Abstract 1453 Table 2 The different roles of the Bitesize presenters. The MDT included nurses and nurse educators, a pharmacist, a Speech and Language therapist, physiotherapist and breastfeeding support specialists. Presenters who delivered more than one session were counted once.

Consultant	5
Trainee	12
MDT	8

The response was positive even after 6 months. When asked what they liked about Bitesize, 78% (n=11) highlighted the brevity of the sessions.

Participants were asked if they would like Bitesize to continue (if staying in the NICU) or to be initiated in their new department (if rotating) and 100% (n=14) said that they would.

Conclusions Bitesize teaching is a valuable technique for delivering concise and relevant teaching in a busy department. The brevity promotes inclusivity of different team members and encourages the virtual participation fostered in the current pandemic climate.

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Association of Paediatric Palliative Medicine

1454 MEDICATION ACCESS AND SUPPLY ISSUES AS A BARRIER TO GOOD SYMPTOM MANAGEMENT: HOW BIG IS THE PROBLEM?

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Background The number of children living with life limiting conditions (LLC) has increased over the last 17 years with a current prevalence in the UK of 66.1 per 10000. Care of these children is complex, requiring care in a number of settings including district and tertiary hospitals, hospices, communities and family homes from a number of professionals – specialist doctors, general practitioners, nurses, pharmacists as well as parents and carers. Differences in access and supply of medications across settings, as well as differences in confidence in prescribing unlicensed or off label medications, not to mention lack of effective communication between individuals and institutions, can lead to delays in delivery of needed symptom management.

Objectives To identify and quantify access and supply issues for patients receiving care from a specialist palliative care team at a tertiary centre and to consider the impact of these

issues on patients, their families and professionals, as well as ways in which problems could be ameliorated.

Methods Identification and review of all instances of medication access and supply issues for patients referred to a tertiary palliative care team between February 2020-August 2020 (inclusive) through chart review, reporting and discussion at the weekly multidisciplinary team (MDT) meetings, daily on call handovers and via telephone requests to the team. Access and supply issues were coded by type (e.g. availability, prescribing, dispensing), location (e.g. community, local hospital, tertiary hospital and national) and patient consequences (e.g. change in location of care, delay in receipt of medication).

Results 102 patients were referred to the tertiary palliative care team over the study period. 87 symptom management plans (SMPs) were written for 58 patients. 14 patients (24% 14/58) patients had documented difficulties with medication access and supply. This issues occurred across all service providers, but were most common in the community and local hospitals. Common issues identified were:

- Lack of ability to source drugs locally (e.g. ketamine, gabapentin, lansoprazole, diamorphine, aprepitant)
- Difficulty or inability to prescribe medications in the community
- Incorrect preparations dispensed
- Delay in prescribing medications for symptom management
- Issues with ongoing supply for non-formulary medications

Resolving these issues took a significant portion of palliative care team members time. More significantly, however was the impact on patients. Notably two patients required emergency readmission to hospital for symptoms which could have been managed effectively at home had there not been access and supply issues.

Conclusions Medication access and supply issues affect a significant number of children with LLC and can impact effective symptom control and place of care. Next steps to address these issues include: education program for professionals involved in care of children with LLC focused on medications commonly used in paediatric palliative care, need for timely/anticipatory prescribing and effective collaborative working amongst professionals in a variety of settings where these children are cared for.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1455 USING A PATIENT REPORTED EXPERIENCE MEASURE (PREM) TO ASSESS THE EXPERIENCE OF CARERS IN PAEDIATRIC INTENSIVE CARE DURING THE COVID-19 PANDEMIC

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Background In April 2020, in response to the emerging COVID-19 pandemic, NHS England recommended limiting visiting to hospital inpatients, with resultant changes to our hospital policy of open visiting limiting visits to a single carer. In addition, changes to the way healthcare professionals interacted with carers had to be implemented, such as remote

meetings, use of personal and protective equipment and social distancing.

Objectives Our objective was to understand the impact of these changes on carers of children requiring intensive care during the Pandemic.

Methods A patient reported experience measure (PREM) focusing on experiences of attending the hospital and the impact of the necessary changes was developed by clinicians, family liaison nurses and the PREM team at our institution. The PREM was distributed to carers whose child was either a planned or emergency admission to the Paediatric, Neonatal or Cardiac intensive care units between December 2020 and March 2021. Quantitative and thematic analysis of responses was undertaken.

