On re-audit 32.5% more of discharge summaries were completed within 7 days of discharge. This enables GPs to carry out requests made e.g. repeat prescriptions, thus ensuring a safer discharge process.

Lessons learnt The whole departmental staff wasn't present at the induction session; those who weren't tended to make more omissions from their summaries, and were less efficient. We shall therefore run a session at the departmental teaching, as well as at induction, as part of the rolling audit.

Message for others We audited elements of the discharged summaries we felt necessary for a smooth and safe discharge from hospital to community care. By instructing new doctors on how to use the local computer program, we improved on the efficiency and degree of completion. A rolling audit has been started and further interventions will be made.

G564(P) PRE-OPERATIVE SCREENING FOR SICKLE CELL DISEASE: IMPROVING PARENT AND CARER EXPERIENCES

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Context As part of hospital policy, all children deemed high risk for the carriage of sickle cell disease presenting to the paediatric pre-operative assessment clinic are to be tested for the condition. This involves well children undergoing a blood test.

Problem It was found that considerable parental/carers anxiety was produced by this testing and much time was spent in a busy clinic counselling parents about the condition and the need for testing. Through the production of an information leaflet explaining sickle cell disease and the reason behind testing children prior to an operation, it was hoped parents/carers would feel more informed and thus more willing for their children to testing.

Assessment of problem and analysis of its causes Prior to implementation of the leaflet, of 21 parents/carers only two thirds (14) felt they fully understood the reason for testing (5/5 on qualitative scale) and only two thirds (14) felt fully happy for their child to have the blood test (5/5). 71% of parents/carers (15) thought an information leaflet would be useful.

Intervention An information leaflet was written by the authors, with expert review from a consultant paediatric haematologist. This passed the local procedure for patient information and was introduced to the clinic. Nursing staff handed out the leaflet to parents of children from at-risk ethnicities on arrival, giving parents time to read it before their consultation with the doctor.

Study design Over four weeks all parents/carers of children requiring sickle cell screening presenting to the clinic completed a qualitative questionnaire about their attitude to screening. An information leaflet was subsequently designed aimed at improving parent/carers' knowledge about sickle cell disease prior to consenting for the test. Following implementation of the leaflet a repeat qualitative questionnaire was carried out to assess the leaflet's impact.

Strategy for change Collaboration and education with nursing staff played a vital role in integrating the leaflet into the standard practice of the clinic.

Measurement of improvement A repeat questionnaire was carried out after introduction of the leaflet. Unfortunately there were relatively few children requiring screening during this month (total 9). Of those screened, 100% of parents felt that the reason for testing was completely clear (5/5 on quantitative

scale). 89% were fully willing for their child to have the blood test. 89% reported that they found the leaflet useful.

Effects of changes Subjectively, we have found that the consultations with parents are quicker and easier due to reduced parental anxiety.

Lessons learnt Patient information leaflets are a useful method of improving communication with families and improving families' experience of the service in pre-operative assessment.

Message for others This was a small project but was successful and we hope that our experience will encourage others to develop patient information when screening policies are in place as this is an area where medical concerns may not line up with parents' concerns.

G565(P) MULTI-PROFESSIONAL WORKFORCE TASK MAPPING IN GENERAL PAEDIATRICS

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Context Task mapping exercises have a valuable part in shaping future workforces. Our project examined the tasks undertaken by a multi-professional, non-consultant workforce in a large, busy general paediatric department, which provides secondary level paediatric care and also assists in the care of tertiary subspecialty patients, providing a total of 12000 inpatient episodes of care per year.

Problem Uncertainties around numbers of doctors in training allocated to the department in the future and the anticipated contraction of the junior medical workforce had led to new models of care provision. Introduction of international fellows and non-medical practitioners such as advanced nurse practitioners and physician associates into the team are seen as a way of developing a resilient and future-proof workforce.

Assessment of problem and analysis of its causes There was a perception of mismatched distribution of competencies within our team, with an assumed deficiency in middle grade level skills. Therefore, we embarked on a task mapping project to examine the spectrum of everyday tasks undertaken by the team in order to ensure that the non-consultant workforce had the right competencies to deliver safe and timely patient care.

Intervention A series of initial stakeholder meetings were held, and a task mapping sheet developed which coded all clinical and non clinical tasks that could be anticipated to be performed over the working day. Each team member was required to enter a code at 15 min intervals, as well as a code for any pending tasks, daily for 3 weeks. A pilot was run with senior trainees in the department following which amendments were made. Champions for the project were identified, and educational sessions with power point presentations were given prior to commencing the project.

Study design The study used a Plan-Do-Study-Act model as a framework. The data collection sheet was partially anonymised, requiring the individual to complete only their clinical grade and location of work.

Strategy for change Data analysed shows the amount of time each team-member group spent on each coded task. There is a reliance on middle grade staff for practical procedures – 66% of lumbar punctures are first attempted by registrars, and 40% of intravenous access. Attendance rates at educational sessions are highest by FY trainees, with lowest rates by registrars. There needs to be a cultural change, with reallocation of tasks from

registrars to allow the non-medical professionals to gain necessary experience and competence.

