anonymously. A 5-point likert scale was used to gauge the experience of adolescents with the addition of a free text response to allow for further comments on patient experience.

Results Fifty-three patients completed the survey with 99% rating their overall experience as good or better. The majority of participants were not known to paediatric services (85%). 43% of respondents had attended an ED in the previous twelve months of which eleven had previously attended an adult ED. Over half of these patients (55%) preferred the paediatric setting. Conversely, 70% of those who previously attended a PED wished to continue to be seen in this setting. Common themes included reduced fear and anxiety in PED, as well as the perception that paediatric staff have a better understanding of needs. Additionally, adolescents with specific needs expressed a lack of readiness to attend adult services with concerns surrounding lack of familiarity and challenging sensory environments.

Conclusions The majority of adolescents surveyed showed preference for the PED with environment and communication approaches identified as influencing factors. Our study highlights the importance of considering the needs of the adolescent as distinct from those of young children and adults. Wherever emergency care services are delivered to young people, providers should strive to provide an 'adolescent friendly' environment to meet physical, emotional and psychological needs. Clinical need, service capacity and individual choice should be considered in future decision-making tools to determine the setting in which emergency care is delivered.

Paediatric Mental Health Association

1625

CAMHS INTENSIVE OUTREACH DURING COVID-19 LOCKDOWN: HOW DID CHANGES NECESSITATED BY COVID-19 IMPACT SATISFACTION WITH THE SERVICE?

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Background The views that service users hold concerning their healthcare needs have long been regarded as important, as they are a key component of person-centred care. The first COVID-19 lockdown in England, beginning in March 2020, necessitated Child and Adolescent Mental Health Service (CAMHS) providers to conduct many consultations and assessments remotely, where remotely is defined as in a format other than in-person (such as a telephone or video call). However, such practices were previously uncommon, hence little is known about whether service users feel that these remote ways of working can continue to meet their healthcare needs. This study aims to investigate whether remote CAMHS consultations and assessments are as acceptable to children and young people (CYP) and their parents or carers as the in-person equivalents.

Objectives To assess the acceptability of the newly remote practices of a CAMHS Intensive Outreach Team implemented during the first COVID-19 lockdown (March 23rd 2020 – May 30th 2020). This was facilitated through telephone

interviews with the CYP (aged 0–17) who accessed the service during this time, along with their parents or carers.

Methods The emergency departments of three hospitals within the same region of England were used to source participants for the study, along with a CAMHS Intensive Outreach Team serving the same locality. A database of CYP who were referred to this outreach team from these emergency departments during the first COVID-19 lockdown was generated (n=84), along with their primary parent or carer (n=84). All were invited to the study by a postal letter (n=168), and telephone interviews were carried out with those who responded to the letter. Acceptability was assessed through questions inviting a rating on a 10-point Likert scale. The questions assessed whether the service user felt 'supported and heard' and 'respected,' during their consultation, and whether they were 'happy' with it. Of the participants, some had consulted with the CAMHS team in-person, and others had consulted with them remotely. Responses from each category were separated after the data collection phase, to allow for statistical comparison of the results between the in-person and remote consultation groups.

Results Telephone interviews were conducted with 36 CYP, and 77 parents or carers. Results were statistically analysed through use of an independent two-tailed T-test. Of the CYP, there was no significant difference between the Likert ratings of acceptability for in-person consultations (n=27, M=8.7) and remote consultations (n=9, M=9.3), conditions $t(29)=2.064$, $p=0.020$. Of the parents or carers, there was also no significant difference between the Likert ratings of acceptability for in-person consultations (n=53, M=8.1) and remote consultations (n=24, M=7.9) conditions $t(56)=0.586$, $p=2.667$.

Conclusions The COVID-19 pandemic has provided a unique avenue to investigate whether previously uncommon remote ways of working are as acceptable to CAMH service users in the mainstream. Our findings support the idea that remote CAMH consultations are just as acceptable to both CYP and their parents or carers as their in-person equivalents, suggesting that their continued use could be a welcome addition to mainstream practice.

Association of Paediatric Emergency Medicine

1626

SINGLE CLERKING: A MORE EFFICIENT PAEDIATRIC ADMISSION PROCESS FOR THE COVID-19 ERA AND BEYOND

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Background Traditionally, patients requiring admission from the Emergency Department (ED) are initially clerked by the ED team. Following this clerking they undergo a further clerking by a junior grade from the specialty team, and then they are reviewed by a senior member of the specialty team. This traditional clerking style creates duplication of work, reduces patient flow whilst awaiting further clerking and delays the time to review by the specialty senior decision maker.