Results To date, 80 PREMs have been given to carers and 67 completed questionnaires have been received (76% response rate). Overall levels of satisfaction were very high, with 94% reporting that they were very or mostly satisfied with the intensive care team and the service they provided. Nearly two-thirds of the carers were concerned about catching COVID whilst on the intensive care unit but this decreased to 43% for other public areas of the hospital, such as the cafeteria.

All carers understood the need for them to wear a mask but only 65% agreed that staff were able to interpret and respond appropriately to their emotions when they were wearing one. One third of respondents reported that they did not get the emotional support they needed from family or friends. Some carers found the restricted visiting policy challenging, with 24% reporting that it was not acceptable that the sole carer permitted at the bedside could not change as needed. This was supported by the qualitative comments, which indicated that whilst parents understood the rationale for the one carer policy, it caused additional distress.

Loneliness and lack of physical contact were identified by parents as particularly stressful, together with the need to cope alone with complex information. Carers described being 'fully alone' without their partners, which affected the mental health of both parents and resulted in feelings of despair and confusion.

Conclusions Our intensive care is one of the largest paediatric units in the UK and during the pandemic we increased our capacity to accommodate intensive care patients from other paediatric units that reconfigured to treat adult patients. During the pandemic, our usual approach to carer support was challenged by visiting and communication restrictions, the impact of which may have long-term consequences. Despite these challenges, we were able to sensitively provide the high standards of care expected by patients and their families.

Paediatric Mental Health Association

1457

IMPROVING RISK ASSESSMENTS FOR PAEDIATRIC INPATIENTS WITH ANOREXIA NERVOSA USING A TECHNOLOGY-BASED APPROACH

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Background Anorexia Nervosa (AN) has the highest mortality rate among mental health disorders in adolescence. Yet, patients with AN can appear misleadingly well, making it challenging to predict who is at risk from complications. No single measurement is sufficient to determine this risk. Only where careful assessment is made and taken together with the correct physiological and biochemical tests, can level of clinical concern safely be gauged. The Royal College of Psychiatrists provide a framework for such assessments, in a publication named *Junior MARSIPAN*. These set out a number of parameters each of which, if sufficiently deranged, may constitute a 'red flag' indicating high clinical risk. As young people with AN often present to inpatient paediatric services, it is important that these parameters are considered by the clinicians caring for them in these contexts.

Objectives To evaluate the thoroughness with which inpatients with AN are assessed for severity of their condition on a paediatric ward in the North East of England, where local guidelines advocate for use of the *Junior MARSIPAN* framework for risk assessment. Where possible, to improve upon the completeness of such assessments using a technology-based approach.

Methods A retrospective process audit was conducted on all patients with AN admitted to paediatric services in 2014–17. Clinician's assessments were examined for documentation of 18 parameters recommended for assessment within *Junior MARSIPAN*. Following this, we introduced a calculator designed to strengthen and simplify assessments by processing the *Junior MARSIPAN* algorithm, correcting for age and gender automatically. The impact of this on completeness of assessments was evaluated through subsequent reaudit over 2018–20.

Results 41 admissions spanning 2014–17 were found. In only 10% (4) of these, a clinician had assessed all 18 risk parameters. However, in the subsequent 23 admissions following introduction of the calculator, the rate of fully completed risk assessments increased to 74% (17). After the calculator was implemented, all clinicians completing fully comprehensive assessments had done so with assistance from the calculator. Conversely, all those who did not utilise it had made omissions.

Where assessments contained omissions, the most frequently missed parameters pertained to history and examination. Overall, key risk-determining features were missed in 58% (37) of histories and 52% (33) of examinations, respectively. Meanwhile, postural blood pressure changes were missed in 20% (13), and electrocardiograms in 13% (8) of the admissions. Biochemical tests, weight measurements and vital signs were seldom missed.

Conclusions Thorough assessments are imperative to avoid missing subtle signs of severity in AN. Using a complete audit cycle, we have demonstrated that local implementation of a technology-based solution to such assessments can assist clinicians in completing these comprehensively. This may prevent hidden red flags from being missed. Further, the frequently omitted parameters identified through this audit highlight areas where clinician assessments often fall short. Emphasising through education the importance of these domains, including careful clinical and cardiovascular assessment, may help to further mitigate shortcomings in clinical assessment going forward.