

determine the predictive factors for initiation of TAI in children with intractable constipation and faecal incontinence without neurogenic bowel dysfunction.

Methods We reviewed the records of children who were referred to a dedicated weekly consultant delivered community based multi-disciplinary clinic for severely constipated and encopretic children. Interventions to manage this condition were provided as appropriate for each child by the MDT team and they were reviewed as frequently as their clinical needs demanded by a consultant and a paediatric nurse. Demographic details, clinical information on constipation and faecal incontinence and the range of interventions given to each child were recorded in a customised database. Children and their carers fed back their progress weekly via a secure online customised database Qualtrics XM[®]. We analysed the data from the clinical and demographic details of the children who were referred to the service to identify any predictive factors for initiating trans-anal irrigation. We used descriptive and statistical methods to analyse our data.

Results 80 children (M:53) were referred to the dedicated community based multi-disciplinary PURA clinic for constipated children at The Hillingdon Hospitals NHS Foundation Trust. The average age was 10.2 yr (range 1-18 years). 44 (55%) children had recorded Cleveland Constipation (CC) and St Marks (SM) incontinence scores. 25 (M:16) children received trans-anal irrigation as part of the interventions to improve their condition. Children who received TAI had higher scores than those who did not: 15.9±5.9 vs 14.1±4.8 for CC ($p<0.17$) and 16.7±4.9 vs 13.4±5.3 for SM ($p<0.02$). Amongst those who received TAI, boys had much higher scores than girls 17.8±5.8 vs 13.4±4.5 CC and 17.4±4.8 vs 15±5.6 for SM scores. 16 (64%) of children who received TAI were diagnosed with learning difficulties. Of these 13 (81.2%) were boys. There was no difference in the proportion of male versus female children who received trans-anal irrigation in the cohort X^2 : $p < 0.4$. However, there was a significant difference in the proportion of male children with learning difficulties compared with female children who received trans-anal irrigation to manage their symptoms. X^2 : $p<0.04$.

Conclusion Learning difficulties in male children with severe constipation and faecal incontinence is a significant predictive factor for initiating trans-anal irrigation as part of a suite of management interventions to improve this condition.

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A PROLONGED JAUNDICE CLINIC- A NEED BORN OUT OF NECESSITY

Iyabo Oyibo, Patricia Donnelly, Satyaprabha Mohite. *Department of Paediatrics, Princess of Wales Hospital, Bridgend*

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Aims Neonatal cholestasis is characterized by conjugated hyperbilirubinemia in the newborn, which is a common sign to several hepatobiliary and metabolic disorders. Significant conjugated hyperbilirubinemia is of utmost concern in neonatal practice.¹

Neonates presenting with prolonged jaundice should be timely investigated because timely evaluation for its etiology is critical in order to quickly identify treatable causes such as biliary atresia, many of which benefit from early therapy.¹

In our DGH, these babies present to the paediatric assessment unit at random times to be reviewed. An audit in 2019 identified that a quarter of blood tests done for prolonged jaundice was haemolysed and needed to be repeated requiring multiple hospital visits. This led to increased workload to acute paediatric services. This initial audit also highlighted delay in checking results, and unclear follow up plans.

Hence, there was the need to revise our clinical pathway for babies with prolonged jaundice, and decrease the number of visits without missing serious diagnosis.

Methods We set up a prolonged jaundice clinic in September 2020 as a new service to improve patient experience, identify babies needing further intervention in a timely manner.

An initial telephone triage was done using the NICE guideline for prolonged jaundice.² The babies were booked into the clinic where they had a detailed history taken, thorough physical examination and direct examination of a stool sample, which was compared with the stool colour chart.³ All neonates coming to the clinic had venous blood sampling for conjugated and unconjugated bilirubin as first line of investigations. These results were chased within 24 hours. Results were discussed as per a revised pathway plan and follow up arranged.

A prospective data was collected to assess the new service.

Results A total of 42 babies attended the first 6 months of the clinic. Eighty percent (80%) were discharged at first visit as compared to 20% before the establishment of the clinic. Using venous blood sampling, haemolysed samples were significantly reduced from 28% to 14%. One baby was followed up but not jaundice related, and there was no referral to tertiary care.

Conclusion It was evident that a dedicated clinic with continuity of care was reflected in a better patient experience; also resulting in reduced workload for the acute services.

A clear written pathway plan for management, and timely availability of conjugated and unconjugated bilirubin results led to safe discharge and follow up of these babies.

