Conclusions There had been some initial hesitancy to use new system and availability of probes in all delivery areas. Simulation sessions for staff training and provision of spare probes in the emergency resuscitation kits have facilitated use. Hypothermia during transport is an identified area to improve.

British Paediatric Respiratory Society

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THE DIFFICULT ASTHMA MULTI-DISCIPLINARY CLINIC: SILVER LININGS OF THE COVID CLOUD

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Background An estimated 5–10% of children with asthma have problematic severe asthma, defined as asthma which is poorly controlled (chronic symptoms, episodic exacerbations, continued requirement for short-acting β agonists) despite a daily dose of at least 800 μ g budesonide or equivalent for 6 months or longer. Such patients should be referred to a specialist difficult asthma team in a tertiary care, in order to facilitate systematic specialist assessment and a multi-disciplinary approach to management.

Objectives As with most outpatient services, the delivery of paediatric difficult asthma (DA) clinics was disrupted by the COVID-19 pandemic. Teams were required to restructure clinics and operating procedures, in order to optimise patient care despite the restrictions on face-to-face appointments. This study aimed to assess the impact that the COVID-19 pandemic had on the initial assessment of patients referred to the paediatric DA clinic at a tertiary care, specifically in relation to being seen by the appropriate multi-disciplinary team (MDT) members and having relevant investigations completed.

Methods The electronic notes database was interrogated to provide a list of children and young people with asthma referred to the paediatric DA clinic between 1/9/2016 and 31/12/2020. In total 144 patients were identified, and their electronic medical records were retrospectively reviewed. Patients were considered to have been seen 'pre-COVID' if their initial appointment in the paediatric DA clinic occurred prior to 23/03/2020, and considered to have been seen 'post-COVID' if their initial appointment was on or after 23/03/2020.

Results Of the total 144 patients, 130 were initially seen in the paediatric DA clinic pre-COVID and 14 were initially seen post-COVID. In the post-COVID group, fewer patients had fractional exhaled nitric oxide (FeNO) (71%) and spirometry (57%) as part of their initial work-up. In the pre-COVID group, 85% had FeNO measured and 96% had spirometry. This was in contrast to the proportion of patients having a physiotherapy and psychology assessment; in the post-COVID group, 64% had physiotherapy review and 50% had psychology review following their difficult asthma referral, compared to 52% and 26%, respectively, in the pre-COVID group. The wait for initial specialist assessment after being seen in the DA clinic for the first time was also reduced in the post-COVID cohort. The median wait for physiotherapy and psychology assessment decreased from 91 and 180 days in the pre-COVID group to 70 and 35 days, respectively, in the post-COVID group.

Conclusions Unsurprisingly given strict restrictions on in-person appointments and aerosol generating procedures, assessment of FeNO and spirometry was lower in patients first seen in the DA clinic post-COVID. However, improvements were seen in relation to physiotherapy and psychology assessment in the post-COVID group, as the physiotherapist and psychologist were able to attend more DA clinics to see new patients at their first appointment. This highlights that changes to working in response to the COVID-19 pandemic can actually help to streamline services and promote early input from the wider MDT when managing patients with problematic severe asthma.

Association of Paediatric Emergency Medicine

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IMPROVING THE TRIAGE ORDER FOR PAEDIATRIC PATIENTS – A COLLABORATIVE QUALITY IMPROVEMENT PROJECT

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Background The Royal Hospital for Children (RHC) in Glasgow is the busiest paediatric emergency department in the UK with over 70000 attendances a year. With increasing attendances yearly and added system pressures due to COVID, we reviewed our triage system. In previous winters approximately only a third of the sickest patients presented by ambulance. The current system allows patients brought by ambulance to be triaged first, resulting in those brought by car waiting.

Objectives To develop a Scottish Ambulance Service (SAS) arrival flow chart to be used by ambulance staff to improve getting the right patient triaged at the right time. By utilising the flowchart, patients needing immediate triage or treatment must be identified, whilst identifying those safe to wait in time of arrival with patients brought by other modes of transport.

Secondary aims were to identify data for a group of patients that could potentially wait for triage without the SAS team.

Methods We developed a Flow Chart to be used by ambulance staff with 2 outcome arms – immediate SBAR handover and triage with nursing staff (urgent), or wait for triage by time of arrival (non-urgent), based on red flags, observation parameters (national PEWS) and clinical concern. Red flags were exclusion criteria for subsequent completion of the chart and indicated the need for urgent triage. Following a 2 week pilot study in September 2020, all SAS arrivals notes were reviewed in conjunction with their flow chart outcomes.

Results A total of 183 patients arrived by ambulance (10%). 71.6% of patients had a completed triage form or appropriate use of red flags/stand by status. 13.0% were stand by calls, 26.7% had red flags, 20.6% were classified as urgent and 39.7% as non-urgent.

Review of all cases showed that patients subsequently triaged as category 1 and 2 had attended by car and patients of low acuity triage categories had attended by ambulance.

