ software. A 360° video of an anaesthetic room was also developed.

Information provided within the VR environment was produced by Paediatric Healthcare professionals with input from experts in acute Paediatric anxiety.

Focus groups of CYP will provide qualitative feedback to drive improvement cycles of the VR environment on a regular basis along with integration of interactivity and gamification.

Following this patients will be invited to experience the virtual environment. **Results**
CYP felt that a VR environment could help reduce preprocedure anxiety. They identified reducing uncertainty, optimising comfort, familiarity and trust in healthcare professionals and understanding medical devices as key factors for consideration when developing the VR environment. A calm environment with a relatable character, interactivity and gamification were identified as design priorities.

The initial focus group review of the MVP is scheduled imminently with a plan to complete improvement cycles on a three monthly basis.

Patients will be offered the opportunity to explore the VR environment at their pre-assessment appointment if the healthcare team and parent/guardian believe they may benefit. **Conclusions**
Preprocedure anxiety is a major factor affecting the experience of CYP. This project aims to counter that using VR technology. The engagement of key stakeholders to inform throughout development ensures constant relevance is maintained in design and delivery.

Reducing uncertainty, optimising familiarity and trust in the healthcare environment and team were identified as key factors in reducing anxiety. Interactivity and gamification are important in enhancing engagement.

Ongoing review with CYP will shape and extend this tool with a view to building an interactive VR hospital allowing exploration of the whole hospital journey.

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**Quality Improvement and Patient Safety**

**Background**
Errors in prescribing and administering drugs, make up a huge proportion of monthly Datix’s. These errors reduce the effectiveness of treatment, prolong patient stay and can put patient’s lives at risk. We reviewed the drug error rate, in our Pediatric Department at Luton and Dunstable University Hospital. Following this, we listened to our staff and introduced interventions.

**Objectives**
* Educate- Alert all staff regarding common prescribing errors and specific drug related topics.
* MDT discussion- Increase communication within the team (Pharmacists, the medical and nursing staff).
* Feedback- Enable the team to receive feedback on anonymised errors in real time and share learning points.
* Change in behaviour- Draw attention to areas for improvement and change behaviour over time, to improve the standard of prescribing and reduce errors.

**Methods**
We sent out a questionnaire to our colleagues (Paediatric Doctors, Nurses and ANNs) to understand what currently makes them feel confident or unconfident, when it comes to prescribing and administering drugs. Using this initial survey results, we introduced 2 interventions to be trailed over a 4month period.

1. Daily ‘Dedicated Prescribing Time’ to minimise distractions and include pharmacists in ward prescribing and administering practices.
2. Fort-nightly ‘Pharmacist led teaching’

**Results**
From June to September 2020.
- There was a downward trend in errors relating to drug dose or frequency (24%à37%à25%à13%)
- There was a downward trend in errors relating to drug route (26%à12%à8%)
- There was a huge increase in the number seeking pharmacy support for help and advice (2% June, 19% in July, 12% in August and 17% in September).

Surveys pre and post the scheme showed the majority feel errors are made when they are rushed or short of time (>50%). Whilst the survey did not show much change in prescribing confidence, it did show an increase in the number who felt willing to seek pharmacy advice.

**Conclusions**
Drug errors can cause significant harm to patients. A high proportion of staff feel under confident when prescribing and administering drugs, due to time pressures and distractions on the ward. Our interventions over a 3month period, whilst they did not negate all the pressures, did help staff feel more able to contact pharmacy staff for support and also help reduced errors. Thus we hope by continuing this project and having regular teaching sessions, we can further reduce errors and increase confidence.