interference of medical equipment, infection control concerns, and reported parental complaints.

Mobile devices provide a multitude of benefits for clinical staff including increased access to useful apps such as drug-dose calculators, and other validated point-of-care tools, which are of high educational value and have been shown to support better clinical decision making and improved patient outcomes.²

Methods We designed a survey assessing parental and staff perception on the use of mobile phones, using a five point Likert scale. 40 staff and 40 carers participated in the questionnaire.

Following this, we designed two clinical scenario's assessing administrator and prescriber performance for healthcare professionals. We assessed length of time to complete task and degree of accuracy. Scenario 1 participants were prohibited from using mobile phones. Subsequently, participants were granted access to mobile phones for assistance in Scenario 2.

Results 38/40 (95%) parents surveyed felt that healthcare professionals should be allowed to use mobile technology in a clinical environment. Similarly, of the 40 staff members surveyed, 39/40 (97%) felt access to mobile phones for clinical reasons was appropriate.

For the drug administration scenario (performed by nursing staff), all participants were quicker using mobile phone for assistance. The average length of time was 1 min 22 s quicker. Task accuracy was maintained at 100% with and without mobile phone use.

For the prescriber scenario (performed by medics and non-medical prescribers), again all participants were quicker using mobile phone aide, with an average length of 1 min 26 s quicker. Accuracy of 100% was maintained in both cohorts.

Conclusion Despite previous reported parental concern, this survey highlights the strong carer support for healthcare professionals appropriately using mobile phones in clinical areas. Staff members were similarly keen for the use of mobile technology to aid their practice.

We have demonstrated an improvement in efficiency of performing clinical tasks with the assistance of mobile phones, ensuring accuracy was maintained. The appropriate use of mobile phones promotes well-informed, safety-conscious, technology-assisted, effective clinical care.

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G168

AN OBSERVATIONAL STUDY OF CLINICIAN'S GAZE BEHAVIOUR DURING SIMULATED PAEDIATRIC EMERGENCIES

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Aims Clinicians collect, prioritise and respond to visual cues when making decisions about patient care. This is of particular importance in the resuscitation environment where they

are required to absorb and process large volumes of complex visual information in a time critical manner. Eye tracking technology allows for the measurement of an observer's point of gaze based on where their pupil is focused. Eye tracking technology has been used in aviation and surgery to describe differences in the gaze behaviour between experts and novices. The aim of this study was to describe the gaze behaviour of clinicians from different training backgrounds during a simulated paediatric emergency.

Methods Twenty-seven clinicians from different clinical areas within a tertiary children's hospital undertook a standardised, six minute, high fidelity simulated paediatric emergency. Participants wore SMI Eye Tracking Glasses. We measured the number of times participants looked at predefined key areas (fixation count) and the duration of time spent looking at each of these areas (dwell time). The time taken to key clinical interventions was also recorded.

Results Participants from all groups looked more frequently and for longer at the patient (chest and airway) than any of the other key areas of interests. Paediatric Intensive Care Unit (PICU) consultants focused longer on the chest and airway than any other groups. The gaze behaviour of paediatric consultants and trainees was similar. Both groups spent longer looking at the defibrillator and algorithm (51,180 ms and 50,551 ms respectively) than the PICU consultants and consultants in paediatric emergency medicine (19,804 ms and 28,095 ms respectively). The PICU consultants were quickest to perform key clinical interventions.

Conclusions This study is the first to describe differences in the gaze behaviour between clinicians from different backgrounds during a simulated paediatric emergency. Differences observed between experts and novices are similar to those described in aviation and surgery. Further research is needed to evaluate the potential use as an educational tool in the resuscitation setting.

G169(P)

ACT^{UP} – AN INTERDISCIPLINARY APPROACH TO PREPARING SENIOR PAEDIATRIC TRAINEES FOR CHALLENGING CLINICAL SCENARIOS

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Aims In recent years there has been an increasing recognition of the importance of non-technical skills training in medical education. Strong communication and interpersonal skills are crucial to good clinical practice. These are of particular relevance when communicating with team members, parents and patients in challenging situations. We identified a lack of post-graduate training opportunities for paediatric trainees to develop these skills. Our aim was to devise an interdisciplinary training opportunity which would enable senior paediatric trainees to develop their communication skills by undertaking simulated scenarios based on challenging clinical situations.

Methods Level 3 trainees in our deanery were invited to attend the ACT^{UP} course. We recruited a diverse faculty consisting of paediatricians, paediatric nurses, social workers and psychologists. In a unique collaboration, we worked closely with drama students from our local university. The drama students acted in the role of parents for the simulations. The

scenarios focused on challenging clinical encounters which may be seen in paediatric practice. These included safeguarding cases, sudden unexpected death of an infant and discussions around withdrawal of care. Feedback was collected through questionnaires and focus groups conducted by the psychology team.