Use of the flow chart showed that zero patients subsequently triaged as category 1 or 2 were classified as non-urgent by use of the flow chart.

Mean time to triage for those who arrived by ambulance was 10:03 (mm:ss) with a maximum wait of 36:00. In comparison, those attending by other transport methods had a mean time to triage of 10:18, with a maximum wait time of 57:00. The total number of patients was significantly smaller than the previous year ruling out direct statistical comparison.

29 (15.8%) patients were brought by ambulance and subsequently triaged as category 4 or 5. None of these patients deteriorated.

Conclusions Arrival by ambulance does not always equate to acuity of presentation. The pilot demonstrated that the flow-chart is safe in paediatrics with a robust list of red flags. With the national PEWS incorporated we can safely identify low acuity patients. The next pilot introduces a 3rd arm identifying low acuity patients with normal PEWS who do not require a verbal handover. This has the potential to impact on ambulance turnaround time and improve space within the socially distanced waiting room.

Child Protection Special Interest Group

697 CHAPERONES IN PAEDIATRICS – ARE WE THINKING ABOUT IT?

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Background Since the 2004 Ayling report (1), the offer of formal chaperone during intimate examinations has been mandated in health care settings and reflected in the GMC guidance (2). The use of Chaperone Policies across NHS Trusts has considerable variability (3 4) and in practice adherence with chaperone policies is often poor (5). Within paediatrics there may be confusion about whether the presence of caregivers negates the need to offer a formal chaperone, further compounded by the absence of clearly defined age limits.

Objectives The aim of the project was to evaluate compliance with the Trust formal chaperone policy within a tertiary paediatric hospital and to then develop strategies to improve performance.

Methods The Trust chaperone policy applies to all children and young people (CYP) under 18 years of age. The audit was conducted within the children's emergency department (CED) and children's outpatient department (COPD). Criteria for offer of a formal chaperone included unaccompanied CYP, intimate examinations (including upper torso examinations of female patients) and CYP or parents/carers with a history of difficult or unpredictable behaviour.

A prospective analysis of notes for CYP meeting the eligibility criteria was undertaken for paediatric CED attendances over a 7- day period and COPD attendances over a 2-day period in July 2019.

Data collected included:

- type of examination;
- documentation of formal chaperone offer (even if declined);
- name and designation of formal chaperone;
- gender (or gender identity) of formal chaperone and patient.

Results Of 567 attendances in paediatric ED and 118 COPD clinic attendances, 66 met eligibility criteria (9.6% of all attendances). Of these 6% were unaccompanied CYP and 94% underwent an intimate examination.

Only 10% of eligible patients in the paediatric ED and 8% in paediatric outpatients respectively had documented a formal chaperone. When a formal chaperone was documented there was >80% compliance with documentation of their name and designation and with being of the same gender/gender identity as the CYP.

Following the analysis, it was clear there were gaps in staff awareness of the policy and inconsistent documentation. A plan-do-study-act quality improvement method was used and the following interventions were implemented between November -December 2020:

- A chaperone poster was developed with staff and patient feedback and displayed in all clinical areas;
- A quick reference guide to the trust chaperone policy was created and disseminated to trainees at induction;
- An educational training video was created and presented to the consultant body and in the departmental trainee teaching;
- A chaperone sticker was introduced to be used in medical notes in paediatric ED and Outpatient departments to improve documentation.

Post-intervention evaluation is ongoing.

Conclusions The use of formal chaperone in the paediatric setting is increasingly important as a means to safeguard both young patients and the staff involved in their care. Compliance with Trust Chaperone policy in a busy Paediatric hospital was poor and highlighted gaps in staff awareness and inadequate documentation. A quality improvement approach may help to improve compliance in this challenging area of paediatrics.

British Society of Paediatric Endocrinology and Diabetes

698 THYROID DYSGENESIS IS NOT A COMMON AETIOLOGY FOR CONGENITAL HYPOTHYROIDISM

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Background Congenital hypothyroidism (CH) is one of the commonest endocrine problems in infancy. It is also the most treatable cause of mental retardation worldwide. In Hong Kong (HK), CH is screened by cord blood assay of thyroid function undertaken by the Clinical Genetic Service (CGS). Most neonates and infants with abnormal thyroid functions are referred to their birthing hospitals for further investigations and treatment if necessary.

Conventionally the subtypes of CH are identified by thyroid scintigraphy. It has been considered thyroid dysgenesis (TD) comprises the majority of cases of CH, with prevalence up to 85%, with the remaining best described as gland-in-situ (GIS), of which less than 50% is due to thyroid dysmorphogenesis (TH). However, this observation has been challenged recently, which may carry a prognostic implication on the need of lifelong thyroxine replacement.

Objectives We hereby report the prevalence of different causes of CH in Princess Margaret Hospital, a paediatric endocrinology center in HK, and compare to the data reported in the literature.