1940 EATING DISORDER 'PANDEMIC'

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Objectives Children and young people (CYP) admitted with eating disorders (ED) during COVID19 increased dramatically, by 69%, from 2019–2021 according to NHS England.[1] This was reflected in Belfast on our general paediatric ward.

This project aimed to improve multidisciplinary team (MDT) communication and knowledge in the management of CYP using Junior Marsipan guidelines (JMG)[2] and the subsequent Medical Emergencies in Eating Disorders guidelines (MEED).[3] Secondary aims included educating healthcare staff regarding admission criteria, improving acute medical management of ED and providing patient centred care.

Methods An MDT admission care pathway and triage card were designed with contribution from paediatric medical and nursing staff, dietetics and CAMHS Eating Disorder Youth Service. The triage card and care pathway aimed to identify high risk CYP with suspected ED and guide medical staff regarding admission. The pathway directs history taking, investigations, medical management, potential complications, meal plans and CAMHS review. The eating disorder triage card was launched in May 2021 and admission care pathway in November 2021 in the Ulster Hospital.

We assessed staff confidence levels managing CYP with ED prior to the intervention in November 2021, using an online anonymised questionnaire. This evaluated staff knowledge, confidence and patient care provision. Respondents included consultants, registrars, SHOs and nurses.

A subsequent PDSA cycle in July 2022 involved review of the 2022 MEED Guidelines,[3] incorporating these into the admission care pathway. A key change was the updated risk assessment framework.

Results The initial questionnaire showed that 100% of respondents observed an increase in the number of ED patients encountered in their practice compared with pre Covid. 33% of respondents felt confident managing ED, 39% equivocal and 28% did not feel confident. Only 33% felt confident applying JMG when managing these CYP. Current MDT communication was deemed poor/very poor by 66.7% and 94% felt introduction of a care pathway would help management of children and young people with ED and MDT communication.

Conclusions CYP with ED are a challenging patient group and management requires an MDT approach. This project has improved MDT management/communication of CYP with ED on general paediatric wards. We are currently undertaking a questionnaire to assess staff feedback following introduction of the triage card and admission care pathway.

Our next step is to develop a regional eating disorder admission care pathway for use throughout NI. We plan to introduce an information leaflet for parents of CYP admitted for medical management of eating disorders and to collaborate further with the CAMHS ED service to streamline the referral process.

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1942 HOW CAN WE IMPROVE THE SERVICES WE DELIVER TO CYP EXPERIENCING A MENTAL HEALTH CRISIS?

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Objectives To evaluate the service provided by an Acute Children's Hospital for patients admitted with mental health issues during the first wave of Covid-19.

Methods Data was collated on patients admitted with mental health-related complaints between 1st March 2020 and 31st May 2020. This included 'intoxication'; 'overdose'; 'psychosis'; 'self-harm'; 'suicidal ideation/attempt'; 'CAMHS', 'disordered/reduced eating/anorexia'; 'mental health'; 'anxiety'; 'unwell'. Only patients admitted via Children's Accident & Emergency Department were included. Current inpatients, and those attending with injuries were excluded.

The following parameters were evaluated: presenting complaint; age; length of hospital stay; time medically fit for discharge (MFFD); time to see mental health professional (MHP); time MFFD to discharge; nursing ratio; number of readmissions; episodes of restraint; absconsions; and safeguarding referrals during admission.

Results 72 mental health-related admissions were identified. The mean age at presentation was 14.8years, with modal age 16years(33%). 10%(n=7) of these were admitted for disordered eating, while 90% were admitted for a range of mental health diagnoses. The modal presenting complaint was overdose(n=20), of which paracetamol(70%, n=19) was the most common substance.

The average length of stay was 59hours. 62%(n=42) patients were MFFD at time of admission, whilst a further 16%(n=11) were MFFD within 6 hours of admission. The mean time to see a MHP was 21hours with a modal time of within 24hours(42%, n=22), which correlates with the modal time from MFFD to time of discharge(n=24 within 24hours).

During the period of analysis, 10 patients(14%) were readmitted, of which 80% were readmitted twice, and 60% within 48hours of discharge. 18%(n=13) patients required 1:1 or 2:1 care, and a further 4 patients(6%) required hourly observations. Of those requiring 1:1 care, a resident parent/carer provided this in 18% of cases and RMN staff in 36% cases, whilst nursing staff made up 45% of the support. When 2:1 support was required, this always required a member of the nursing team to be re-allocated.

14%(n=10) of patients required physical restraint, which always involved the security team, and involved police in a third of cases, whilst chemical restraint by sedation was required in 10%(n=7). During admission to the ward as a 'place of safety', 3% patients attempted strangulation, and 3% took an overdose during their stay. 14%(n=10) patients absconded or attempted to abscond from the ward and 15% (n=11) patients triggered a safeguarding referral as a result of admission.

