Methods Two 75-minute sessions for seven and eight fourth-year medical students respectively were delivered remotely, with two Paediatric Education Fellows at the patients' bedside, and a third Fellow remotely.

Each session included two paediatric inpatients. Selection criteria:

1. Clinical stability
2. A cubicle
3. Clinical signs visible via webcam
4. Condition precluding F2F students (e.g., awaiting SARS-CoV2 results)

Families provided written consent Students on their fourth-year paediatric attachment were invited to partake voluntarily and all agreed. Students completed a confidentiality agreement. Approval was provided by the University, hospital management and Trust IG department.

Patient and parent acceptability, and educational utility for students was assessed via questionnaire. A faculty focus-group met after each session.

A large amount of quantitative and qualitative feedback data was collected.

Results Parent feedback:

(n=3, 1 lost to follow-up) All parents stated they felt adequately informed about what the session involved, they and their child felt comfortable, and they would be willing to participate again. Parents commented positively about the reduction in infection risk, and used the analogy of online school to explain the format to their children.

Student feedback:

(n=13, 2 lost to follow-up)

Twelve of the total thirteen students felt able to participate actively. Ten students reported the sessions improved their approach to history-taking, and twelve their approach to differentials, investigations and management. Seven reported the sessions improved their approach to clinical interactions. Three reported their structuring of clinical examination improved, potentially reflecting that most sessions were history-taking focused. Only one student reported technical issues significant enough to affect learning. Despite positive feedback on remote, students prefer F2F, as expected.

Themes from qualitative student feedback included:

1. Useful when self-isolating
2. More students learn from one 'interesting' patient
3. Exposure to patients not allowed to see F2F

Faculty experience:

No IG concerns identified during/after sessions, reflecting extensive pre-planning. All patients and families invited agreed to partake including an acutely unwell teenager. Sessions required considerable investment of time on the part of facilitators.

Conclusions We present an innovative approach to overcome COVID-19 limitations to medical education. This work demonstrates that bedside paediatric clinical teaching can be successfully delivered remotely to medical students. Our results highlight educational benefit for students, acceptability to patients and families, and that IG requirements are met. It is expected that student feedback on remote learning of clinical skills will improve as facilitators gain more experience and explore different session emphases. A training package for facilitators is now planned.

British Paediatric Allergy Immunity and Infection Group

1655

A REVIEW ON *STAPHYLOCOCCUS AUREUS* BACTERAEMIA PRESENTATION AND MANAGEMENT AT A TERTIARY CHILDREN'S HOSPITAL

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Background *Staphylococcus aureus* bacteraemia (SAB) is one of the most common causes of sepsis and PICU admission in children. However, there is limited research done on paediatric SAB worldwide, and thus there is a wide variation in management.

Objectives To review the demographics, presentation and management of SAB at Sheffield Children's Hospital (SCH) over a one-year period.

Methods A list of all blood cultures positive for *Staphylococcus aureus* (SA) between June 2019 and June 2020 were provided by the Microbiology department. Blood cultures taken from the same patient during the same illness were grouped together as 'patient episodes'. The patients' hospital electronic notes were then reviewed.

Results 25 positive blood cultures were analysed within the study timeframe. This represented 18 patient episodes. 9 (50%) episodes were associated with a central line. 1 episode was associated with methicillin-resistant *Staphylococcus aureus* (MRSA). 16 episodes were associated with fever.

All 9 patients with central line associated SAB had complex medical needs, and 7 out of 9 patients were under 5 years of age (77%). 5 (55%) patients had paired central and peripheral blood cultures collected, and 4 out of 5 showed SA in both cultures. None of these episodes required admission to intensive care. 5 patients developed SAB within 2 weeks of central line insertion. When reviewing line management after diagnosis, 7 patients had their lines removed within 30 days of being unwell. The remaining 2 patients experienced recurrent exit site infections that required multiple courses of antibiotics, and eventually had their lines changed.

In contrast, the patients in the non-central line associated SAB group were evenly spread below 5 years and above 10 years of age. 4 patients were fit and well prior to their illness. Sources of SAB were evenly distributed between pulmonary, skin and joint foci. 2 patients required fluid resuscitation and inotropes at presentation, resulting in intensive care admission.

In terms of investigations, 16 out of 18 patients had echocardiograms, of which 15 were normal (1 was equivocal). We found that the CRP took a similar time to peak (average 1 day), halve (5 days) and to be less than 10 (9–13 days) in both groups.

Antimicrobial choices and length of treatment in both groups varied greatly, and decisions for oral switch and antibiotic duration were often poorly documented.

Conclusions This study was limited from its small population size. However, the findings still highlighted the importance of early central line removal to treat SAB, as well as high incidence of SAB within 2 weeks of line insertion. In this evaluation it was interesting to note that positive paired peripheral cultures did not alter management, and the yield of abnormal

echocardiograms was low. The study has shown a wide disparity in antimicrobial choice and duration for SAB even within one hospital, and the need for central line infection prevention and management guidelines, better central line-associated infection surveillance outside critical care, and improved documentation of long antibiotic courses. It is hoped that further research could be done to optimise paediatric SAB management.

