Methods A retrospective Audit of current services for children with Down syndrome was completed which identified number of deficiencies within existing services. Recommendations included; establishing a specialist multidisciplinary Down Syndrome Clinic and developing local care pathway for improved documentation and communication. Quality Improvement tools including; Process Flow Analysis, Fishbone diagram, Purpose to practice, and Parent feedback questionnaire were used during this project.

Results and conclusion A specialist Multidisciplinary Down Syndrome clinic was established with first clinic in January 2017. Pilot of once a month clinic with PDSA cycle for 6 months. A local care pathway was developed including core clinic members, clinic frequency, templates, referral criterion and MDT communication framework. Children and young people with Down syndrome are involved in service development. Promoted joined up working in partnership with patients and families

REFERENCES

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G402(P) THE COMPLETION OF ADVANCE CARE PLANS

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Aims

- To establish the availability and completion of Advance Care Plans (ACP) in paediatric palliative hospice patients.
- To review changes to this in light of new guidance and following recommendations from a previous audit.

ACPs are a valuable resource for patients, their families and healthcare professionals. Between the first and second audits there were two significant implementations. The National Institute for Health and Care Excellence (NICE) published guidelines about end of life care in children and young people in 2016. One of their quality statements is that all children with a life-limiting condition should be involved in developing an ACP. The second implementation was the adoption of the Children and Young Person's Advance Care Plan (CYPACP) by the local palliative network.

Methods All patients under the care of the palliative medical team were identified. Patients referred within the previous two months were excluded. Notes of all patients were reviewed and computer records accessed. The presence of an ACP was noted and, if available, was reviewed against set standards based on national recommendations. This included items such as patient identifiers, documented discussions about place of care, signature completion, and others.

The first audit was done in December 2016 (n=41), with a repeat audit (to complete the cycle) in September 2017 (n=41) following institution of recommendations from the first audit. These recommendations included implementation of a teaching programme about using the new proforma (CYPACP).

Results

- In 2016, 80% of patients had ACPs. This improved in 2017 to 88%.
- In 2017, 25% were on CYPACP proforma compared to 6% in 2016.
- Patient identifiers were consistently well completed in both audits.
- Many ACPs were not signed (62% in 2016, 78% in 2017) which poses risk and challenges for nurses expected to follow documented recommendations.
- Discussion regarding place of care/death was completed in 100% of cases in 2017, compared to 79% in 2016.

Conclusion The process of writing ACPs is time intensive and transfer to new documentation is a significant undertaking. However, the introduction of the CYPACP has led to more comprehensively completed ACPs, particularly around place of care/death.

G403(P) SURVEY OF STAKEHOLDERS OF A PAEDIATRIC ANAESTHETIC ROOM

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Aims To quantify and evaluate stakeholder satisfaction of our paediatric anaesthetic room (PAR), which at present contains limited child-friendly interventions.

Methods We conducted a survey using anonymous paper questionnaires offered to patients, parents and staff over two weeks (29th March – 12th April 2017). Questionnaires were dispensed by nurses and anaesthetic trainees in the paediatric ward and PAR, and collected anonymously via collection boxes.

Inclusion criteria: paediatric patients undergoing elective surgery, parents accompanying patient to PAR; all staff using the PAR (paediatric consultant anaesthetists and operating department practitioners; paediatric nurses and play-therapists accompanying patients)

Exclusion criteria: stakeholder refusal; not fluent in English.

Our survey investigated stakeholder satisfaction of the PAR and elicited particular feedback on lighting, colour, toys, and multimedia (tablet/television/music). At the time of the survey, there was no functioning television, no available tablets or music, and soft toys were not routinely used (none were used during the survey period).

Results We collected 58 responses: 9 patients, 20 parents, 29 staff.

Patients: In the PAR, 4/9 (45%) felt indifferent, 3/9 (33%) felt negatively and only 2/9 (22%) felt positively. All respondents wanted a change in colour and décor, and all wanted to play with toys. Almost all (8/9, 89%) wanted some form of multimedia.

Parents: 13/20 parents (65%) felt the general environment, colour and décor were not child-friendly. The same proportion felt available toys and multimedia were insufficient. 9/20 (45%) felt lighting was poor.

