been referred and appointments booked pre-COVID but urgent (2-week) referrals from GPs were also seen.

Patients/parents/carers were called at least 3 times on 3 different occasions over at least 2 days. If they did not answer they were listed as 'was not brought'. Calls were made between 9am to 5pm Monday to Friday.

Results 262 new patients had new General Paediatric Clinic appointments and 235 (90%) were successfully contacted. 27 (10%) of patients 'were not brought'. These 27 patients were excluded from on-going analysis.

Following one telephone consultation, 105 (45%) contacted patients could be discharged from the General Paediatric clinic with parental agreement. Of these 27 (11%) patients had a complaint which had resolved by the time of the appointment and 19 (8%) patients had already been seen by a private consultant or other NHS consultant. Thus 46 (20%) of the contacted patients did not need their General Paediatric appointment.

Only 7 (3%) patients needed urgent face-to face-review of which 4 were urgent 2-week wait referrals by the GP. 155 (66%) patients needed no investigations.

Conclusions The NHS is going through uncharted, challenging time. However, this provides opportunities to adapt and evolve services, improving efficiency of care for both the families we look after and health service staff. The data above highlights that almost half of the new General Paediatric out-patients could be successfully discharged from clinic after one telephone consultation. During a time of significant anxiety and uncertainty families avoided hospital contact. A similar system when we return to normality could lead to fewer absences from school and less time off work for parents. Our experience suggests that initial telephone consultations with new General Paediatric patients may be an efficient way to make first patient contact.

42 CLINICAL CORRELATES OF CORD ARTERIAL LACTATE IN TERM BABIES

Pei Sen Tee. UK

10.1136/bmjpo-2021-RCPCH.29

Background Umbilical cord blood gas analysis is recommended to be taken when there has been concern about the baby in labour or immediately following birth and cord arterial lactate (CAL) has become a standard measurement on blood gas reports. However, evidence regarding thresholds for concern or appropriate management remains limited. Within our unit, guidance on further management of infants following detection of potentially 'raised' CAL was ratified based on available literature.

Objectives This study reports on the clinical correlates of a raised cord arterial lactate following introduction of a guidance to manage newborns with raised CAL.

Methods A single-centre retrospective review of all term neonates (>35 weeks gestational age) with a recorded CAL over a 6-month period (July 2018 to December 2018). Babies were identified from maternity monthly statistics and data extracted from electronic medical records. Clinical course and adverse events were evaluated between risk groups: Low-risk CAL ≤ 5 mmol/L, moderate-risk CAL 5–10 mmol/L and high-risk CAL ≥ 10 mmol/L. Adverse events include therapeutic hypothermia,

Abstract 42 Table 1

CAL (mmol/L)	Immediate Action	Further management/ investigations
<5	Baby to stay with mother. 'Routine' postnatal care	No follow-up
5–10	Baby to stay with mother, keep warm, encourage early breastfeeding.	<ul style="list-style-type: none"> • 4-hourly observations on postnatal ward for 24 hours. • Consider repeat blood gas in 4–6 hours from well perfused heel
>10	Consider admission to unit, cerebral function monitoring and careful neurological assessment	<ul style="list-style-type: none"> • Close observation including regular blood gases and blood glucose monitoring. • Discussion with senior clinician regarding plans (feeding).

mechanical ventilation, neonatal death and usage of non-invasive ventilation.

Results Among 2591 infants born ≥ 35 weeks gestation, 658 (25%) had a recorded CAL (44% had a CAL <5 mmol/L, 49% had CAL 5–10 mmol/L and 7% had CAL ≥ 10 mmol/L). Gender gestation and birth weight were in equal proportions in all 3 groups. The high-risk group with CAL ≥ 10 mmol/L required more resuscitation at birth, NICU admission and had more adverse events compared to groups with CAL ≤ 10 mmol/L. There was no difference in these events in infants where CAL <5 mmol/L compared to those with a CAL 5–10 mmol/L.

A repeat blood lactate level was taken in 48% and 98% of CAL 5–10 mmol/L and CAL ≥ 10 mmol/L groups respectively. The time range for first repeat varied widely and babies who had increased lactate level after repeat did not receive more treatment than those where the lactate fell. Routine repeat of blood lactate levels in clinically well babies with CAL 5–10 mmol/L did not appear to change management.

Conclusions A large number of babies are currently labelled as moderate to high risk based on a single raised CAL which may lead to unnecessary medical interventions. Better evidence is needed to determine the significance of a raised CAL, define clinically important thresholds for concern and optimal interventional strategies.

43 MEDICATION ERRORS IN PAEDIATRICS DEPARTMENT AND THEIR IMPACT ON PATIENT SAFETY

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Background Medication errors (MEs) represent a significant burden to healthcare system and the frequency of potentially harmful MEs was found to be three times higher in paediatric population when compared to adults¹.

Objectives This review aims to analyse MEs to improve medication safety and compare the frequency of MEs compared to the previous audit cycle.

Methods This is a retrospective analysis of medication errors in paediatric ward and neonatal unit utilising critical incident reporting forms (Datix) that were submitted from October 2018 to September 2019. These reports were obtained