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- Yellow Alert Campaign: <http://yellowalert.org/Baby-Jaundice>

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CONSULTING WITH CHILDREN AND PARENTS TO CO-CREATE RESOURCES ABOUT RECEIVING PAEDIATRIC OUTPATIENT PARENTERAL ANTIMICROBIAL THERAPY (OPAT)

¹Holly Saron, ¹Bernie Carter, ²James Munro, ³Rob Young, ⁴Enitan Carrol, ⁴David Porter, ⁴Ruth Cantwell, ⁴Claire Crouch, ⁴Julia Roberts. ¹Edge Hill University; ²Misternunro – Animation and Illustration by James Munro; ³Rob Young; ⁴Alder Hey Children's NHSFT

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Aims We aim to showcase how we engaged with children and their parents via a teleconferencing platform (Zoom) using the power of illustration to trigger their recall of going home on outpatient parenteral antimicrobial therapy (OPAT). This co-

creative consultation work was conducted to address the need, identified by children and parents in a previous research study, for enhanced preparation and information about OPAT.

Methods Children (n=4) who had received OPAT and their parents (n=4) were invited to participate by clinicians in the OPAT team at the children's tertiary centre. The children were sent specifically designed activity sheets asking them about their experiences in advance of an online activity consultation via Zoom. There was no set schedule for the online activity, instead conversation was triggered by the researchers asking the children about their drawings and responses in their completed activity sheets. Meanwhile, the illustrator listened, shared their screen, utilised the children's drawings and words and created new images that brought to life, in real-time, the experiences children and their parents shared. Children and their parents were in control of the process as they could direct, confirm or alter the drawings that appeared on the screen and ask for text to be added.

Results The freely available, co-developed resources include a 3-minute long animation (figure 1) and an information leaflet (figure 2), has been designed by and for children and their parents. Although remote engagement with children has become more commonplace, the use of real-time, co-creation based on children's illustrations and augmented by professional illustration and animation during the online activity is novel. The strengths (e.g. children enjoyed the approach) and limitations (e.g. reliance on stable Wi-Fi) of this approach have been explored. The findings from this consultation aligned with and added depth to understanding the experiences of children and parents about being at home on OPAT.

Link to animation: <https://www.youtube.com/watch?v=JERVuqmLLDM>

Link to information leaflet: https://figshare.edgehill.ac.uk/articles/figure/Things_you_might_like_to_know_about_having_your_medicine_at_home_information_leaflet_OPAT_/19180895/1



Abstract 872 Figure 1

How will I have my medicine?

When you go home, the medicine you will be given usually only needs to be given once a day. This means more time to play and do the things you like to do.

Your medicine will be given using your 'line'. You will need to be a little bit careful about your line. You might find that mum or dad keep reminding you about this.

Top tip

Keep your line covered up and don't let it get wet.



Abstract 872 Figure 2

Conclusion The COVID-19 pandemic has had a profound impact on the way consultation activities are conducted. This illustration driven, virtual consultation method with children receiving OPAT and their parents was successful and allowed the co-creation of free resources for other children and parents to use. Rather than constrain what was done, using virtual methods meant that children and their parents were able to engage with and co-create ideas for resources from the comfort of their own homes.

853 DISSEMINATING NEW CLINICAL GUIDANCE DURING A PANDEMIC

¹Zoe Cocks, ²Margaret O'Connor, ²Cassandra Barrett, ²Halina Kamarova. ¹St Helens and Knowsley Teaching Hospital NHS Trust; ²Alder Hey Children's Hospital

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Aims Establishing an innovative method of disseminating a new bronchiolitis guideline in a tertiary paediatric hospital.

The ripple effect of the Covid-19 pandemic and subsequent lockdown periods on the paediatric population has been far reaching.¹ With isolation drawing to a close, we saw a resurgence of patients presenting to hospital with other respiratory tract infections, including bronchiolitis, across the world.²⁻³ The median age of affected children also rose – attributed to the infection of older RSV-naïve children.²

In Autumn 2021, as social restrictions were lifted in the UK and children returned to schools and nurseries, our UK tertiary centre was seeing a rising number of admissions with bronchiolitis. It was imperative that our clinical practice in general paediatrics aligned with the most up-to-date evidence base, as outlined in the trust's new bronchiolitis guideline.

With social distancing of staff prevailing in our hospitals, we looked to novel ways to disseminate current best practice to our colleagues.

Methods A team of senior nursing and medical staff formed a focus group to explore ways of circulating this information effectively. We formulated an infographic, highlighting key points in our management of bronchiolitis, from the new guideline – figure 1. We created a personalised QR code to allow staff to access the full guideline by scanning our poster.

Multiple iterations were discussed within the team, in both face-to-face and online meetings.

The final draft was printed on A3, laminated and put up throughout clinical and non-clinical areas within the hospital. We worked alongside our IT colleagues to launch the poster as a screensaver on all trust computers and to share via hospital-wide communications emails.