(42%).[3] This audit aims to survey the availability of paediatric DATs and difficult airway equipment in regional paediatric emergency units.

Methods A standard questionnaire for DAT and difficult airway equipment was devised according to the RCPCH guideline.[4] In February 2014, data was collected from senior nursing staff in all 34 regional paediatric EDs via telephone, email or in person.

Results 30 out of 34 units were included. Only 40% had a paediatric DAT on the unit, although all units had some paediatric difficult intubation equipment. A significant number of departments did not have capnography recording (23%), cuffed endotracheal tubes of all sizes (33%), or a cricoidotomy set (33%). Variation in the choice of laryngeal blades reflected individual preferences by specialists. 90% of units kept a daily checking rota.

Conclusion This survey highlights the need for improved availability of paediatric DATs and intubation equipment. Particular effort should be made to secure the more advanced equipment, and ensure the availability of a full size range for basic equipment.

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G74 IN THE AGE OF THE RAPID DIAGNOSTIC TEST, ARE THREE ROUTINE BLOOD FILMS NECESSARY TO EXCLUDE IMPORTED MALARIA IN CHILDREN PRESENTING TO THE EMERGENCY DEPARTMENT?

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Aims The number of children returning from areas endemic for malaria is increasing. Laboratory diagnosis of malaria has evolved with the advent of reliable rapid diagnostic tests (RDTs).[1]

We aimed to evaluate the reliability of RDTs at one of the UK's busiest children's EDs and to assess whether this might have implications for serial testing for malaria which can be distressing to children, inconvenient for families and costly to the NHS.

Methods We audited the use of malaria RDTs (Table 1) (*Carestart-Malaria*, *Apacor*) requested in the ED over a 12-month period (October 2013–October 2014), and compared their performance against the gold standard of microscopy.

Results Population (n = 104), 48% female (n = 50), with a median age of 2.5 years. Two children were excluded from the analysis as an RDT had not been performed alongside microscopy. Most children had returned from South Asia (58%), with 18% from Sub Saharan Africa.

There were no negative RDT results on preliminary testing with a positive diagnosis on microscopy. Overall, a first RDT had sensitivity of 100% and specificity of 97.8%. Of the children tested, 82% had only one RDT and blood film performed.

Abstract G74 Table 1 2 × 2 contingency table for malaria RDT

	Malaria	No malaria	Total
RDT positive	7 (4 *P falciparum*, 3 *P vivax*)	2	9
RDT negative	0	93	93
Total	7	95	102

Conclusion In this series, a single RDT combined with one film excluded malaria in returning travellers, and this is common practice within the ED and the wider Trust. However, other studies have reported that RDTs and preliminary microscopy can rarely miss infections.[2] A larger study needs to confirm the safety of a single RDT and film.

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G75 THE RAPID DEBRIEF: A TOOL THAT TRANSFORMS LEARNING AND SYSTEM CHANGE

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Aim To test the rapid debrief tool as a way of extracting immediate learning to implement system changes following the care of the critically child; overcoming the dispersion of people and memories in the traditional incident reporting cycles.

Method A rapid debrief was tested immediately after the care of a critically ill child was completed by the team. A template was used to collect what improvements were needed technically (resources, skills) as well human factors such as communication and leadership. Action plans were generated by the team. The debrief and action plan was then circulated to all staff and discussed at the weekly service meetings. Outcomes were monitored by the Paediatric Resuscitation Group.

Results A total of 29 rapid debriefs were completed over 12 months, generating 81 action plans, of which 50 have been completed. Many of the actions were completed before the incident forms reached the clinical governance system. 20 related to equipment, 5 to medications, 7 to team issues (communication, leadership), 10 training issues and 11 planning and organisation wide issues. Compared to the year previous to the rapid debrief, clinical Incident reporting now shows a 1.7 times increase of low risk incidence reporting; incidents of moderate or high risk have been reduced by half. Staff feedback has been very positive.

The learning outcomes include the development of safe handover tools, improving resuscitation resources and team needs, incorporating human factors into the resuscitation training to build team resilience and an open challenging culture.

Conclusion The rapid debrief has helped improve our care of the critically ill child through the immediate extraction of learning and implementation of improvements. The tool enables faster system change compared to traditional reporting governance systems.