British Association of Perinatal Medicine and Neonatal Society

1657 NEONATAL DRUG WITHDRAWAL FROM INTRAUTERINE EXPOSURE TO ANTIEMETICS

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Background Neonates exposed to a variety of substances in-utero can develop transient signs and symptoms of toxicity or withdrawal after birth. Whilst the neonatal abstinence syndrome (NAS), typically observed after gestational exposure to physically addictive substances such as opioids, benzodiazepines and illicit drugs is well described, other substances affecting the central nervous systems (CNS) can also cause withdrawal but symptoms may differ from those observed in NAS. This is unsurprising given their different pharmacodynamic properties, yet clinical guidelines and scoring systems focus heavily on withdrawal from addictive substances.

There is a general lack of systematic data on medication during pregnancy, as pregnant women have traditionally been excluded from clinical trials. Current knowledge is thus largely based on data obtained from case reports and voluntary reporting systems such as the yellow card system. It is likely that toxicity or withdrawal from substances other than those implicated in classic NAS is underrecognized by health care professionals (HCP). This in turn will result in underreporting, and may adversely affect clinical care through over-investigation of transient symptoms and parental anxiety due to diagnostic uncertainty and well as disconcertment within the team. Furthermore, symptoms clinically consistent with withdrawal, but not considered attributable to maternal medication history may result in suspected information withholding about maternal substance use with resulting negative consequences.

Objectives Review of cases of suspected neonatal drug withdrawal from intrauterine exposure to antiemetics and review of literature.

Methods Descriptive case series of neonates admitted to the neonatal unit in Crosshouse between August 2020 and November 2020, having been exposed to antiemetics in-utero and showing altered psycho-motor behaviour not explained otherwise.

Results Two babies were identified 1) A term baby had been exposed to regular metoclopramide, cyclizine and prochlorperazine in-utero and developed severe respiratory distress requiring invasive ventilation shortly after birth. The baby was subsequently also noted to be hypotonic and jittery, with poor feed tolerance. Within a week all symptoms resolved and breastfeeding was established. 2) A baby was delivered at 32 weeks for maternal hypertension and had also been exposed

to cyclizine in-utero. The baby required non-invasive respiratory support for 3 days. Full enteral feeds were established within 5 days, and marked jitteriness was noted from day 2 of life but gradually resolved throughout the 2 weeks stay. Investigations to excluded other causes in both cases included cranial USS, CXR, blood tests for hypoglycaemia and electrolyte abnormalities, as well as investigations and treatments for suspected infection. Maternal history was scrutinized for exposure to other substances. The observed neonatal transient signs and symptoms were consistent with those previously described for drugs of the same drug group, namely jitteriness due to antihistamines (cyclizine; previous case report) and hypotonia, respiratory and feeding difficulties due to antipsychotics (prochlorperazine; summary of product characteristics).

Conclusions Whilst causality cannot be inferred from a case series, these cases highlight the need for more systematic research into medication during pregnancy to improve drug safety, and as well as the need to increase awareness and understanding of antenatal drug exposure amongst HCPs.

1658 TRANSCUTANEOUS BILIRUBIN MONITORING CLINICAL PATHWAY FURTHER REDUCES SEVERITY OF HYPERBILIRUBINAEMIA AT READMISSION OF HEALTHY TERM JAUNDICED BABIES

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Background Neonatal jaundice presents in approximately 60% of all term-babies. Management of jaundice contributes a significant proportion of up to 17.9/1000 babies readmitted in the first 28 day of life. In 2011 we adopted a unique whole systems approach for jaundice managing neonatal jaundice. This approach christened JETSET has been shown to reduce admissions, length of stay and severity of jaundice in healthy term jaundiced babies. In 2020, we implemented routine transcutaneous bilirubin (TcB) monitoring of jaundiced babies in community and hospital settings to complement our long-established clinical pathway.

Objectives We carried out a before and after study comparing the outcomes of jaundiced babies who met JETSET criteria and admitted to Transitional Care Unit but did not receive phototherapy.

Methods We retrospectively analysed data from Transitional Care Ward records for patients assessed for jaundice over 4-month time periods, 1 Aug to 30 Nov 2019 (pre-intervention) and 1 Aug to 30 Nov 2020 (post-intervention). Relevant demographic and clinical outcome details were collected and analysed. We used comparative statistical methods to compare the results from the two time periods. JETSET criteria were: Healthy term baby born at $\geq 36+0$ weeks with a birth weight of ≥ 2500 g who developed jaundice after 24 hours.

Results A total of 1423 (1372 $\geq 36+0$ wk) babies were born between 1 Aug 2019 and 30 Nov 2019 compared with 1441 (1384) babies in 2020. 137 babies were admitted to the Transitional Care Ward in the 2019 cohort compared with 157 in 2020. A total of 51 babies (26.2%) patients were assessed for jaundice and admitted to the Transitional Care Unit across both time periods. 10 (19.6%) patients were excluded for incomplete data sets. Data from 41 babies were included in