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 stan-
dards. 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 bronchodila-
tor 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 pre-
scribed adrenaline auto-injector had follow up arranged before
discharge.
Conclusion Lack of formal structure to the management of chil-
dren 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 intro-
duced guidelines locally as an aide-memoir to facilitate consist-
ency of care as per National standards.
It was also recommended to include common paediatric emer-
gencies 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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10.1136/archdischild-2015-308599.98

Aims Critically sick children need to receive appropriate resusci-
tation 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 trol-
leys 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

<table>
<thead>
<tr>
<th></th>
<th>Trainee 1 (Pre Changes)</th>
<th>Trainee 2 (Post changes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway test</td>
<td>2 mins 34 s</td>
<td>1 min 49 s</td>
</tr>
<tr>
<td>Circulation test</td>
<td>6 min 31 s (incomplete)</td>
<td>1 min 7 s</td>
</tr>
</tbody>
</table>

Prior to the changes, Trainee 1 took a protracted amount of
time to find a paediatric non-rebreath mask and during the cir-
culation 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 air-
way 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 resus-
citation bay. We showed with no money or extra resources you
can ensure a safer environment for patients by ensuring uniform-
ity and clear labelling. Staff reported finding the area easier to
navigate, more intuitive and clearer to resroke.

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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10.1136/archdischild-2015-308599.99

Aims Currently the challenges faced by urgent and emergency
services overwhelm the capacity of the system. The publicly per-
ceived lack of accessible and effective alternatives to the emer-
gency 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% eligi-
ble for OOH-GP redirect. GP/OOH-GP referrals made up 17%
cases but 30% of these also fulfilled the RP to OOH-GP
services.