G379 'DEPARTMENTAL INDUCTION...LESS MANDATORY AND MORE OPPORTUNITY'

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10.1136/archdischild-2018-rcpch.368

Aim To consider if a comprehensive clinical induction improves paediatric trainee anxiety and confidence about starting a tertiary neonatal intensive care unit (NICU) placement. Working in a tertiary NICU is compulsory training for paediatric doctors. Feeling competent and confident to manage common neonatal scenarios is often a cause of trainee anxiety. Departmental inductions deliver a wealth of information to ensure the process of safe handover between rotations of junior doctors. Rarely, however, are they used to cover the topics most needed by the new doctors or used as a teaching experience.

Methods A standardised clinical induction was implemented to a tertiary NICU departmental programme. Every trainee rotated through simulated sessions covering airway management, central access, neonatal life support and an emergency simulation scenario. This allowed trainees to practice essential skills for the job in a safe environment with the department's equipment and resources including permanent NICU staff.

Results Qualitative and quantitative feedback was obtained from a total of 14 trainees over a one year period at two separate NICU clinical inductions. Trainees completed questionnaires rating their confidence overall and in relation to NICU specific situations, before and after the induction [1 (least) to 10 (most)]. These responses were analysed using the Mann-Whitney-U test. In all situations, there was an overall improvement in trainee confidence post induction. This was statistically significant ($p \leq 0.05$) in trainee confidence to manage a neonatal airway problem with airway manoeuvres or non-invasive respiratory support and trainee confidence to initiate management in situations requiring neonatal resuscitation. Other positive factors trainees reported as a result of the clinical induction included feeling part of the NICU team (13/14 trainees scored $\geq 7/10$) and feeling inspired (11/14 $\geq 8/10$).

Conclusions Empowering trainees through a good clinical induction improves confidence and experience of working in a tertiary NICU, potentially improving patient care and management. The departmental induction is an excellent education opportunity for all involved.

G380(P) THE ROLE OF A 'ONE STOP SHOP' ADHD SERVICE ELECTRONIC LIAISON COMMUNICATION TOOL IN REDUCING PATIENT JOURNEYS AND CONTRIBUTING TO QUALITY OF PATIENT CARE

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10.1136/archdischild-2018-rcpch.369

Introduction GP surveys (2010) and letters from GPs and other professionals had highlighted difficulties with responding to ADHD related queries by the ADHD Service in a timely manner. Anecdotally, responses to queries took up to 2 weeks.

Aims/objectives

- Reduce time taken to respond to ADHD related queries with the aim of reducing the patient care journey which in the medium to long term can lead to increase in quality of care and patient experience.

- Provide easy accessibility to ADHD Specialists and resources via communication tool.

Methods Following discussions with the Head of communications/IT department, a dedicated ADHD Service liaison NHS was launched in December 2014. The liaison tool email details including aims/objectives were circulated via the Trust GP liaison to all local GPs in December in 2014 and recirculated again in 2015 and 2016. The tool was advertised in the local Trust liaison GP newsletter and circulated to the ADHD Adult Mental Health teams and CAMHS via the Adult Mental Health Transition worker and ADHD Nurse Specialist.

Results Following its initial launch in 2014, Professionals accessed the ADHD dedicated liaison email a total of 15 times. Professionals who accessed this included GP/Practice managers and Adult Community Mental Health Transition worker. Queries were mostly about the ADHD referral pathways, ADHD tool/pathway training updates and transitions. The average time taken to respond to ADHD related queries by the ADHD Team was 20.8 hours an improvement from the 2 weeks average response.

Conclusions Developing a 'one stop shop' dedicated ADHD Service liaison communication tool demonstrated a reduction in the average time taken to respond to ADHD related queries and offered the advantage of Professionals accessing ADHD resources more readily. A dedicated communication email can potentially result in shorter patient journeys thus enhancing quality of care, patient experience and safety, all necessary ingredients for quality improvement.

G381(P) ACCURACY OF NEONATAL HYPOGLYCAEMIA MEASUREMENT – BLOOD GAS ANALYSER VS HAND HELD GLUCOSE MEASUREMENT DEVICE – A TRICKY SITUATION!

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10.1136/archdischild-2018-rcpch.370

Introduction Hypoglycaemia is a common reason for admission for term and near term infants to neonatal units (NICU). Early recognition and management of neonatal hypoglycaemia has important clinical and economic consequences.

In our hospital neonatal blood sugar is measured using both a standard 'blood gas analyser' and a branded hand-held glucose measurement device (HHGMD), and there is tendency to trust the HHGMD result in preference to blood gas result.

Aim We aimed to compare the blood glucose results of both the blood gas analyser and HHGMD on same blood sample at same time to ensure no significant difference was detected.

Methods Blood sugar results in individual neonates were recorded using both the HHGMD and blood gas analyser. We obtained basic demographics and route of sample for all babies. A quality control measure for the HHGMD was carried out most days by the biochemist and a calibration of the blood gas machine was done daily. Data are mainly descriptive; categorical variables are described as percentages with binomial 95% confidence intervals (95% CI). Wilcoxon Matched-Pairs Signed Ranks Test was used to test for statistical significance.

