NURSING METRICS IN TEMPLE STREET: WORKING TOGETHER TO ACHIEVE NATIONAL STANDARDS

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Background Nursing and Midwifery Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes aligned to evidenced based standards and agreed through national consensus in healthcare settings in Ireland. Quality Care-Metrics will enable midwifery and nursing staff to frequently review real time data in order to improve clinical practice appropriately (Harrison 2011).

Aim and objectives To highlight Quality Improvements that have occurred in Nursing Practice In Temple Street and areas for improvement that are on-going as a result of Quality Care Metrics. Quality initiatives include; safe storage of drugs, co-signing of student nursing documentation, safe discontinuation of drugs. quality improvements involve; nurses, pharmacists and doctors.

Methods/Intervention Test Your Care generated quantitative data which highlighted areas of the Nursing process which required improvement. The Quality Initiative took place and the data was re-evaluated using Test Your Care.

Results/Findings Improvements evident in Medication Storage Custody Metrics as a result of the implementation of swipe Access in the Intensive Care Unit and the Emergency Department.

Conclusions Nursing Quality Care Metrics have an important role to play in optimising safe Nursing Care. This can be achieved through working together to meet National Standards.

MACROCEPHALY: COULD IMPROVED REFERRALS LEAD TO GENTLER IMAGING?

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Background Macrocephaly and/or increasing occipitofrontal circumference (OFC) are common reasons for referral to our tertiary general paediatrics clinic. The main concern is excluding hydrocephalus, a serious but rare condition (79 per 100,000 births in high-income countries (Dewan et al, 2018)). The Triage of Referrals Clinic (TORC) is a new initiative that seeks to improve patient flow through outpatients by organising relevant investigations prior to appointments.

Methods We performed retrospective analysis of referrals and imaging of patients triaged by TORC who subsequently had neuro-imaging requested due to large/enlarging OFC during August 2017 to October 2018. We devised a standard ‘ideal referral’ for large/increasing OFC based on a review by Seal (2013) and evaluated referrals of infants who went on to have neuro-imaging compared to this standard.

Results Seventeen patients had neuro-imaging requested. Median age at referral was 9 months. Four infants (23.5%) were referred due to large OFC, one (5.9%) due to large anterior fontanelle and twelve (70.6%) due to increasing OFC-centile. One patient’s scan was cancelled as they were seen urgently and deemed clinically normal. Two with closed fontanelles went immediately for CT-scan (both normal), fourteen had cranial ultrasounds; of these eleven (78.6%) were normal or showed increased subarachnoid fluid (considered normal variant). Three patients had abnormal cranial ultrasounds. The first infant had prominent lateral ventricles that were normal on subsequent CT. The second infant had a small cyst consistent with previous haemorrhage and was discharged after a normal clinical assessment. The third patient had enlarged ventricles that were confirmed on CT-scan, they had additional risk factors having undergone neonatal cardiac surgery.

Regarding referrals, 14/17 (82.4%) included ≥2 OFC measurements. Three referrals (17.6%) did not mention infant development. Normal development was reported in the remaining fourteen. One referral mentioned the presence/absence of symptoms of increased intra-cranial pressure (ICP). Signs of increased ICP (absent/present) were included in three referrals (17.6%). Only eleven (64.7%) detailed if the anterior fontanelle was open. A family history (absent/present) of macrocephaly was mentioned in five (29.4%) and none mentioned family disability. Seven (41.2%) included weight/length centiles and three (17.6%) infant’s birth-gestation.

Conclusions Of the seventeen patients referred for neuro-imaging, one had a significant abnormality. This raises the question of whether neuro-imaging is needed in all these cases and if we may be able to reduce the number of scans ordered by improving quality of referrals.
**Results** In the first 6 months of the 22q11DS Clinic 17 children were assessed. This attendance rate was 94% and 29% of this group had their appointment co-ordinated with another specialist on the same day. Overall, 46 children have been seen to date. Following their first assessment, in accordance to the guidelines and clinical need, overall 82% required surveillance investigations, including: blood testing (66% of children), renal ultrasound (30%) and X-Ray spine (9%). Specialist referrals were needed in 73% of children, to a variety of services, most commonly to mental health (48%), dental (20%), cardiology (18%), immunology (14%), cleft team (14%), ophthalmology (14%), audiology (9%), endocrine (7%) and orthopaedics (7%).

**Conclusion** We have identified multiple areas of unmet need with reference to best practice guidance in this dedicated clinic. It is hoped that we can improve care co-ordination further by engaging other specialists to run clinics on the same day, appoint a nurse specialist and adopt a clear care pathway, tailored to the Irish healthcare system using a life course approach to ensure the regular monitoring and anticipation of issues and early intervention that helps in maintaining health, well-being and quality of life.

**GP108 NATIONAL PEWS IMPLEMENTATION IN IRELAND; OUTLINING THE EXPERIENCE OF IMPLEMENTING A MANDATED PAEDIATRIC PATIENT SAFETY IMPROVEMENT INITIATIVE**

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Background The Irish Paediatric Early Warning System (I-PEWS) and associated National Clinical Guideline No.12 was developed in response to a ministerial mandate as a funded workstream of the National Clinical Programme for Paediatrics. I-PEWS is a multifaceted approach to improving patient safety and clinical outcomes, based upon the implementation of several complementary interventions, including 5 age-specific paediatric observation charts incorporating a PEWS scoring tool and escalation guide, promotion of effective communication using the national standard (ISBAR communication tool for patient deterioration), timely nursing and medical input, and clear documentation of management plans.

Objectives I-PEWS was developed to improve prevention, recognition and response to children at risk of inpatient clinical deterioration in Ireland. For a defined period, national implementation was overseen by a Working Group of stakeholders and supported by a National Coordinator.

Implementation strategy Over a three-year period, we piloted and refined the PEWS charts and associated education resources and facilitated national implementation of the Irish PEWS in 29 public hospitals. We developed a centrally-delivered, standardised training programme to establish hospital-level PEWS Trainers. Locally nominated PEWS Leads and Trainers were supported by regular communications, site visits and remote support culminating in a paediatric patient safety celebration day to mark the conclusion of the Working Group and Coordinator involvement. National Key Performance Indicators (KPI) were developed to demonstrate adherence to National Clinical Guideline recommendations by the local governance bodies to include development of locally applicable continuous education standards and regular audit to promote frontline ownership of the change.

**Results** Implementation of PEWS was challenging due to the number of sites involved and the different specialties, resources and levels of engagement within each. The four quarterly KPI reports from 2018 demonstrate inconsistency in implementation and embedding of PEWS.

21 of 29 (72%) hospitals overall report full compliance with the standards set out in the KPI suite. Issues include (ranges indicate variance in reporting across quarters): no local governance group (33%) no provision for continuous education programme for nurses (1–4 hospitals) or doctors (3–5 hospitals) all admitted children are not monitored using PEWS (1–2 hospitals) audit practices are not as recommended (1–3 hospitals) outcome data is not being collected (4–6 hospitals)

**Learning** Implementing a national QI initiative is complex. The flexibility for locally relevant adaptations is essential for applicability and buy-in. The KPI data demonstrates a deficit in implementation standards and should be addressed by the Irish health service.