of meningitis is rarely considered or treated. The use of anti-viral agents in meningitis have been shown to reduce morbidity and mortality from viral meningitis. Antiviral agents should therefore be considered in the management of meningitis in this setting in order to improve outcomes of patients and promote judicious use of antibiotics. Further research to describe the viral aetiology of meningitis in this setting is required.

Quality improvement and patient safety

Plenary

P03

THE KIDZMED PROJECT: TEACHING CHILDREN TO SWALLOW TABLET MEDICATION

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Aim Tablets are safer, more convenient and cheaper than liquid medications. Children and young people (CYP) often remain on liquids due to habit, reluctance to change or staff and parents' lack of knowledge about switching to tablets. We describe a quality improvement project to train staff and embed a system of converting eligible children to tablet medication.

Method Working with families and teams, we created an interactive training package with training video and comic poster. We ran interactive hour-long training sessions for staff. Using positive reinforcement and play, the trainer sat facing the learner with sweets or dummy capsules filled with sweets of increasing sizes.

Starting with one small team over 12 weeks we embedded a process for children ≥ 5 years attending complex renal clinics to be converted from liquid to tablet medication unless contraindicated (e.g. swallowing or cognitive impairment). We overcame practical barriers by placing easily accessible 'switching kits' in clinic filled with the necessary dummy pills, awards and certificates as well as standardising clinic processes.

Results In the initial test of change in one team, over three months, 90 CYP were seen in 13 multi-disciplinary renal clinics, 25 were suitable for conversion to tablet medication. 21 CYP (median age 8.4 years range 5.1 to 15.5) were successfully converted (only one patient required two sessions). 36 medicines were switched, generating £46 588 per year recurrent savings.

Feedback was good. Staff liked the opportunity for positive interaction with children and families appreciated the ease of obtaining tablet medications versus liquids.

Conclusion In a short timeframe it is possible to embed a system to convert children to tablet medication, improve the families' experience of obtaining medication and realise considerable cost savings. It requires staff training and cultural change. Pill swallowing is an easy skill to teach and learn and we encourage all paediatric departments and clinics to set up tablet schools. Since then our project has spread within our hospital via nurses and play specialists, regionally and beyond to larger audiences.

G80

USING QUALITY IMPROVEMENT TO IMPROVE IDENTIFICATION AND SUPPORT OF FAMILIES LIVING IN POVERTY IN PAEDIATRIC PRACTICE

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Aims Poverty is the most important determinant of child health in the UK associated with adverse health, developmental, educational and long-term social outcomes. Despite growing levels of child poverty, paediatricians feel powerless when faced with it. Training gaps and underdeveloped pathways lead to missed opportunities to help impoverished families.

Our aim was for >80% of doctors in the paediatric assessment unit to ask about child poverty as part of their routine clinical assessments and to signpost families to local resources where appropriate.

Methods Measures:

- Percentage of doctors who asked about child poverty for the last patient clerked.
- Percentage of nurses and doctors aware of local resources for families living in poverty.
- Resources given and family feedback.

This project was piloted in an area with 21% child poverty but is expanding to areas with greater deprivation. Stakeholder focus groups co-designed screening questions for (a) nurses: 'how did you get to hospital/how will you get home?' and for (b) doctors: 'have you been on holiday in the last year?' These questions were used in addition to identifying poverty risk factors from the family and social history, which included: single parents, unemployment, >3 young children, chronic health conditions and social worker involvement. When appropriate, the bespoke child poverty leaflet was discussed with parents offering local resources to help increase income, provide essentials and increase participation.

Results At baseline, no doctors screened for child poverty or advised on local resources. Plan-do-study-act cycles were conducted to test screening questions, increase colleagues' buy-in and resource leaflet prescribing. The percentage screening for child poverty increased from 0% in March 2019 to an average of 84% in July-August 2019. The resource awareness percentage increased from 0% to 100%. Patient feedback was extremely positive: 'thank you for being so thoughtful, you really helped me.'

Conclusion Paediatricians can play a significant role in helping families living in poverty. This quality improvement project demonstrates one approach to asking about child poverty in routine clinical assessments and for offering local resources to help empower families. Further PDSA cycles are recommended to promote sustainability and advocate multidisciplinary progress of social paediatrics across children's services in the UK.

G81

POSTNATAL MANAGEMENT OF HYPOGLYCAEMIA – KEEPING MOTHERS AND BABIES TOGETHER

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Aim To keep mothers and babies together and decrease term hypoglycaemia admissions through implementation of a new guideline for management of healthy term babies with asymptomatic hypoglycaemia in the first 48 hours; in line with the British Association of Perinatal Medicine neonatal hypoglycaemia framework for practice, by the 1st of October 2018.

