

G574(P) IMPROVING PATIENT CARE THROUGH PAEDIATRIC SIMULATION AND MULTI-DISCIPLINARY RESUSCITATION TRAINING BASED UPON PREVIOUS SERIOUS INCIDENTS AT A DISTRICT GENERAL HOSPITAL

J Halbert, M Virgilio, A Dhalaria. *Paediatrics, Lister Hospital, Stevenage, UK*

10.1136/archdischild-2015-308599.523

Context The quality improvement project was undertaken at a District General Hospital and included staff who care for seriously sick or injured children including doctors and nurses working in general paediatrics, accident and emergency and anaesthetics. The appropriate initial assessment and resuscitation of serious ill and injured children together with on-going reassessment and emergency management are essential for reducing morbidity and mortality.

Problem There was no integrated multi-disciplinary team (MDT) paediatric resuscitation training and several paediatric serious incidents had involved more than one department. Simulation training increases the acquisition of skills and provides a platform to review performance and make errors without compromising patient safety. Both the Department of Health and RCPCH recognise the importance of simulation training in improving patient safety through reducing human and system errors. High fidelity manikins can be monitored which significantly adds to their realism.

Assessment of problem and analysis of its causes A retrospective review was undertaken by a paediatric trainee of all the paediatric serious incidents during a ten year period to identify common themes and key recommendations. The development of MDT resuscitation training was one of the principle recommendations to improve the emergency assessment and care provided to children.

Intervention MDT paediatric resuscitation training sessions involving healthcare assistants, nurses, doctors and other allied healthcare professionals from general paediatrics, accident and emergency and anaesthetics were planned several months in advance through a consultation process. Dates and times were chosen to maximise trainee availability and minimise disruption to routine services. For MDT training in accident and emergency, strategies were implemented to ensure patient safety at all times. Resuscitation officers provided support and resuscitation equipment. The hospital switch board was notified so a simulated paediatric crash call could be initiated through the hospital paging system. Scenarios were developed based upon previous paediatric serious incidents to review whether key recommendations had been successfully implemented and sustained. The focus was on familiarisation with paediatric resuscitation equipment, drugs and guidelines in real time as well as teamwork, communication and leadership skills and dynamics between and within the different specialties. A pilot paediatric simulation MDT training session was also undertaken in the Education Centre.

Strategy for change MDT paediatric resuscitation training was coordinated through the paediatric and emergency departments as well as the hospital resuscitation committee. Anonymous feedback through questionnaires was collected from participants.

Measurement of improvement The MDT paediatric resuscitation and simulation training received very positive feedback: "Excellent scenario, felt more real than other simulated scenarios I have attended." Participants found the MDT simulation training much more realistic than weekly departmental resuscitation training with 79% strongly recommending the simulation training compared with just 33% for the weekly departmental training.

Effects of changes MDT paediatric resuscitation training was successfully implemented. A business case was developed for the purchase of a paediatric simulation manikin to improve the reality of the training.

Lessons learnt MDT paediatric resuscitation training is a very valuable tool for improving teamwork and paediatric resuscitation skills. Paediatric high fidelity simulation training can enhance this further through providing a more realistic experience.

Message for others MDT resuscitation training should be routine practice in district general hospitals. Basing scenarios on previous serious incidents is a useful way to review previous key recommendations. A business case can be developed by demonstrating improved experience through a pilot high fidelity simulation trainer.

G575(P) PROMOTING QUALITY IN A COMMUNITY PAEDIATRIC DEPARTMENT

C Furnell, F Finlay. *Child Health, Sirona Care and Health, Bath, UK*

10.1136/archdischild-2015-308599.524

Context Work was done within a busy community paediatric department. The work looked at how we assess and promote quality.

Problem A lack of focus and evidence of quality.

Assessment of problem and analysis of its causes Within the department we had completed audits over the years on an adhoc basis, there were guidelines and pathways which were used but they were not always up to date. There was no universal way documentation could be accessed to see what had been done when, or when it needed repeating/updating. This meant that there was variability in the service we provided.

Intervention Initially we spent 2 days collecting data about the quality work being done already. Next we planned four interventions.

1. We created a database of audits, who was responsible for them and when they needed repeating. The database also noted if there were protocols and audit tools and if the audit had been presented.
2. We formed a centralised set of online files based on the current CQC standards. Supporting evidence was filed making it accessible to everyone in the department. Audit reports, pathways, patient information sheets, induction material and department protocols can be easily found.
3. We asked each member of the department to join a "champions" group focused on different areas of change. New trainees in the department are allocated to a group. These included:-

- Staff Wellbeing
- ASD
- ADHD
- Patient Voice
- Expectations

1. We organised a monthly "quality" meeting. This is an opportunity for the department to present any work so that we can all learn and share. Changes can be ratified quickly so consistent high quality care can be provided.

Strategy for change The most important strategy was encouraging each team member to feel responsibility for quality. An away day allowed us to develop a shared vision and the champion

groups will feed back on their progress at the monthly meetings to encourage action and momentum.

Measurement of improvement We have now completed departmental audits that are up to date and shared with the team. Our monthly meeting has a full agenda promoting and sharing best practice.

