## 67 TRANSITION TO ADULT CARE AUDIT CYCLE: IMPACT OF A CENTRAL TRANSITION TEAM

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**Background** Transitional healthcare is increasingly recognised as a priority for young people with chronic medical conditions. NICE quality standards for Transition were developed in 2016 to enable services to identify areas for improvement.[1] We performed a trust-wide audit examining compliance with the NICE quality standards in 2017, implemented new measures, and repeated the audit in 2019. The new measures were led by a central transition team and included a transition section in electronic notes, electronic 'live' transition plan, learning from complaints and incidents, identifying transition champions, addressing organisation-wide barriers to transition, developing clear pathways for accessing support for patients with complex transitional needs, and obtaining feedback on transitional experience.

**Objectives** Objectives were

1. To assess compliance with NICE Transition Quality Standards
2. To assess whether measures implemented after the 2017 audit resulted in a change to compliance with NICE Transition Quality Standards
3. To review subgroups of patients, including complex patients requiring transition under three or more specialties, to assess whether more input is required in these particular patient groups.

**Methods** We reviewed two weeks of inpatient data (30th Sept - 13th Oct 2019) to identify patients with long-term medical conditions requiring transition, and assessed their transitional care against the NICE quality standards. The methodology was identical in 2017 and 2019.

1. Did discussions around transition begin by age 14 (or at diagnosis, if later)?
2. Was there an annual meeting where transition was discussed?
3. Was there evidence of a named transition worker?
4. Did they meet a practitioner from adult services before transferring? [partially assessed as most patients had not yet had their care transferred]

**Results** We identified 43 transition episodes in 2017 and 90 in 2019. Overall, transitional discussions had started in 70% of patients, an improvement from 2017 (58%). Most patients still had not started transition planning early (36% 2017, 24% 2019) but more had an annual review (44% 2017, 73% 2019) and a named worker (20% 2017, 48% 2019). We identified three patients who had transferred to adult care without meeting an adult care provider. The transitional care of complex patients (under 3+ specialties) had significantly improved across all criteria between the two audits with 100% having started transition vs 66% in 2017.

**Conclusions** The 2019 audit demonstrated improvement overall, but identified areas requiring ongoing development particularly with early transitional planning. Next steps include age-based transition prompts in electronic notes, embedding links to transitional information in clinic letters, and arranging virtual visits to adult services.

### REFERENCES

1. National Institute for Health and Care Excellence. (2016). Transition from children's to adults' services for young people using health or social care services (NICE Guideline NG43)

## 68 SINGLE VERSUS SPLIT DOSE OF PREDNISOLONE IN THE TREATMENT OF RELAPSES OF CHILDHOOD NEPHROTIC SYNDROME

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**Background**

**Introduction** Childhood nephrotic syndrome follows a relapsing and remitting course. Corticosteroids are the mainstay of treatment and can be administered as a single early morning dose or as split doses. Usually, in the treatment of relapses, corticosteroids are administered **daily** until remission is achieved, followed by alternate day therapy. Early attainment of remission results in reduced morbidity and a reduced steroid burden.

**Objectives** To compare the time duration to attain remission using a single dose **versus** a split dose regime of prednisolone in the treatment of relapses of childhood nephrotic syndrome.

**Methods** Children between 1 and 14 years of age admitted to a tertiary care paediatric nephrology unit from August 2019 to February 2020 with a relapse of nephrotic syndrome were randomised to two groups. Patients in Group A received oral prednisolone at 60 $mg/m^2$ as a single morning dose while those in Group B received the same total dose as two divided doses(2/3 mane; 1/3 vesper). The treatment regime was continued until remission was achieved following which all patients were switched to alternate day prednisolone at 60 $mg/m^2$ which was given as a single morning dose. The time duration from the commencement of prednisolone to the attainment of remission for the two groups was compared.

**Results** 104 children were included, of which 49(age 2.16–13.8 years) received prednisolone as a split dose while 55(age 1.83–13.67 years) received a single morning dose. The mean duration to achieve remission was 5.04 days(SD 1.59;SE 0.22) for the split dose group and 6.74 days(SD 3.72;SE 0.50) for the single dose group. This difference was statistically highly significant. [$t(102)=2.967;p=0.001(<0.05)$]. There was no difference in the side effect profile.

**Conclusions** Use of prednisolone as a split dose results in earlier remission when compared to a single morning dose in the treatment of relapses of childhood nephrotic syndrome.

## 72 GOING HOME SAFELY, A FAMILY CENTRED APPROACH: FACILITATING THE DISCHARGE PROCESS OF PRETERM INFANT FROM NEONATAL INTENSIVE CARE UNIT

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**Background** Qatar is a sovereign state in the Middle East. Our Neonatal Intensive care unit in Woman's Wellness and Research Center(WWRC) is one of the largest Tertiary units in the Middle East with 20,000 deliveries per year and 4000 NICU admissions annually. Discharge process of preterm infants is a very complex issue that starts from the time of admission to discharge and follow-up post discharge. Preterm babies experience a much higher rate of hospital readmissions and death during the first year after birth compared with healthy term infants. Discharge plan should be individualized

to address both parent and infant needs. Careful preparation for discharge and good follow-up arrangement after discharge may reduce these risks. Comprehensive discharge planning includes assessment of the neonate's readiness for discharge and preparedness of families to care of their infant at home.

