After 15 simulation sessions 8/17 participants found the sessions very helpful and 9/17 found them helpful. 6/17 'strongly agreed' and 10/17 'agreed' that the sessions improved their confidence in participating in simulations. 10/17 participants felt they learned more by observing the simulations. 17/17 participants found the sessions helpful and 15/17 felt they improved their confidence dealing with sick children. Feedback on improvements made to the sessions was variable and suggestions for further improvement were received.

Conclusions 100% of participants felt the sessions were helpful and 88% felt they improved their confidence dealing with sick children. Low-fidelity, in-situ simulation can improve caregiver confidence but it important to be aware of the various levels of experience within your department and to seek feedback and strive for constant improvement.

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P272 MANAGEMENT OF FINGERTIP INJURIES IN THE PAEDIATRIC EMERGENCY DEPARTMENT CLINIC- MORE THAN LOCAL ANAESTHESIA

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Trauma and injuries represent a significant portion of presentations to the Paediatric Emergency Department, with a major subset comprising hand and fingertip injuries. These require input from specialist hand surgeons. In co-ordinating this care pathway, the aim is to provide effective and definitive treatment in a manner that is straightforward for parents and least stressful for the injured child.

Frequently, these injuries are suitable for repair under local anaesthesia. In the presence of a well-stocked treatment room, repair of simple fingertip injuries can be facilitated, avoiding the need for full hospital admission and prolonged fasting for repair under general anaesthesia.

Our study evaluated all fingertip and nailbed injuries presenting to our Emergency Department in an 8 month period from January to August 2018. Out of 964 presentations for Plastic Surgery review, 226 concerned hand or finger injuries. Of these, 140 represented fingertip or nailbed injuries. Almost 40% of these underwent repair in the Emergency Department under local anaesthesia with or without nitrous oxide sedation. 25% required repair in the operating theatre under general anaesthesia and 35% were managed conservatively.

August was the busiest month for such injuries. Children undergoing nitrous sedation with local anaesthesia for these injuries ranged from 15months to 14 years, with a median of 4 years. In general, younger babies and more anxious or upset children were less suitable for sedation and local anaesthesia. All cases were followed up routinely in the Plastic Surgery clinic. Side effects of nitrous sedation were uncommon. There were almost no complications following these procedures.

This audit provides a snapshot of the usefulness of nitrous sedation in combination with local anaesthesia as a safe and

reproducible method of managing simple fingertip injuries in the paediatric setting. It highlights issues around provision for these services in the Emergency Department- staffing, equipment and training to name but some- but will surely assist in future resource planning.

P273 'KETING' THE KIDS TO SLEEP – IMPLEMENTATION OF A PAEDIATRIC PROCEDURAL SEDATION GUIDELINE AT A MIXED EMERGENCY DEPARTMENT

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Introduction Ketamine hails from a stormy past, falling in and out of favour among our anaesthetic colleagues. However, the most recent data shows it has a favourable safety profile with relatively few absolute contraindications. This, combined with its applicability to a diverse patient cohort makes it a suitable choice for paediatric procedural sedation. University Hospital Waterford, a mixed emergency department, implemented a ketamine sedation guideline for use in our paediatric population in 2018. 33 patients successfully underwent sedation throughout the year with no major adverse events.

Aims The primary objective of this protocol was to enhance patient (and parent) experience within the ED. Secondary aims were reduced quaternary hospital referrals and less in-patient bed days. In-direct outcomes would include less parental (work) absenteeism, cost saving for parents, reduced hospital crowding, and a cost saving to the hospital.

Methods An extensive literature review, incorporating current UK (RCEM), Australian (ACEM) and American (ACEP) guidelines (and recommendations) for paediatric sedation was undertaken. Ketamine was chosen as the sole agent of choice and a comprehensive guideline was constructed. This four page document incorporated patient selection, resource requirement, adverse event management and a parent advice leaflet. Sedation training was offered to APLS trained middle grade doctors, while induction level training was provided to house officer doctors highlighting patient selection and the 'proceduralist' role.

Results 33 Paediatric procedural sedation have occurred since implementation. This has resulted in a direct cost saving to parents of €1680 for admission avoidance at UHW. Furthermore a cost saving of at least €4489 was made by parents in preventing onward travel to Plastic surgery at Cork University Hospital.

A post sedation survey of parents was carried out which revealed a high level of satisfaction of the sedation. One parent reported nightmares in their child that night, and one parent reported an episode of vomiting in the car journey home. All would opt for local ketamine sedation again if required.

Conclusion This successful implementation underscores the role of paediatric procedural sedation within a mixed ED. Positive parent feedback stresses the benefit of providing paediatric procedural sedation to a select cohort of suitable patients in reducing travel for quaternary hospital services, and less hospital bed days. Cost saving to parents, and local access to services bolsters a positive patient and parent experience