Staff: 26/29 (90%) felt the PAR was not child-friendly and the colour/décor was poor. 28/29 (98%) felt there was insufficient multimedia, 21/29 (72%) felt selection of toys was inadequate and 16/17 (94%) felt they preferred a previous PAR they had worked at.

Conclusion Our survey identified stakeholder dissatisfaction, which has initiated plans for further needs-assessments and renovation. Our patients were largely indifferent towards the PAR environment, which was in contrast to parents and staff. Evidence suggests parental distress is associated with child distress during induction of anaesthesia, and it is therefore imperative that parents must be consulted in our re-design process which should focus on relieving distress of both parent and child.

G404(P) CATCHING UP WITH THE 21ST CENTURY (THROUGH CHARITY!): IS A COMPUTERISED CLINICAL JOBS BOOK SUPERIOR TO A PAPER BASED JOBS DIARY?

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Background With increasing workload and reducing length of stay, a robust system was needed to keep track of outstanding clinical jobs regarding patients whose early discharge was made possible by the on-site presence of senior decision makers. A paper based diary initially proved successful and results were presented as a (P) at the RCPCH annual conference 2015. However, this system did not keep up with demands and posed several clinical governance challenges. Therefore, a computerised network based system (PaedsTMS) was developed with help of employees of a multinational technology firm as a charity project.

Aims To assess the effectiveness and quality of jobs recording and completion, before and after the introduction of PaedsTMS.

Abstract G404(P) Table 1

	Pre-paedsTMS audit (n=31)		Post-paedsTMS audit-1 (n=27)		Re-audit-2 (n=30)	
	No of patients	% achieved	No of Patients	% achieved	No of Patients	% achieved
Jobs added to system	30/31	96	21/27	78	26/30	87
Sufficient task information provided	9/30	30	19/21	90	26/26	100
Task Completed	17/30	57	21/21	100	26/26	100
Task completed by due date	Information not available	-	13/20	65	20/26	77

Methods PaedsTMS was introduced in June 2017 after an initial audit of the existing paper based system. The project was led by a registrar under guidance of a consultant paediatrician. A team of champions from medical, nursing and clerical background was assembled. Team discussions were done on messaging apps. Training was accomplished face to face and by video tutorial on YouTube. PaedsTMS was run parallel to the existing system for two weeks. Two audits were completed

after introduction of PaedsTMS in July and September 2017. We looked at the percentage of tasks added to PaedsTMS, percentage of tasks added with sufficient clinical information, percentage of outstanding tasks completed and percentage of tasks completed within due date. The results were compared with pre-PaedsTMS introduction audit.

Results The re-audit showed significant improvements as depicted in table 1 below:

Conclusion The computerised system has significantly increased the quality of clinical details recorded with jobs as well as their timely completion whilst providing a clear audit trail to satisfy clinical governance standards.

G405(P) SENIOR SAFETY WALK IN A DISTRICT GENERAL HOSPITAL

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Background Senior safety walk (SSW) is a structured process to bring senior managers and front line staff together to have patient safety conversations with a purpose to mitigate service user/staff harm.

Aim To Introduce Senior Safety Walks in Paediatric Department:

- To demonstrate senior managers' commitment to quality and safety for staff and service users,
- To Increase staff engagement and develop a culture of open communication and
- To Identify, acknowledge and share good practice

Method PDSA Cycle used as QI methodology. A literature search was completed. SSW team members included a senior operation manager, senior clinician and admin person. Monthly SSWs scheduled. SSW toolkit developed including: MDT Communication frame, Sample guide for SSW discussion, Data collection templates and Impact measurements.

Impact measurements: Number of problems identified which were addressed within time period; Number of safety-based changes made by staff by per year; Number of compliments/complaints received (outcome measure); and Response to staff safety culture survey (process measure).

Results

- Senior Safety Walks started in Feb 17.
- SSW Themes measured: 1)Leadership, 2)Communication and Team working, 3)Environment and Processes, 4) Patient/carer feed back
- Each SSW Included following actions:
 - Observation of Environment, Process and Leadership
 - Staff discussion including feedback measures discussed and implemented
 - Services user/Patient/carer discussion

Impact measurement results:

- 85% of identified issues were resolved within agreed time frame.
- Multiple safety based changes made in the department.
- Number of complements received from services users during this period.