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.