hypoglycaemia in neonates receiving PN 2012, and the UK National Confidential Enquiry into Outcome and Death (NCEPOD) recommendations 2010 for venous access.

Methods A questionnaire was devised by a pharmacist, paediatrician and neonatologist. Questions focused on key areas commonly encountered in routine PN practise, for which guidance is available. These included protein and lipid introduction, monitoring and complications of lipids, management of hyperglycaemia and venous access. One researcher conducted a telephone survey to registrars working in all 58 level 3 neonatal intensive care units (NICU) throughout the UK.

Results The response rate was 58/58 units (100%). For preterm neonates requiring PN, protein is commenced on day 1 in 88% of units and lipids by day 3 in 91%. Most units exclusively use central lines for PN administration. All units use x-ray verification of catheter tip position with 19 units also using contrast. Triglyceride levels are not monitored in 22 units. Management of hyperglycaemia is variable, with 25 units using insulin first line and not altering glucose infusion. Seven units avoid insulin use completely.

Conclusion Many nutritional support practises were consistent and in line with guidelines. However over a third of units fail to monitor triglyceride levels despite the known consequences of high lipid infusions and recommendations for monitoring. The high usage of insulin in the management of hyperglycaemia may not be advantageous considering recent findings around the risks of hypoglycaemia and mortality. The use of contrast for line verification is not nationally standardised.

G59(P) LONG-TERM PSYCHOLOGICAL AND SOCIAL IMPACT REPORTED BY CHILDHOOD CRITICAL ILLNESS SURVIVORS: A SYSTEMATIC REVIEW AND THEMATIC SYNTHESIS

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Aims Over 250,000 children annually in the US and UK experience critical illnesses. Advances in medicine and care have significantly reduced mortality, with over 95% of patients that survive. However, the long term psychological and social impact, as reported by children and adolescents that survive critical illness, is unclear. This paper reports a systematic review and thematic synthesis of qualitative literature that aims to explore and understand these phenomena.

Methods CINAHL; MEDLINE; PMC; PsychINFO; ASSIA and Dissertation and Thesis Databases were searched between 1806 and February 2012. Studies were selected using eight predetermined criteria (e.g. only qualitative empirical studies) and methodological quality was assessed using two standardised checklists (1, 2). Thematic synthesis (3) was used to extract, code and synthesise data.

Results From the 1307 studies identified, three met the inclusion criteria which were all of moderate methodological quality. All included studies were conducted in the UK involving a total of 51 participants aged 1–25 years. Reasons for participant critical illness were predominantly due to head/spinal injury, sepsis, or malignancies.

Eighty-six codes and six novel themes emerged from the data. Themes included: confusion and uncertainty; other people's narratives; focus on former self and normality; social isolation and loss of identity; transition and transformation. Analytical synthesis culminated in a framework which attempts to conceptualise the childhood survivors' journey.

Conclusions Childhood critical illness can expose survivors to a complex trajectory of recovery with residual psychosocial adversity manifesting in the long-term. Health professionals need to comprehend and support the potential complex psychological and social

needs that may occur. Further empirical research is required to explore and test the conceptual framework developed from this thematic synthesis.

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G60(P) THREE YEAR RETROSPECTIVE REVIEW OF VIRAL RESPIRATORY INFECTION IN PAEDIATRIC INTENSIVE CARE ADMISSIONS

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Introduction During the H1N1 2009 Pandemic season, all children ventilated on Paediatric Intensive Care (PICU) for respiratory failure had respiratory samples taken for virology screen.

H1N1 (2009) was declared eradicated both national and internationally in August 2010. We reviewed results of samples taken during and beyond this period and compared the respiratory isolates.

Methods All Nasopharyngeal Aspirates, Non-direct bronchoalveolar lavage or tracheal secretions from admissions in the months of September to April of 2009/2010, 2010/2011 and 2011/2012 were reviewed. The months of May to August of each year were regarded as off peak and so left out of the study. PICU admissions, discharges and death notifications records were correlated with virology reports.

Results Samples were processed from 287 PICU patients or episodes. 192(67.1%) of the children were ages 0–2 years. (154)53.8% of the patients were male. One or more Respiratory viruses was isolated in 159 samples (55%). RSV accounted for 77(48.4%) of the positive samples, Rhinovirus 45(28.6%), Para-influenza virus Type1–4, 14(8.8%), Adenovirus 9(5.7%), Pandemic H1N1 (2009) 8(5.1%), Influenza A or B 3(1.9%) and Human Metapneumovirus 2(1.3%). Coinfection was found in 12(7.5%) of the positive samples.

