G535(P) THE DEVELOPMENT AND IMPLEMENTATION OF A POLICY PROMOTING PARENTAL (PATIENT) INVOLVEMENT IN ESCALATION OF CLINICAL CARE

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Context Rapid recognition of deterioration in a child's clinical condition improves their quality of care and outcome.^{1,2} Parents of children who unexpectedly deteriorate often report awareness of the child's decline prior to medical staff.³ 'Equity and Excellence: Liberating the NHS' highlights the need for parents to be involved in all decisions regarding clinical care.⁴ Additionally, the Francis Report reinforces the need for 'openness, transparency and candour' in relation to all aspects of care.⁵

Problem In our tertiary children's hospital, a child on a medical ward deteriorated with acute renal failure. His parents recognised his worsening condition, but believed their concerns were not acknowledged, and felt powerless to intervene on their son's behalf. Child deaths reviews have highlighted parental concerns regarding delayed recognition of clinical deterioration.

These incidences prompted awareness of a need for a practical framework that enables parents to initiate escalation of their child's care when they believe it is required.

Intervention and Strategy for change across the Hospital A Standard Operational Policy (SOP) entitled 'Parent (Patient) Involvement in Escalation in Clinical Care' was developed by senior staff on PICU, the hospital liaison team, and parents.

The SOP contained the following elements:

- A requirement for staff members to formally record parental concerns in the medical notes using specific SBAR stickers
- A requirement for staff members to record their actions in response to parental concerns
- Options for 'escalation' to include formal review by duty nurse, the clinical nursing site team, or the on-duty medical team as appropriate
- Option for parents to discuss their concerns with their own Consultant at an appropriate time

The SOP was communicated to staff throughout the hospital at ward meetings, induction lectures, with posters in all in-patient and parent areas and via emails. Parental information was developed in Admission booklets and for the Hospital intranet.

Measurement of improvement An audit was performed 4 months following initiation of the SOP. Feedback was received from staff, patient records, and from 24 parents. Assessment criteria included the visibility of posters, parental and staff awareness of the SOP, and correct use of the escalation pathway with accurate documentation and appropriate follow up.

Additionally all cases in which the SOP was used were retrospectively reviewed.

Results

- All ward areas had posters displayed, although the number in each area varied
- Matrons, Ward Sister's and the Clinical Site Team were all aware of the SOP pathway; junior nursing (Band 5 and 6) staff were less informed
- There was poor awareness by trainee Medical staff and some Consultants
- No parent surveyed had formally 'accessed' the pathway
- When used, correct documentation using the 'SBAR' sticker was evident in all cases. Each case was appropriately escalated and managed. No parents expressed ongoing concerns regarding their child's care.

Effects of changes Where parents were aware of the SOP, the anecdotal feedback was positive. Additionally staff welcomed the escalation pathway.

Preliminary results have prompted us to further raise awareness amongst the medical staff and to provide more comprehensive literature to families.

This is being introduced in a sequential process with a need to re-audit once this work has been completed.

Lessons learnt Assessment of the impact of this initiative would have benefited from a survey of parental views pre and post introduction of the SOP.

Messages for others A formal pathway facilitating escalation of parental concerns empowers parents and may aid early recognition of clinical deterioration. This relatively simple intervention works to promote patient safety by integrating parental experience into clinical care.

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G536(P) THE CHALLENGES OF SETTING UP A KETAMINE SEDATION SERVICE IN THE PAEDIATRIC ED – LEARNING LESSONS AND EFFECTING CHANGE

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Context Our Emergency Department (ED) is a busy District General Hospital caring for 20,000 acute paediatric cases per year. Many children sustain minor injuries that need basic emergency treatment, often requiring a level of sedation to ensure it is undertaken safely, and without distress to the patient.

Problem Many children with minor lacerations and foreign bodies are currently referred onto inpatient specialties for these procedures. Sedation in the ED reduces the number of admissions for this and reduces the child and parent's distress.

Assessment of problem and analysis of its causes We audited 61 children aged 0–16 who attended the Emergency Department and were referred to our Maxillofacial Surgeons during September and October 2014. Of those 61, 9 were required to undergo a general anaesthetic (GA) for repair of their facial wounds.

A lack of set guidelines, which allow for a consistent and safe approach to ketamine sedation, was cited for the lack of service.

Intervention Based on the College of Emergency Medicine Guideline on ketamine sedation in the ED, we developed our own ketamine sedation guideline. It is a comprehensive guide that, accompanied with adequate training of individuals performing sedation should produce consistent methods of ketamine sedation, which adheres to college guidelines.

We also developed a standard operating procedure (SOP) checklist to be completed during sedation. Trainees must undergo a period of experiential training and observation of