Methods Hypoglycaemia threshold in healthy term babies <48 hours was redefined as ≤ 2.0 mmol/l (previously ≤ 2.6 mmol/l) and the use of buccal dextrose gel in its treatment.

A multidisciplinary group was set up in the level 3 NNU. The guideline was disseminated using a 'read and sign' approach. A buccal dextrose monograph was developed. The blood gas analyser on labour ward was upgraded to allow neonatal sampling. Champions supported implementation through educational 'buzz' sessions and training videos. Test PDSAs were carried out, resulting in further training and guideline revision.

Results Baseline data revealed that hypoglycaemia made up 4% of term admissions (2% full admissions, 2% short stay ≤ 4 hours {SS}). 37% of babies required IV fluids, 44% required nasogastric feeds and 19% were given oral formula top-up feeds. 41% of women intended to exclusively breastfeed, 7% were doing so at discharge. For quality assurance, a prospective audit of blood gas glucose and lab blood glucose was carried out. Our outcome measure is % of term admissions to NNU with hypoglycaemia. Since implementation there is a trend towards reduction in admissions - 2 SS admissions only. Our process measure is compliance with the hypoglycaemia bundle - currently 65%. Our balance measures are: any adverse events, incorrect protocol (term vs preterm) use and an increase in breastfeeding rates. 1 infant >48 hours with no hypoglycaemia risk factors was treated on this protocol. There has been no incorrect protocol use. 72% of women intended to breastfeed, 47% were exclusively breastfed at discharge.

Conclusion There is a trend towards reduction in separation of mothers and babies. Bundle compliance requires ongoing work. Understanding barriers has been key to maintaining interdisciplinary staff engagement. There are ongoing challenges around equipment, the use of two different thresholds in term and preterm infants and avoiding person dependency.

G82 CHANGING THE 'NO CHANGE' CULTURE: INCREASING USEFULNESS OF THE SCBU WARD ROUND

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Aim This Quality Improvement project aimed to increase the usefulness of ward rounds in a busy Special Care Baby Unit (SCBU; i.e. low dependency neonatal unit). Most babies' primary reasons for remaining inpatient in SCBU are to gain weight and establish oral feeds. Despite this taking weeks for some, they were seen daily on ward round. Baseline data showed that 86% ward round plans for these low risk babies made no changes to management. My aim was to halve this number in four months.

Method Babies that required daily medical review (table 1) were identified and excluded from the project, leaving only low risk infants. The medical team were instructed to actively seek out babies of concern by discussion with nurses before ward round.

Abstract G82 Table 1

Exclusions

- Any nursing concerns (ask explicitly)
- Any parental concerns
- On treatment dose antibiotics, intravenous fluids, morphine
- Being observed for drug withdrawal
- Known cardiac defect that could lead to heart failure
- 'Rooming In' prior to discharge

The first PDSA cycle introduced the project to colleagues. Subsequent cycles reduced the frequency of ward round to three times per week, trialling different days. Data was collected from clinical notes. Balancing measures were details of babies that became unwell in the data collection period.

Results The frequency of ward round plans making no changes to management of low risk babies dropped from 86% to 17%, which surpassed the aim. Doctors felt they had more time to help colleagues on the postnatal ward, complete discharge paperwork further in advance (thus facilitating morning discharges) and for projects. Medical and nursing teams were satisfied that well babies were not examined and disturbed daily.

Conclusion Medical and nursing teams are more satisfied with ward rounds occurring three times per week instead of daily for low risk babies in SCBU. More work is needed to look into ways to empower nursing staff to lead on care in low risk babies on their journey to discharge. This project would have had more impact if a reliable measure could be found for staff efficiency.

G83 REDUCING LENGTH OF STAY FOR CHILDREN WITH PROLONGED ADMISSIONS TO HOSPITAL

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Aims To reduce the length of stay for patients with prolonged admission to a tertiary paediatric hospital. To improve experience for patients by reducing the disruption to their personal and family life, development and education, reduce discomfort and risk of healthcare associated harm. To improve capacity for the institution to undertake additional activity, improving financial performance. This additional activity would also reduce waiting times and improve access to care for other children. To improve the experience for health care professionals by enabling better care and reducing conflict.

Methods We systematically collected data on length of stay for inpatients across our institution (excluding neonatology) retrospectively and prospectively. We reviewed this data and shared it with clinicians (and continue to do so), we engaged with families and staff to identify their priorities and learn from their experiences. We initiated a range of projects related to this theme, including new care standards, new electronic documentation, education and collaboration sessions, new working practices and new staff roles. We developed a governance structure to monitor and sustain these new approaches, and are continuing to work on continuous improvement across a range of metrics.