**Objectives** Applying the concept of Family centered care increasingly offers families opportunity to participate in care-giving and decision making throughout their hospital stay, gradually building their confidence and competence.

We aimed to improve the family participation in discharge process and reduce the percentage of cases being discharged post 4 hours from decision of discharge from 49%(our base line preintervention) to less than 20% in 12–18 months and reduce the readmission(in <72 hrs) rates to zero.

**Methods** A task force was formed to develop a comprehensive discharge readiness checklist. Discharge checklist contained various components to tick and sign by a team member/parent starting from 2 weeks prior to discharge till the day of discharge. It was reviewed daily during the ward rounds. As per the checklist parents were educated about medications, basic life support training, warning signs and symptoms of illness etc.

This checklist was continuously audited with PDSA cycles and interventions introduced to correct the problems resulting in delayed/incomplete discharges.

Parents were given a discharge folder that included all teaching handouts, medication sheets, growth charts, supplies, follow-up appointments with confirmed dates, relevant phone contacts and a copy of the discharge summary.

**Results** We achieved >95% compliance with the discharge process checklist and a reduction in delayed discharges from 49% to 2%. we also achieved zero readmission rates

**Conclusions** Discharge process requires a multi-disciplinary approach. Development of a comprehensive discharge planning toolkit facilitated the discharge process. This tool kit also enabled us in early identification of chronic cases nearing discharge.

We recommend that NICU should form a discharge facilitation task force and develop a discharge checklist/toolkit according to their available resources. This will not only facilitate timely discharges but also has a positive impact on staff and parental satisfaction, bed occupancy rates, cost savings, and better patient flow. We believe this process makes parents a stakeholder in the care of the baby. We will be happy for any unit to contact us for further information and guidance.

## 73 THE ROLE OF FECAL CALPROTECTIN IN PREDICTING ACTIVITY OF INFLAMMATORY BOWEL DISEASE IN PEDIATRIC AGE GROUP IN DUBAI HOSPITAL, UAE: 2012- 2016

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**Background** Inflammatory bowel disease (IBD) is affecting patients at increasingly younger ages. Endoscopy (upper/lower) with histopathology remains to be the gold standard for the diagnosis. Biochemical markers, as endoscopy is sort of challenging in children, were more and more evaluated in order to define children with high likelihood of needing such invasive procedure. Fecal calprotectin (FC) is raised in patients with IBD. However, it is also raised in other causes of intestinal inflammation. On top of that Studies evaluating FC during the initial investigation of children with suspected IBD have been limited, especially with regard to their small patient groups.

**Objectives** We aimed to evaluate the diagnostic accuracy of FCin diagnosing IBD patients in comparison with those who had other (non IBD) GIT stressors. Also to define a level at which FC can be safely relied on to distinguish between both.

**Methods** Using a retrospective case-control design all podiatric patients (<14 years) who underwent endoscopy in the period between January, 2012 to May 2016 were reviewed. All IBD and non-IBD patients who had a FC measurement available before or within 6 months of endoscopic evaluation were examined and FC results were obtained. FC was measured using the PhiCal Test. SPSS version 23 for windows were used to statistically analyse the results.

**Results** A total of 138 patients (45 IBD and 93 non-IBD controls) met the inclusion criteria. The median FC at diagnosis for IBD group was 1360 mg/L IQR: (556.5 -4085 mg/L), compared to median FC of 91 mg/L IQR: (34.5–277.5 mg/L) in the control group(P. value = 0.2653).There was no significant difference between different types of IBD (P.value = 0.24).Significant difference was noticed between the 2 groups when FC was taken at levels ≥850 mg/L with sensitivity 66.7% (95% CI: 51.1–80) and specify 87.1(95% CI: 78.6–93.2)

**Conclusions** This study validates FC as a highly sensitive marker for gut inflammation in general when low cut-off levels are taken. However it is poorly specific for IBD with significant result being only observed at relatively high cut-off values. Thus, FC can safely rule out IBD yet further investigations are needed when FC are above normal.

## 75 REVERSAL OF STUNTING IN HOLISTIC HEALTHCARE-EDUCATION PROGRAMME IN ODISHA STATE, INDIA

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**Background** Stunted childhood growth is a global problem, and is a major cause of morbidity and mortality. Its causes are complex and multi-factorial, reflecting chronic undernutrition during crucial periods of growth and development in early life. Its consequences are evident at the individual, family and societal level, and can extend into future generations.

A child has stunting if their height-for-age z-score (HAZ) is below 2 standard deviations (SD) from the median of the World Health Organisation (WHO) Child Growth Standards. Until recently it was thought that children could not recover from stunting after the age of 2 years, but this has been refuted by several studies.

**Objectives** We aimed to investigate the impact on children's height and weight, following enrolment in a free programme offering holistic healthcare, education and play, in Odisha state, India.

**Methods** We conducted a retrospective observational study analysing anthropometric data for children who are enrolled in the Love the One (LTO) programme in Odisha, India. LTO provides a holistic approach to education, healthcare and childcare for poor and deprived children. Children's height and weight were collected at admission to the programme, and annually thereafter for 5 years, and converted to a centile