Results 5/21 tertiary hospitals and 14/33 DGH participated in this survey. Of the 19 (n) responses, 5 (26%) were tertiary hospitals and 14 (74%) were DGH.

All respondents from the tertiary hospitals revealed they had availability of Specialist Clinical Psychologist (SCP) who participated in all CF meetings including MDT (Multi-Disciplinary) and Annual Reviews.

3/14 DGH (21%) had availability of SCP locally who saw patients in CF Annual reviews and MDT meetings.

In another 3/14 DGH (21%), CF patients had no access to SCP either locally nor in tertiary hospitals. These patients were referred to CAMHS locally for psychological concerns or a Diabetes Psychologist if patient had Cystic Fibrosis Related Diabetes (CFRD).

In the remaining 8/14 DGH (58%), CF patients had no access to SCP locally but out of these, SCP from tertiary hospitals visited CF clinics in 2 DGH. CF patients from the remaining 6 DGH visited tertiary hospitals to access psychology services.

Conclusions From the analysis of the results from the online survey, we concluded that very few DGH have local SCP services. Where SCP services are not available, patients have to rely on tertiary hospitals or local CAMHS services. It is known that patients with long term physical health problems are likely to have mental health problems. NHS England highlights that prevention of mental health problems is the most cost-effective service that can be provided. Hence, it is recommended that all children and young people with CF should have access to psychological services so that they benefit from early psychological intervention and improved health outcomes through improvement in wellbeing. Our survey indicates that there is an unmet need to develop psychological services within DGH. A major limitation of this survey is the low response rate which we attribute to the work and capacity pressures from COVID-19.

British Association of Perinatal Medicine and Neonatal Society

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DOCUMENTATION AROUND THE COMMENCEMENT OF THERAPEUTIC HYPOTHERMIA FOR HYPOXIC-ISCHAEMIC ENCEPHALOPATHY (HIE). A QUALITY IMPROVEMENT PROJECT

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Background Healthcare Safety Investigation Branch (HSIB) have begun to investigate infants who have been 'cooled' for HIE in England. This triggered an audit of iCLIP electronic records for infants cooled Jan 2020 to Jan 2021 at St Georges University Hospital (SGH), London. Perinatal HIE has a significant risk of long term neurological and developmental sequelae. 1–3.5/1000 births in the UK have perinatal asphyxia severe enough to cause neonatal HIE. SGH is a level 3 unit receiving infants from level 1 and 2 units in the network. Infants must meet cooling criteria A, B and C. Criteria

A is pH <7.0 or BE >-16, Apgar <5 at 10 mins, ongoing resuscitation at 10 minutes. Criteria B signs of moderate to severe encephalopathy including altered consciousness plus hypotonia, abnormal reflexes, weak or absent suck or clinical seizures. Criteria C based on aEEG for a minimum of 30 minutes showing intermittent or continuous seizure activity, abnormal or suppressed activity. Without intervention, risk of death or severe disabilities in survivors of moderate to severe HIE is 25% and 75% respectively. With therapeutic hypothermia, mortality and disability has reduced but it remains an area of interest for quality improvement and litigation.

Objectives An audit to identify gaps in the documentation around commencement of therapeutic hypothermia in infants with HIE. This will enable the team to highlight areas that need to be developed to allow more robust documentation in the future; improving patient safety.

Methods Infants identified from Badger system from Jan 2020 to Jan 2021. iCLIP entries were examined for; maternal history, delivery details including CTG, resuscitation, cord gases, first gas, neurological examination, Cerebral Function Monitoring (CFM), time of cooling, seizures, medication and reasons for re warming if occurred.

Results 18 infants were cooled in 12 months. 33% were transferred from level 1 and 2 units. One was cooled out of cooling criteria as had borderline blood gases but went on to develop seizures. Two infants were <36 weeks, three had cooling commenced more than 6 hours of age from birth due to changing neurology, one rewarmed early due to diagnosis of chromosome disorder. One patient died after rewarming. 27% had no maternal history documented, cord pH not mentioned in 27% of cases, 22% had no resuscitation note, 27% did not have the age in hours documented at commencement. 11% of patients had no neurological examination documented prior to cooling. 5% did not have CFM results documented.

Conclusions Audit identified good documentation around infants who were cooled outside of cooling criteria. Some deficits were identified in the documentation around the maternal history, resuscitation, neurological examination at the time of commencement of therapeutic hypothermia. These results alongside the HSIB investigation have prompted an update of the HIE Guideline, triggered departmental teaching and production of an electronic pro forma for iCLIP. We aim to start a pro forma to improve and standardise documentation around commencement, during and after cooling.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

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THE MAGNITUDE OF PICKY EATING BEHAVIOUR AND ITS IMPACT ON CHILD HEALTH IN PRESCHOOL CHILDREN IN FOUR PRIMARY HEALTH CARE CENTRES IN KHARTOUM CITY 2020

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