

other healthcare facilities. It is resistant to a large number of antibiotics. MRSA bacteremia in children often has serious sequelae. Children with severe disability have chronic illnesses, receive frequent antibiotics, have invasive procedures and are more likely to be hospitalised multiple times. They are therefore assumed to be more at risk of MRSA colonisation.

Method As part of the trust infection control surveillance, the trust funded a pilot survey of MRSA colonisation among 25 children who attended the play group for severely physically disabled children at the child development centre. All children were under three years of age, wheel chair bound or with multiple disabilities. All had disabilities from birth or soon after and 80% had spent time in the neonatal unit. More than 50% of the children had had invasive procedures such as placement of a nasogastric tube or a gastrostomy or had cardiac surgery. All children had been hospitalised on more than one occasion and in more than one hospital. These factors were considered to place them at higher risk of being colonised with MRSA.

25 children were swabbed after obtaining informed consent from their parents. 2 Swabs were taken from the nostril, axilla or groyne of each of the 25 children and transported in appropriate media directly to the laboratories for testing for MRSA. The swabs were taken opportunistically by the doctor from each child when they attended clinic for their medical review.

Results All the swab results were reported negative for MRSA.

Conclusion The severely disabled children in our survey were not colonised with MRSA in spite of multiple predisposing factors. The risk of spreading MRSA within the playgroup was low and the children could continue to participate fully in communal activities.

G226(P) WHY DO WE REVIEW CHILDREN?

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Background The waiting list for review appointments in our Community Paediatric clinics is getting longer. We get frequent calls from parents and other professionals regarding delayed appointments. This audit was undertaken to attempt to change the mind-set of clinicians about offering review appointments "just in case".¹

Aims To identify the main reasons for offering follow-up appointments and to explore whether children could be reviewed by methods other than 'face to face appointments'. We also looked at whether some children could be reviewed by other health professionals.

Methods The audit was conducted prospectively on all patients seen by Community Paediatricians from 1st May to 31st May 2012. A form (table 1) was devised and agreed at the team meeting to be completed on all children who were offered a further follow-up appointment.

Results In total 305 forms were completed. The main reasons for follow up were to monitor developmental progress, to review children with complex special needs and medication review. 16/305 was offered further appointment on parental request. For 247/305 (81%) children, continuing with 'Face to face' review in clinic was the preferred option. For 44/305 (14%), Clinicians felt the children could be reviewed in an alternative way. In this group, for 34/44 children the preferred option was by another trained professional and for 10/44, by telephone review. It was identified Team around Child meetings was not a suitable option to review children.

Conclusions Most children still need to be seen at 'face to face' clinic review. However in 14% (1 in 7) of children, alternative

Abstract G226(P) Table 1

Why do we review children?

Main reasons:

- Monitor developmental progress
- Medication review
- Complex special needs
- Parental request
- Special schools(MLD/SLD)
- Safeguarding concerns
- Other

Review after:

- 3 mths
- 6mths
- 9mths
- 12mths
- Other

Could this be done differently?

YES NO

If yes please select the correct method -

- Tel
- School Nurse/ Specialist HV
- TAC/ESP meetings
- Other

methods to review children can a preferred option. This can offer opportunity to increase capacity without adversely affecting quality of care.²

Specialist Health Visitors, Nursery Nurses, and Tier 2 Primary Mental Health Workers were identified; as possible professionals who can be trained to review children. Following the audit it has been planned to develop a system to record a specific reason why Clinicians wish to offer follow-up appointments and to develop a pathway to identify children who can be seen by other professionals with appropriate training. A monthly telephone review clinic will also be piloted.

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G227(P) AUDIT OF RCR 2008 STANDARDS FOR RADIOLOGICAL INVESTIGATIONS OF SUSPECTED NON ACCIDENTAL INJURY

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Aim Review compliance with above guidelines and compare with performance from a previous year.

Background RCR and RCPCH consider imaging the injured child critical to the process of child protection. The RCR guideline published in March 2008 seeks to provide an evidence based framework which supports the radiologist in contributing to child protection. It encourages best practise and communication between different agencies working together to safeguard children in the investigation of suspected physical abuse. This follows recommendations from the Climbe enquiry and ensuing legislation.

Methodology We compared the performance before (2007-08) and after (2009-10) RCR guidelines were published. Notes were

requested from both sites in the trust. The standards to compare were identified and information collected in a proforma. This information was later summarised using Excel spreadsheet.

Results 31 case-notes where skeletal survey (SS) was performed over these two periods were reviewed, of these 17 cases were suspected physical abuse, 12 were for unexpected child death/SUDI and 2 were for genetic reasons.