Effects of changes These changes have allowed the department to move to a more cohesive and coherent view of their work around quality. We have helped to standardise care, share good practice and maintain a quality service for the future. The staff wellbeing group has started a free fruit and lunchtime walking initiative. While the patient voice group have raised the profile of recoding this in clinic letters and meetings.

Lessons learnt One of the greatest challenges was getting colleagues to prioritise “quality” work above their clinical case load. In a busy department it can be hard find time to implement change. The quality day provided a different environment away from clinical duties to allow people to think about what we could do better.

Message for others Identifying “quality” and the evidence required to show this is the first step. Forming a central easily accessed folder containing all the information along with an index or database to assess progress is the next. Using the CQC standards as a template for our files helped us to organise our thinking in line with national standards. Engaging colleagues and encouraging personal responsibility to support ongoing improvement is also essential.

G576(P) LOOKED AFTER CHILDREN AT RISK OF BLOOD-BORNE INFECTIONS: A QUALITY IMPROVEMENT AUDIT

P Mikrou, G Cropp, V Sadavarte; Child Development Centre, University Hospital North Midlands, Stoke-on-Trent, UK

10.1136/archdischild-2015-308599.525

Looked After Children (LAC) is a term used to describe any children under the care of local authority. Currently, 83,000 children are Looked After in the UK and the number is steadily increasing. As part of a statutory health assessment, the British Association for Adoption & Fostering (BAAF) has published in 2008 a guidance to help with the identification, assessment, testing and referral of those children at risk of blood-borne infections (BBI).

In Community Paediatrics in our University teaching Hospital, specialist LAC clinics run 3 times per week. Our department trying to ensure that best care is delivered to this vulnerable population launched a quality improvement project, aiming to assess, how well and how effectively our service identifies and tests children at risk of BBI, interrogating simultaneously its cost-effectiveness. Taking into account the difficulties in organising and getting consent for investigations in the LAC population, the cost of those investigations to NHS, but, on the other hand, the implications of potentially missing a serious infectious disease, we wanted to ensure that only those children who met the criteria had a BBI screen.

We assessed our service provision through an audit, basing our standards on the 2008 BAAF guidance. This was a retrospective audit from June 2013 to June 2014. In total 212 children attended the specialist LAC clinic. A risk assessment was carried out, based on information about parental health and lifestyle and the results of antenatal screening for Hepatitis B, Syphilis and HIV. Hepatitis C results were only available in high risk population (IV drug users). 37 children (17%) were identified as

needing a BBI screen. Out of these, only 22 children (60%) were screened. 8 out of the 22 children (36%) had a complete screen (including Hepatitis B/C and HIV); with the remaining having a partial screen. 12 children had Hepatitis C positive mothers. Worryingly, only 8 of those 12 children (66%) had a BBI screen. There were no Hepatitis B or HIV positive mothers. Reasons for not having a BBI screen were difficulties in obtaining consent, failure to identify the children at risk or to get the extended information about parental lifestyle and screening results. BBI screen revealed 2 children positive for Hepatitis C antibodies and appropriate follow-up was arranged. No children had a BBI screen when that was not indicated.

We subsequently developed a protocol in the form of two flowcharts. These will be included in the LAC health assessment paperwork and aim to promote clarity and good clinical practice. As failure to obtain consent played an important hindering factor in getting our vulnerable population screened, we suggested, when possible, consent is taken at the time of consultation. Improved communication and information sharing between Health and Social Care is essential. Finally, team education is greatly important and will be reinforced by the integration of BBI risk assessment to the induction programme of the new community trainees.

The feedback has so far been very positive. We strongly believe it promotes good clinical practice. We plan to implement this in March 2015 and we aim to maintain and reinforce those changes by continuous monitoring and evaluation of our service.

Looked After Children are, sadly, a growing population in our society. Their health promotion and safeguarding is a responsibility of both Social Care and Health Authority. It is crucial that we, as health professionals, constantly strive to offer a high quality service, by enhancing clinical enquiries and audits, supporting changes to practice and implementing those for improved patient outcomes and experiences.

G577(P) IMPROVING RECORDING OF POSTNATAL WARD NEONATAL OBSERVATIONS

K Parkinson, Y Lim, A Demetriou, J Ziprin. Department of Paediatrics and Neonatal Medicine, Imperial College Healthcare NHS Trust, London, UK

10.1136/archdischild-2015-308599.526

Context This audit was carried out on two postnatal wards at different sites within the same trust.

Problem Whilst working on the postnatal wards we observed that the observations that babies required (e.g. after meconium delivery) weren't being carried out according to the frequency specified in the guidelines. Therefore causing a negative impact on patients due to the potential for missing a deterioration if observations were not carried out appropriately.

Assessment of problem and analysis of its causes We found on average 41% of the recommended frequency of observations were carried out on site 1 and 52% on site 2. More than 50% of the recommended observations were not done in the following categories; maternal GBS, phototherapy and hypoglycaemia in site 1 and in site 2; hypoglycaemia, and 33–35+6/40 gestation.

It was felt a possible reason why such a low percentage of observations were completed was due to lack of awareness of the frequency specified in the guidelines. Additionally at site 1 there is no set place to record observations whereas at site 2 separate charts are used. This may explain the higher percentage of recorded observations at site 2.