Results There were 118 separate paired blood gas and HHGMD results logged from 32 patients in the 8 week period

of this study, of which 53% (n=17/32) were term and 47% (n=15/32) were preterm babies. One third (67%, n=79/118) of these samples were preterm. Only 0.3% (n=4/118) samples were taken from babies not currently admitted to NICU.

3% (n=4) of cases both HHGMD/blood gas results were same while in 6% (n=7) of cases HHGMD result was lower than the blood gas result. However in 107 cases HHGMD result was higher than blood gas result with a mean difference of 1.07 mmol (95% CI 0.94–1.15, $p<0.05$) glucose per sample tested

Conclusions A mean difference of approximately 1 mmol/L glucose between both measurement devices on the same blood sample has potential clinical and economic significance particularly in our population where hypoglycaemia and subsequent neonatal unit admission is common. A more robust way of standardising glucose measurement is required in this cohort of babies.

G382(P) RADIATION EXPOSURE IN NICU

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10.1136/archdischild-2018-rcpch.371

Aims To reduce the radiation exposure in babies admitted to a single tertiary centre by reducing the number of duplicate X-rays taken from 30% to 0 within a period of 6 weeks and by increasing the use of point of care ultrasound to detect the tip of the UVC from 0% to 80%.

Methods We used the USAID quality improvement process for the study. This involved the use of process map and fish bone analysis, retaining of staff and testing of changes (use of 2 personnel method to take X-rays) was implemented.

Results The number of duplicate X-rays decreased from 30% to 8% over a period of 3 months. Similarly the use of point of care ultrasound also increased for the detection of UVC tip from 0% to 70%.

Conclusion Retraining of the nursing staff to take X-rays, implementation of systemic changes in the procedure of taking X-rays resulted in the reduction in the number of duplicate X-rays from 30% to 8% thereby leading to improvement in the care that we provide to sick newborns in a resource limited setting.

G383(P) AN INNOVATIVE METHOD OF GATHERING FEEDBACK AS PART OF THE 'WHAT MATTERS TO YOU?' MOVEMENT

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10.1136/archdischild-2018-rcpch.372

Aims Increasing user feedback and co-production are a priority of the National and Trust agendas. Our aim was to gather feedback, opinions and constructive suggestions from parents and young people in an interactive, fun and informal environment. This was part of a National Initiative in which departments devised their best method of establishing 'What Matters To You?'

Methods We designed a feedback morning with a variety of activities. The full multidisciplinary team were involved including doctors, nurses, education, play, ward clerks and

housekeeping teams. This enabled children of all ages and their carers to provide feedback in real time, both verbally and in writing. Tools used included 'pants and tops' feedback clothes lines, knitting lessons from the Royal Free volunteers, raffles, games and home made cakes.

We asked people specific questions using a mini structured interview. These included, 'what matters to you in your life? What matters when you come to hospital? What has and hasn't gone well? What would you change and how?'

Results There were 50 attendees including patients, carers and staff. All contributed to feedback in different formats which was largely positive. Parents and young people valued the opportunity for face to face conversation and suggestions for service development.

Qualitative results were grouped under headings, General, Attitudes, Listening, Staff, Systems.

Examples of comments and actions taken include:

'The nurses and doctors are all so kind and caring. They make you feel at ease and do an amazing job'

'Able to come to school/be in education while getting support for eating disorder'

'Try and support patients with a language barrier' – we have increased use of and access to language line.

'To be listened to and for my views to be taken into consideration in any decision' – we have highlighted and embedded use of parental concern into PEWS scores and safety huddles.

'First contact when arriving at the hospital is very important' – in our ward refurbishment we have moved the reception desk to the front door so as to welcome patients in.

Conclusion This event improved dialogue and openness between staff and families. We recommend other departments undertake a similar approach in order to identify what matters most to patients.

G384(P) INTRODUCTION OF A NOVEL JUNIOR DOCTOR -LED PROLONGED JAUNDICE CLINIC IN ORDER TO REDUCE THE WAIT TIME FOR RAPID ACCESS CLINIC APPOINTMENTS WITHIN THE PAEDIATRIC DEPARTMENT

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10.1136/archdischild-2018-rcpch.373

There has been an increasing demand for rapid access clinic appointments in the Paediatric department in Northampton General Hospital over the past 2 years, which has led to an increase in wait time for an appointment. (21 patients per month on average in 2015 and 34 per month in 2016). This rapid access clinic is led by a consultant, and runs up to two times per day.

A large proportion of the patients seen in this clinic have prolonged jaundice, and can be managed by a junior doctor. Therefore, our proposal is to introduce a junior doctor led clinic to see patients with prolonged jaundice, to free up more space in the consultant-led rapid access clinic. The overall aim of the project was to reduce the average wait time for the paediatric hot-clinic to below 2 days by December 2017.

Training on running the clinic, using a new proforma, was delivered to support the junior doctors with the new clinic. A process was established to ensure all investigations undertaken after the appointment were discussed with the Consultant of the Week. A