- Improved parental/patient understanding of diabetes management: Promoting autonomy
- Improve quality of service by increasing efficiency and efficacy.

Methods Discussion in diabetes multidisciplinary team meeting. Process mapping of patient journey and ways to improve upload at home

Collected baseline data of number of patients/families uploading their metres and pumps at home in all three hospitals across the trust.

Multi-faceted approach was implemented to achieve our aim.

- Did home visits to understand the issue more closely.
- Preparation of flyers and leaflets to help parents open their Diasend account and link with the clinic.
- Contacted parent support groups and sent flyers and leaflets to parents via email.
- Encouraged team members to discuss the issue with the parents in clinic.
- Provided a Tablet for the clinic to open Diasend account and link with the clinic.
- Organised a family evening to run 2 Diasend workshops for the parents to open Diasend account and link with the clinic.

Result All three units recorded an increase in number of patients/parents uploading at home. Over the period of 6 months we recorded an increase from 8% to 30%, 35% to 47% and 41% to 62% respectively in diabetes clinics at Princess of Wales Hospital, Morriston Hospital, and Neath Port Talbot Hospital.

Conclusion Downloading at home:

- Enables more efficient use of clinic time and reduces waiting time in outpatient department.
- Has the potential to help improve the patient/parents understanding of diabetes management leading to improved clinical outcomes.
- Motivated healthcare professionals to discuss this issue on every contact.

G372 RAPID CYCLE AUDIT – EMBEDDING MULTIDISCIPLINARY QUALITY IMPROVEMENT IN THE CHILDREN'S EMERGENCY DEPARTMENT

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Aims Quality Improvement is central to the development of any successful department and individual involvement can lead to an increased sense of ownership and potentially improved morale. We set out to design a programme that would involve all members of the Children's Emergency Department (CED) team in measuring performance, designing innovation and monitoring change.

Methods 4 important targets were identified amongst the CED senior team: Pain management; Observation frequency; Sepsis screening and handover. An excel proforma was built allowing different team members to collect data on a rotating weekly basis using the 'Medway' computer system. The proforma auto-populated run charts to measure change which were then posted in a central space within the CED with key messages

shared amongst the multidisciplinary team and discussed at handover.

Results Collection of data took place on 82% and 75% of potential weeks for pain management and observation frequency respectively over 10 months. Of the four initial projects the biggest improvement in care came in the recording of pain scoring at triage from 12% to 75% after introducing mandatory scoring at triage and using a 'pain sticker'. Observation frequency was more problematic with no improvement seen over the time despite increased education. Sepsis was abandoned as the small number of potential patients made the methodology unsuitable. Handover was swapped to safeguarding when local practice was reviewed and is ongoing.

Conclusion This work demonstrated success in embedding data measurement as part of the regular weekly timetable for the department. This first iteration however, failed to make significant improvements in the majority of areas studied and showed the need for both individual project ownership and also time for the team to meet and potentially co-design change. Going forward the programme has been adjusted to study one area for a month at a time with an individual champion for each project.

G373 ABSTRACT WITHDRAWN

G374 IMPROVING THE QUALITY OF PAEDIATRIC PRESCRIBING ON A GENERAL PAEDIATRIC WARD

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Aims Prescribing errors are the most common form of medication errors with potential to cause harm, especially in paediatrics. Majority of prescribing is done by junior doctors, some with little paediatric experience. Previous audits highlighted high incidence of errors but lost momentum following change in junior doctors.

The aim of our project was to measure inpatient prescription errors, identify the most common drug errors, and implement interventions to reduce these.

Methods An enthusiastic multidisciplinary team including doctors, pharmacists, nurses and physician's assistant (to provide continuity) used The Model for Improvement to test interventions according to errors noted.

The importance of the project was communicated to all paediatric trainees (by email/face to face teaching) and ward nursing staff. Safe prescribing sessions were emphasised during induction of different junior doctor groups.

Our ward pharmacist assessed all drug charts of inpatients for two days each week collecting data on error rate and drugs involved.

PDSA cycles from April 2017 tested versions of a weekly 'Druggle' where an observed drug error was highlighted by pharmacist to all members of the ward multidisciplinary team following ward safety huddles, with interactive 'Spot the Error' sessions.

A (P) outlining the Druggle was displayed in the doctors' office and emailed weekly to junior doctors with learning points/reminders. Junior doctors designed a prescribing checklist and requested anonymised pictures of errors on (P)s.