

G129(P) CAN A COMBINED TOOL WITH PAEDIATRIC ILLNESS SEVERITY ASSESSMENT AND PAEDIATRIC EARLY WARNING SCORE BE USED AS A SAFE TOOL FOR DISCHARGE OF PATIENTS FROM OBSERVATION AND ASSESSMENT UNIT?

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Aim Our aim is to evaluate if Paediatric Illness Severity Assessment (PISA) and PEWS can be used as a combined tool for safe discharge of patients from Paediatric Observation and Assessment unit (POAU).

Method We reviewed the PISA and PEWS scoring on patients attending our POAU over a busy winter on three randomised days. All patients routinely had PEWS assessed by nursing staff at the time of admission, discharge and as needed in between these two. PISA was calculated from the clinical notes. The combined tool was used to assess whether patient needed admission or discharged home. If discharged home, data was collected if there were any complications or readmissions.

Results A total of 52 patients were studied. Their age range varied from 1 day to 15 years. 37 patients were discharged home and 15 were admitted to the hospital. All of the children who were discharged had an initial PEWS score of or less than 4 or had good response with the PEWS score dropping to 0 to 2 with intervention, while their PISA grading suggested mild or moderate risk. There were no major complications in those who were discharged home. One patient was readmitted, which the parent was already cautioned. 5 patients who were admitted to the hospital had PEWS score of 0 to 2 but their PISA grading was moderate to severe risk, indicating the need for hospital admission. All those with an initial PEWS scoring above 4 or those with persistent score above 3 needed hospital admission and their PISA grading suggested moderate risk. The combined PISA and PEWS tool, in our study, when used for discharge, had a sensitivity (the probability of the child being discharged) of 100% and specificity of 97.3% with a PEWS scoring below 2 and PISA grading of mild risk.

Conclusion The Combined tool with PISA and PEWS provides clinical guidance in safely discharging patients home from the observation and assessment unit. We recommend performing a prospective study to validate this combined tool in a larger study population.

G130(P) AIRWAY AND NUTRITIONAL MANAGEMENT IN PIERRE ROBIN SEQUENCE: A REGIONAL EXPERIENCE

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Aims To describe the airway and nutritional management strategies used in a regional cohort of infants with Pierre Robin Sequence (PRS), their associated syndromes and anomalies, and their subsequent outcomes regarding growth, development and mortality.

Methods Setting: Regional Cleft-Lip and Palate Network. A tertiary referral Service. Retrospective case note study.

Participants 55 sequential infants with Pierre Robin Sequence (as defined by the triad of micrognathia, Cleft-Palate and Glossoptosis) identified between January 2003 and December 2009; including 4 infants who transferred out of area and 4 infants who died.

Interventions Airway management consisted of Positioning, Nasopharyngeal Airway, Continuous Positive Airway Pressure, Ventilation and Tracheostomy. Nutritional management consisted of oral feeding, nasogastric tube feeding and Percutaneous Endoscopic Gastrostomy.

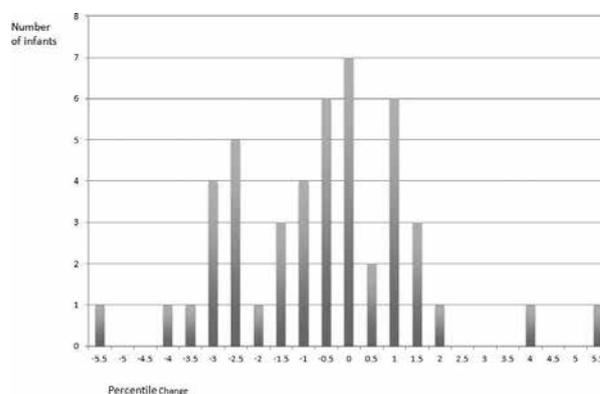
Main outcomes: Weight and growth percentile as measured at birth and cleft palate surgery. Grommet insertion. Developmental Delay. Mortality.

Results 13 (23.6%) of infants had syndromic PRS (sPRS), 17 (30.9%) had other associated anomalies and 25 (45.4%) had isolated PRS (iPRS) (n = 55). The majority of infants had their airways managed with prone positioning 40 (73%) (n = 55).

Abstract G130(P) Table 1 Total number of infants undergoing airway-management strategies

	Total	Percentage
Positioning only	40	73%
NPA only	4	7%
Trache only	1	2%
CPAP only	4	7%
Vent only	2	4%
NPA and Trache	0	0%
NPA and CPAP	0	0%
NPA and Vent	0	0%
Trache and CPAP	0	0%
Trache and Vent	1	2%
CPAP and Vent	1	2%
NPA, Trache, CPAP and Vent	2	4%

The majority of infants 26 (55%) (n = 47) fell to a lower growth percentile by the time of cleft-palate surgery (figure 1).



Abstract G130(P) Figure 1 Change in growth percentile from birth to cleft-palate surgery (n = 47)

13 (24%) had documented developmental delay (n = 55). There were 4 deaths (Mortality rate 78 per 1000 PRS births) (n = 55).

Conclusions Infants with sPRS and aPRS appear at greater risk of death than infants with iPRS. Airway management with positioning alone appears to be associated with a higher rate of mortality and failure to thrive in this cohort than other published techniques; its use should be reviewed. However there is inconsistent data reporting in the published literature. Future studies should include a published mortality rate; use standard definitions for iPRS, aPRS and sPRS; document weight gain in terms of growth percentiles and ideally use polysomnography to determine airway obstruction. Given that the practise of positioning is widespread and data inconsistent a national study including the above may be necessary to provide accurate data.

G131(P) THE EFFECT OF CONSULTANT DELIVERED SERVICES ON PATIENT CARE IN PAEDIATRIC ASSESSMENT UNIT

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