- 17/31 skeletal surveys studied were for presumed NAI, –4/17 before (2007–08); and 13/17 (2009–10) after 2008 guidelines – 2/14 for genetic conditions, 12/14 for child death or SUDI
- Of 17/31 with presumed NAI, presentation included – Bruises 10/17 – Fracture 3/17 – Scalp swelling 4/17 (1 had bruising and scalp swelling) – Occult – suspected shaken baby syndrome
- Communication between paediatrician and carers poorly documented – Concerns 1/3rd (pre) and 2/3rd cases (post) – Explanation of imaging 0/3 (pre) and 1–3/12 (post) – Consent for imaging 0 (pre) and 0 (post)
- Communication between Paediatricians and Radiologists poorly documented, only 2–3/17 cases
- Good performance with respect to – Timing (< 1 day), 3/4 (pre) and 8/13 (post) – Completeness of Skeletal Survey 4/4 (pre) and 12/13 (post) – Verbal report (< 1 day) 4/4 (pre) and 12/13 (post) – Final report (<1 day) 2/4 (pre) and 11/13 (post)
- Report, scope for improvement in –Age of injury 2/2 (pre) and 1/3 (post) – Bone density 3/4 (pre) and 2/13 (post) – Differential diagnosis 1/2 (pre) and 4/7 (post)
- Additional information from skeletal survey 2/17, (~ 12%)

Summary The study revealed good performance in completing and reporting skeletal survey but documentation of concerns, explaining pathway, sharing concerns with radiologist and some aspects of reporting were not consistent.

G228(P) CHALLENGES OF REFERRING CHILDREN TO SOCIAL CARE FOR REFUGEE COMMUNITY ORGANISATIONS

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Aims To describe the reasons why refugee community organisations make safeguarding referrals to children's social care. To describe the actions taken by children's social care after such referrals have been made and their effects.

Methods All safeguarding referrals made by one London refugee community organisation between December 2002 and December 2012 were reviewed. The categories of abuse under which each referral was made, other relevant factors and the outcomes of the referrals were recorded.

Results

Abstract G228(P) Table 1

Category	
Neglect	4
Neglect + physical abuse	4
Neglect + physical abuse + emotional abuse	3
Neglect + emotional abuse	2
Physical abuse	5
Physical abuse + emotional abuse	4
Emotional abuse	3
Sexual abuse	1
No category stated	1

Abstract G228(P) Table 2

Outcome	
Assessment done	21
Result	
No action	18
Child in need	4
Child protection plan	4
Other intervention	1
Effect on relationship with organisation	
Continued as before	17
Continued after a break	5
Permanently broken	5

Conclusions Refugee community organisations frequently make referrals to children's social care. The referral and social care assessment can lead to the breakdown of the relationship between the organisation and the family concerned, leading to a loss of support for the child. Enhanced forums for discussing the cases of vulnerable children with social care outside of making a formal referral are needed to improve the coordination of services.

British Society for Paediatric and Adolescent Rheumatology

G229 A, B, C, DON'T EVER FORGET THE JOINTS! – A YORKSHIRE PAEDIATRIC RHEUMATOLOGY NETWORK AUDIT

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Aims To assess if the musculoskeletal (MSK) examination was being performed, in eight paediatric centres across Yorkshire, when the clinical situation would suggest it was warranted, using the pGALS examination tool¹

Methods 397 case notes were randomly collected and reviewed retrospectively for patients who had presented to hospital between August–November 2012. Each centre assessed approximately 50 sets of patient's notes

The admission notes were reviewed to find out whether a MSK examination had been documented by the doctors on the initial assessment and then the first and second reviews, if there were triggers or red flags for the examination.¹

Evidence of documentation of the systemic clinical examinations performed and pertinent clinical variables, including times of admission and the grade of the doctors reviewing patients, were noted.

The information was collected on excel spreadsheets at source hospitals and collated by the audit team to investigate the trends across Yorkshire.

Results 35% of the 397 admissions had a trigger for a MSK examination.

26% of the 397 admissions had a red flag for a MSK examination. Not a single patient who needed a MSK examination on initial assessment or first review had a full MSK examination documented. In comparison 80% of patients routinely had a respiratory and cardiovascular examinations documented on initial assessment.

Only 1 out of 105 patients who had a red flag for a MSK examination had a complete examination documented.

Conclusions In 2004 the musculoskeletal examination was shown to be poorly documented.² This audit shows that the musculoskeletal