Results Feedback on the course was excellent. All participants found input from a diverse faculty particularly beneficial. Themes identified on analysis of the focus groups included the importance of the drama students in enhancing the fidelity of the simulations, the necessity of further non-technical skills training in paediatric training and the benefits of debrief following challenging clinical encounters.

Conclusions This course provided an opportunity for senior paediatric trainees to develop their communication skills in challenging situations. Initial feedback was excellent. We strive to establish this course as a regular training opportunity for paediatric trainees in our deanery. The course has also been adopted as an essential component of the undergraduate drama module entitled 'Drama, Health and Social Care' now offered in our local university.

G170(P) USE OF BRIEF MULTIPROFESSIONAL SIMULATION TO IMPROVE CONFIDENCE AND SKILLS IN MANAGING CHILD AND ADOLESCENT MENTAL HEALTH CRISES OUT OF HOURS

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Background The benefits of using simulation to improve skills and competence in clinical education is well established. A learning need was identified in managing out-of-hours CAMHS (Children and Adolescent Mental Health Service) emergencies, for junior medical trainees. It was recognised that learning could be augmented by widening participation across disciplines and professions. A pilot simulation delivered six months earlier to junior doctors on psychiatric rotation was well received and showed improved confidence.

Methods The session, comprised an introductory talk and two simulated scenarios, designed to address issues such as capacity, safeguarding, confidentiality and agitation.

The training was delivered by a Consultant Paediatrician, Consultant Psychiatrist, a Fellow in Medical Education, Paediatric Registrar and two external actors. A pre-session focus group with psychiatry and paediatric teams identified concerns with assessing paediatric mental health patients after hours and the logistics of referral pathways and resources. Simulation scenarios were formulated to address these concerns and mapped to the Royal College of Psychiatry and Royal College of Paediatrics and Child Health training curriculum. Pre and post session questionnaires were also completed.

Results Seven participants attended the first session that was delivered; five psychiatry trainees and two paediatric trainees. 15 participants attended the second session; nine psychiatry trainees, four paediatric nurses, one foundation trainee and one GP trainee. Individuals participated in each section of the two scenarios, increasing candidates' direct experience of the simulation.

100% of participants reported feeling confident in all the outcomes assessed, which was an improvement in all domains. 73% of all participants stated they would recommend the

course to a colleague, and that it met their learning needs. Free text qualitative feedback indicated a wider range of paediatric mental health topics to be covered.

Conclusions In future sessions more equal representation amongst the multidisciplinary and inter-professional teams will be sought. The evidence from these sessions and the previous pilot demonstrates that this is an effective, and stimulating way to improve skills in this area. Participants also benefit from sharing knowledge across disciplines and professions whilst developing collaborative working relationships.

G171(P) INNOVATIVE CORE COMMUNITY PAEDIATRICS TRAINING

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Introduction Paediatric curriculum mandates that all paediatric trainees achieve Community Paediatrics (CP) competencies as a part of their core (Level 2) training in the United Kingdom. However there are concerns that shift-based hospital training does not allow dedicated community training time.

Aim To evaluate and streamline core-community training rotations.

Methods Feedback from the community and hospital teams, showed need to improve continuous exposure in CP for better learning experience, achievement of competencies and improve patient care and safety. Using Quality Improvement Methodology key changes and ideas were implemented (table 1). Dedicated CP training was the key change in practice needed alongside supporting hospital service.

An innovative block of 4 months (instead of the traditional 6 months) training was designed and piloted. This was tailored to allow achievement of CP competencies whilst maintaining continuity and hospital requirements. Trainees spent weekdays in CP and maintained some hospital commitments out-of-hours during weekdays only.

An initial pilot was set up with 2 trainees as described above. Monthly consultant trainee forum allowed feedback from both groups trainees and consultants. This was followed by an anonymous questionnaire evaluating the training.

Abstract G171(P) Table 1 Driver diagram: pilot community paediatric training

Aim	Primary drivers	Secondary drivers	Change ideas
Dedicated community paediatric training	Better learning experience	Communication	Early trainee/supervisor identification
		Equipment/paperwork	IT paperwork
	Achievement of competencies	Clear training objectives	CP Handbook
		Linking RCPCH competencies	Formal/informal supervision
Better patient management		Hospital Service	Out of hours hospital weekdays
		Community service	4-month-block rotation