care for children presenting with anaphylaxis. We aimed to audit our local management against national standards.

Method A retrospective audit was conducted including all patients admitted with Anaphylaxis between Feb and August 2014 with an aim to evaluate our practice against national standards. Total of 10 patients were identified who were referred via A&E department as anaphylaxis.

Result Majority of patients were aged above 5 years. More then half of these children had associated food allergies.77% of our patients presented with mild allergic reaction and facial swelling was the commonest presenting symptom. IM adrenaline was given in 44% of patients. However, none of these patients have any life-threatening airway and/or breathing and/or circulation problems. These patients did not receive nebulised bronchodilator or adrenaline. All our patients were observed for 6–8 h.

77% of patients were prescribed adrenaline auto-injector on discharge however; none of these had documentation of training being given for auto-injector.100% of patients who were prescribed adrenaline auto injector had follow up arranged before discharge.

Conclusion Lack of formal structure to the management of children who presented with allergic reaction or anaphylaxis was identified. Children who were managed as anaphylaxis did not meet criteria. Hence, strong need was felt to establish local guidelines for managing allergic reactions according to severity of reaction as well as clear definition for anaphylaxis. We introduced guidelines locally as an aide-memoir to facilitate consistency of care as per National standards.

It was also recommended to include common paediatric emergencies as part of induction programme for both paediatric and A&E staff.

We aim to re audit in six months.

G99(P) RESUSCITATING RESUS

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Aims Critically sick children need to receive appropriate resuscitation as swiftly as possible. The Resuscitation Council state 'Staff (should) have immediate access to appropriate resuscitation equipment and drugs' with a 'reliable system of equipment checks and replacement'. Clinical incident reporting and weekly simulation training identified latent environmental errors in the paediatric resuscitation bay in the emergency department of busy district general hospital. Our aim was to identify reasons for this and areas for improvement.

Methods This was an observational study of time taken for trainees to find emergency equipment. Two lists were devised of simple airway and intravenous access and fluid bolus equipment. We timed one trainee finding specific equipment in our current resuscitation bay, identifying improvement areas using trainee and observer feedback.

After a multi-disciplinary departmental meeting to consolidate opinion, an action plan was devised. We then redesigned the bay and retimed a trainee finding the same equipment.

The changes involved creating three uniform circulation trolleys of paediatric cannulation and fluid bolus equipment. Labels were placed below each piece of equipment and photographic checklists created. The same principles were used for the airway trolley.

Results

	Trainee 1 (Pre Changes)	Trainee 2 (Post changes)
Airway test	2 mins 34 s	1 min 49 s
Circulation test	6 min 31 s (incomplete)	1 min 7 s

Prior to the changes, Trainee 1 took a protracted amount of time to find a paediatric non-rebreath mask and during the circulation speed test, could only find half a culture kit after searching multiple trolleys and used the last bag of 10% dextrose in the paediatric bay. After our changes, Trainee 2 found all airway adjuncts in the airway trolley and only required one grab trolley to successfully collate all circulation equipment with a decrease in time.

Conclusions Although two different trainees were used, both were similar grades with a similar amount exposure to the resuscitation bay. We showed with no money or extra resources you can ensure a safer environment for patients by ensuring uniformity and clear labelling. Staff reported finding the area easier to navigate, more intuitive and clearer to restock.

G100(P) "PRESCRIBING THE REMEDY: CO-LOCATED OUT-OF-HOURS GP – WHAT WOULD THIS *ACTUALLY* MEAN FOR A PAEDIATRIC EMERGENCY DEPARTMENT?"

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Aims Currently the challenges faced by urgent and emergency services overwhelm the capacity of the system. The publicly perceived lack of accessible and effective alternatives to the emergency department is evident. Co-location of an out of hours GP (OOH-GP) facility enables patients to be appropriately streamed to primary care services following a triage assessment.

The College of Emergency Medicine sentinel sites project identified that 15% of ED attendances are 'inappropriate', with young children the largest sub-group. We aimed to explore this further.

We examined the demographics of patients presenting to a tertiary Paediatric Emergency Department (PED) and assessed the ability of the PED triage nurse in identifying appropriate patients for re-direction to OOH-GP services.

The study aimed to assess the potential impact a GP re-direct policy (RP) would have on the PED and patient safety.

Methods Patient records were reviewed for all triage category 4 and 5 (T4 and T5) patients presenting to the PED in June (1st–14th) and September (8th–21st). Demographic data was obtained and reviewed. Cases were assessed for eligibility against a current OOH-GP RP being utilised in a local mixed ED.

Additionally, during the second 2-week period in September the ED triage nurse (TN) provided their subjective opinion, based solely on their triage assessment, on whether the patient was appropriate for GP redirect.

Results 1,556 T4 and T5 cases present to the PED – over 30% fulfilled the OOH-GP RP criteria. This increased to 50% in under 1s.

70% of all T4 and T5 cases were self-referrals with 34% eligible for OOH-GP redirect. GP/OOH-GP referrals made up 17% cases but 30% of these also fulfilled the RP to OOH-GP services.