Oseltamivir (Tamifu) was prescribed to positive cases in the population. Resistance to Oseltamivir was reported in one case treated. There were ten (3.4%) mortalities from the study population two of whom were positive for Pandemic H1N1 (2009). A serious co-morbidity was present in all 10(100%) mortalities. We isolated a virus in 7/10 (70.0%) deaths. No positive swabs for H1N1 (2009) was found after January 2011.

Conclusion While we continue to carry out surveillance for sporadic or seasonal cases of H1N1 (2009), with the pandemic truly over, resources needs to be devoted to common respiratory viruses with greater burden of disease.

G61(P) SEVERE DIABETIC KETOACIDOSIS: THE BENEFITS OF 'PHONING A FRIEND'

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Aim To evaluate the management and outcome of children with severe DKA who were referred by different District General hospitals within the region to Regional retrieval team for advice.

Method Retrospective audit of all patients with diagnosis of DKA, referred to Regional Retrieval Team between November 2010 – June

2012 were included in the audit. Data was collected via the RRT database and Retrieval referral forms.

Results Over twenty months NWTs received 1637 referrals from 29 District General Hospitals in the region out of which 20 patients (1.22%) were severe DKA. 6/20 were newly diagnosed DKA.

At time of referral 10/20 were noted to have significantly reduced GCS, requiring hypertonic saline and an urgent CT scan.

Following advice from NWTs, only 7 were transferred to PICU and rest were managed in their local DGH; each followed up for a period of 24–48 hours with minimum of two follow-up calls.

3 out of 7 transferred to PICU had very low level of consciousness (GCS 3–4/15); the rest had intercurrent illness e.g. sepsis, myocarditis and non availability of HDU beds.

All patients survived and only one patient (who also had problems with severe tachyarrhythmia and associated poor cardiac output) had evidence of neurological injury.

Conclusion With advice and support the local DGH team can be guided through the management of severe DKA including those with reduced GCS, with good outcome.

The DGH clinicians value the support available from Regional Retrieval Team as many are unfamiliar with management of such rare situations.

The majority of patients did not require transfer to tertiary centres which benefited both the patient and family and allows best utilisation of resources.

G62(P) RETROSPECTIVE ANALYSIS OF PICU READMISSIONS OVER A ONE YEAR PERIOD

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Aims Readmission may suggest premature discharge and may be detrimental to the patient's care. Our aim was to determine our PICU readmission rate and review the patterns of readmission.

Methods A retrospective case series analysis was performed. Patients with multiple admissions during September 2010 to August 2011 were identified using the computerised information system, CIS.

Patients who had been discharged home or had an elective readmission were excluded. The CIS and hospital case notes of the patients were analysed using standard proformas.

Information recorded included readmission reason, length of stay, time from discharge to readmission, CEWS scores prior to discharge from PICU and intervention required in PICU (figures 1, 2, 3).

Results 39 patients were readmitted which represents a readmission rate of 3.8%. 10 patients were readmitted within 24 hours of discharge (26%), 14 were readmitted within 3 days (36%) and the remainder between 4 and 7 days. Average time of readmission was 60 hrs (mean) with a range of 3 hrs to 168 hours.

The majority (23–60%) of the patients were readmitted with respiratory distress. 3 patients were readmitted with cardiac failure. 4 patients were readmitted with life threatening events (10%)

The majority of patients were cardiac (52%).

The majority of patients had a CEW score of 0 prior to discharge.

Almost half of the patients (46%) readmitted required ventilation, 12 required inotropic support. The rest required observation only.

9 patients were readmitted for less than 24 hours (23%), 10 (25%) patients for between 1 and 3 days and 20 (51%) for more than 3 days. The longest readmission was 73 days, median 202 hours.

Conclusion A readmission rate of 3.8% is within the accepted norm although there is a lack of paediatric data.

Most of our patients were readmitted with respiratory distress usually caused by the same condition necessitating initial admission. The majority of our readmissions occurred within 72 hours. The patients that did not require ventilation had a generally short admission (mean 38 hrs). There was a large group, however, who required a lot of intervention and had a prolonged second admission. We did not identify any clear avoidable risk factors for readmission.

G63(P) INVESTIGATION OF FAMILIAL VESICO-URETERIC REFLEX IN INFANTS, IS IT WORTHWHILE?

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Abstract G62 Figure 1