Conclusions This study highlights the resource burden of mental health(MH) inpatients – burden on nurse staffing, use of security team for physical restraint and use of chemical

restraint. It also highlights how frequently restraint is used in order to keep CYP safe, and encourages robust trust policies regarding Deprivation of Liberties. Risk of strangulation and further overdose during inpatient stays demonstrates the difficulties with non-mental health trained nursing staff caring for patients with complex MH needs.

With a readmission rate of 14%(60% within 48hours), there is a necessity to improve short term follow-up for CYP discharged with MH issues, and consideration of a separate unit for MFFD patients awaiting MHP review(62%).

1943 THE DEVELOPMENT AND EVALUATION OF A CHILD AND ADOLESCENT MENTAL HEALTH WEBINAR SERIES

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Objectives Increasingly, paediatricians see children and adolescents with mental health concerns in a variety of clinical settings.[1] While mental health features on paediatric postgraduate training curricula nationally and internationally, previous research suggests paediatricians continue to feel ill-equipped in the assessment and management of child and adolescent mental health, in part due to insufficient training.[2] This has been associated with suboptimal coping behaviours, such as clinicians not addressing mental health issues when they arise.[2]

To improve access to child and adolescent mental health education, and therefore, improve mental health care for children and young people, we introduced a free child and adolescent mental health webinar series via the Paediatric Mental Health Association.

Methods Webinar topics were decided by considering mental health presentations frequently seen in clinical practice, and using the mental health themes highlighted in the RCPCH general and sub-specialty paediatric postgraduate curricula. The webinars were initially delivered fortnightly and then monthly by subject experts, including paediatricians, psychologists, and psychiatrists. While webinars were primarily aimed at paediatricians, all healthcare professionals with an interest in child mental health were welcomed.

Subject matter webinars were interspersed with webinars to promote mental health paediatrics as a specialty, enabling more junior staff to interact with those established in the field. Some webinars were held in conjunction with other special interest groups. Each webinar was evaluated using qualitative and quantitative data collection tools. In addition, attendees were asked to consider whether the webinars would change their clinical practice, and how this may occur, in keeping with level three of Kirkpatrick's evaluation model.

Results Between June 2021 and June 2022, 18 webinars took place. There were usually 25–40 attendees from across the UK and beyond, and across different healthcare disciplines.

The webinars consistently scored highly for relevance (94.2%) and utility (93.5%), and generally scored highly for promoting change in practice (79%). When considering how the webinars would influence practice change, qualitative data suggests this would be via improved communication, clinical knowledge acquisition, development of personal clinical practice, and improved team working. Qualitative data also indicated some attendees felt attendance and engagement in webinars led to the formation of a new community, with one attendee stating the webinars 'really made me feel like I had found my people'.

Conclusions The webinars were introduced to improve access to child and adolescent mental health education for paediatricians. We provided curriculum-aligned teaching and offered a space where staff interested in child and adolescent mental health could meet other like-minded individuals. The data collected suggests the webinars promoted behavioural change via a range of means, which we hope will translate into improved mental health care for children and young people.

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1944 A RETROSPECTIVE STUDY ESTABLISHING THE REASONS FOR ADOLESCENTS TO PRESENT TO THE UHNM PAEDIATRIC GYNAECOLOGY CLINIC

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Objectives Paediatric and Adolescent Gynaecology is a diverse subspecialty of gynaecology, covering important issues for adolescents, including menstrual disorders and contraception. The primary objective of this study is to establish the most common reasons for adolescent presentation to a specialist paediatric gynaecology outpatient clinic as well as to understand the symptoms associated with menstruation that cause adolescents to present to secondary care services.

Methods A retrospective study was conducted using electronic documents and outpatient clinic letters to establish patient demographics, clinical details, investigations undertaken and management. The records of 595 patients who attended the Paediatric Gynaecology Clinic at the University Hospital of North Midlands (UHNM) across a 5 year period between July 2016 to June 2021 were analysed. Cases were analysed by age, presentation, investigations undertaken, diagnosis and any management required. Those with incomplete medical records were excluded from the analysis. Details from any follow-up appointments within the 5-year window were included within the clinical picture. Patients aged over 10 years old were considered adolescents within this analysis, to align with World Health Organisation (WHO) definitions.

Results Across the 595 patients included in the analysis, 433 (72.8%) were considered adolescent (≥10 years old). Across the adolescent population, there were 31 different reasons for presentation. The three most common reasons were menstrual disorders (44.6%), secondary amenorrhoea (9.0%) and abdominal pain (8.5%). Regarding menstrual disorders, the most common reason for presentation was heavy menstrual bleeding, affecting 64% of those presenting with menstrual symptoms and 29% of the total adolescents who presented to the clinic. Other concerns, such as oligomenorrhoea and dysmenorrhoea, affected 45% and 31% of those presenting with menstrual symptoms respectively. In total, heavy menstrual bleeding accounted for 20% of the total caseload of the paediatric gynaecology clinic across the 5 years analysed.