Objectives This is an evaluation of a new single clerking referral pathway for children and young people that require admission to General Paediatrics from the Paediatric Emergency Department at Royal Manchester Children's Hospital. It was introduced in October 2020 to streamline the patient admission journey and reduce duplicate clinician contacts in light of the increasing number of COVID-19 cases.

The introduction of the single clerking pathway meant that patients requiring admission were clerked by the ED team and then referred directly for review by a senior member of the paediatric team, avoiding a duplicate clerking from a junior paediatric grade. A senior grade was defined as an ST3 or above.

Methods A retrospective review was undertaken of all referrals to general paediatrics from the ED for seven consecutive days (12th-18th October 2020) prior to the implementation of the pathway. Six weeks after implementation of the pathway a further seven consecutive days (6th-12th December 2020) of referrals were reviewed. The primary outcome was to determine the mean time from attendance to the ED to review by a paediatric senior grade clinician.

Results 76 children were referred to general paediatrics from 12th to 18th October; 21 of these cases had a traditional clerking. The mean time from attendance to the ED to review by a senior member of the paediatric team was 202 minutes. 17 of the remaining 55 cases had either a simultaneous clerking by junior and senior grade, or a direct senior review from the general paediatric team. The mean time from attendance to the ED to senior input for these patients was 170 minutes, suggesting that even prior to implementation of the pathway the single clerking structure streamlined the patient's journey. There were a total of 38 cases excluded from analysis due to incomplete documentation.

During the week of 6th to 12th December, 80 children were referred to general paediatrics from the ED; 25 admissions had a documented single clerking as defined in the new pathway. The mean time from attendance to the ED to review by a senior member of general paediatric team was 151 minutes. The remaining 55 admissions had either inadequate documentation or incorrect implementation of the pathway.

Conclusions The introduction of a single clerking pathway has shown promising early data by demonstrating a 25% reduction in mean time taken for senior specialty input compared to a traditional clerking. The next stage will aim to address the reasons why the pathway was not implemented and strategies to improve documentation of clinical interactions as it is recognised that large number of cases were excluded due to inadequate documentation.

British Association of General Paediatrics

1628

DETERMINING STANDARD PRACTICE FOR IV FLUID MONITORING AND PRESCRIBING IN OVERWEIGHT CHILDREN

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Background Intravenous (IV) fluids are one of the most common therapies prescribed in paediatric inpatients, with maintenance fluid volumes calculated using the Holliday-Segar 4,2,1 formula based on body weight. This does not account for ideal vs. actual body weight and overweight children are at risk of fluid administration above their actual requirements. There appears to be no consensus in the literature on adjustments for overweight children when prescribing IV maintenance fluids, and no recommendation is mentioned within the local or NICE guidelines. For monitoring these patients, the guidelines recommend measuring plasma glucose and electrolytes when starting IV fluids and at least every twenty-four hours thereafter. From experience, blood glucose is rarely measured for monitoring purposes with regards to IV fluids.

Objectives To determine common practice in the Royal Hospital for Children, Glasgow (RHC) for IV fluid monitoring and prescribing in overweight children.

Methods A survey was created using Google Forms and distributed to RHC prescribers and pharmacists. There were ten questions in three sections addressing knowledge about weight/height recording, IV fluid prescription in overweight children and glucose monitoring in patients on IV fluids. Respondents were asked to select one or more ways in which they identify if children are overweight and how they would prescribe fluids in these patients.

Results Seventy-seven responses were received from paediatric medicine, surgery, intensive care, emergency medicine and pharmacy, covering all clinician grades. Of respondents, 99% and 77% know where patient weights and heights can be found, respectively. If heights are required, 56% and 30% find these are not or only sometimes recorded, respectively; 14% do not often look for heights.

To assess if patients are overweight, 23% use subjective judgement alone, while others use a variety of other methods, including body mass index (BMI) calculation or using mean weight for height and age. For overweight children, 70% of prescriber respondents prescribe IV fluids based on the child's actual weight up to a maximum of 83ml/hour for females and 104ml/hour for males. A further 8% prescribe IV fluids at reduced rates without specific calculation. Other methods include using 50th centile values or BNFc mean weight for age.

Of respondents involved in IV fluid monitoring, routine measurement of blood glucose is done by 10%, but not or only sometimes done by 68% and 22%, respectively. Frequency of monitoring was reported as 26% daily and 63% patient dependent, with one respondent stating 'when I remember'.

Conclusions Patient heights are not often available when sought, which prevents accurate assessment of BMI and ideal body weight. Standard practice for IV fluid prescribing in overweight children among clinicians of all grades in RHC is variable and current guidelines on monitoring are not closely followed. Despite guidelines advising daily blood glucose monitoring in patients on IV fluids, this is generally not done. Therefore, further work is required to determine safe and clinically feasible protocols to guide IV fluid prescribing and monitoring in paediatric inpatients.