Measurement of improvement The non-medical professionals needs training to be able to manage the required tasks autonomously, before the mapping process can be repeated.

Effects of changes We anticipate that training of the non-medical workforce to perform more advanced clinical tasks will result in more efficient patient care, with better provision of training and education for those existing trainees.

Lessons learnt A post-task debrief identified a degree of anxiety that the process was being used as a performance assessment tool. This suggests discordance between participants' performance and their declarative knowledge of the task. Another challenge was "mapping fatigue" that became particularly evident as the project progressed. Social acceptability determinants of self reporting affects the validity of data and to ensure the integrity of the data, data collection by independent observers may be a more effective method.

Message for others Diversifying the workforce is inevitable for paediatric departments in the future. The multi professional task analysis we undertook is a pathfinder for other organisations who will need to undergo similar change. While multi professional workforce use is well developed in other areas, there has to be recognition of the time required for non-medical professionals to develop the breadth of knowledge and skills required to function autonomously at middle grade level in general paediatrics. Targeted training would speed up the development process.

G566(P) CHECKLISTS FOR TIME-CRITICAL EQUIPMENT FAILURE DURING PATIENT TRANSPORT

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Context Time critical faults with equipment can and have occurred during patient transport.

Problem Equipment failure can be a major problem during transport as spare equipment is not available in a timely fashion. It is essential to rapidly identify and resolve the problem to avoid patient harm.

Assessment of problem and analysis of its causes Previously our transport team relied on the clinical experience of staff to diagnose the fault, as well as "Quick Guides" for equipment. These "Quick Guides" are often up to 10 pages long and can be difficult to utilise effectively in a stressful situation.

Intervention We drew on the experience of other professionals who also encounter time critical faults. Pilots utilise emergency procedure checklists provided by the Federal Aviation Administration, which supply an immediate action sequence to be followed during emergency situations.

The systematic approach used by pilots (one pilot concentrates on maintaining flight through their Aviate / Navigate / Communicate approach, whilst another runs the checklist in an attempt to diagnose the fault) could be transferable to a medical setting (where one team member concentrates on maintaining patient stability through the Airway / Breathing / Circulation approach, whilst another runs the checklist in an attempt to diagnose the fault).

We produced single page checklists for each of the three different types of ventilator used by our service (see example below). After positive feedback from staff, we are now

producing checklists for therapeutic hypothermia failure and nitric delivery system failure.

Study design Checklists are produced by staff concentrating on their area of expertise, and are checked by senior staff members and with equipment manufacturers where appropriate. Satisfaction with the use of checklists was assessed by survey and their ongoing use will be reviewed during simulator sessions.

Strategy for change Checklists have been used during staff training days, to provide an opportunity for staff to familiarise themselves with them, and to receive feedback about their use. Relevant checklists have now been attached to each transport trolley, for reference in emergencies. Staff from other transport teams have now asked for copies to develop their use within their service.

Measurement of improvement Satisfaction with the use of checklists is high, based on responses to the question "Do you find equipment failure checklists useful?" (1 – not at all useful to 5 – very useful). We will formally audit the time taken to diagnose equipment faults with and without checklists during simulator sessions for bank transport staff, and also plan to use these sessions to refine the checklists.

Effects of changes Our survey suggests staff feel more confident in dealing with time-critical equipment failure since checklists were introduced.

Lessons learnt The process of development of checklists highlighted variation in practice amongst staff and reinforced the need for an efficient systematic approach to be adopted. The format of "Challenge-verification-response" checklists has been tried and tested in the aviation field during time critical emergencies and we believe is transferable to a medical setting.

Message for others Although equipment failure is more critical during transport (where spares are not readily available), checklists may provide a systematic approach to other emergency situations, and could therefore be applicable in neonatal units and paediatric intensive care. However, the information contained in them must be rigorously checked and tested prior to use. In addition, the temptation to provide too much information or to provide too many checklists should be avoided, as this will dilute their effectiveness.

G567(P) IMPROVING EFFICIENCY AND QUALITY OF CARE IN THE PAEDIATRIC ASSESSMENT UNIT

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Context The Paediatric Assessment Unit (PAU) in our District General Hospital arose out of necessity and occupies a small space with limited privacy. Acute attendances continue to rise and demand for PAU increases.

Problem Some children wait an unacceptable time for senior paediatric review and flow through the unit is poor. Longer stays (>4–6 h) are inappropriate. Consultant input is variable and junior rotas are understaffed. Parental questionnaires stated dissatisfaction with waiting times and facilities.

Assessment of problem and analysis of its causes A working group (consultant and trainee Paediatricians, senior nurses) aimed to standardise and improve quality of care, specifically, improving waiting times and patient flow. To assess the scale of the problem we: