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 for assistance, 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.

REFERENCES

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 CRISIS 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 services.

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 weekends 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

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