Results Our primary measure 'bed days per month occupied by patients with a length of stay of over 30 days' decreased from a mean of 635 bed days/month in 2016–18 to 534 bed days/month in 2018/19, a reduction of 16%. This is equivalent to >3 additional beds available on the wards each day.

In 2019 year to date we have sustained this reduction and aim for further improvement. In addition, patient and staff satisfaction with the care of these patients has improved and the rate of readmission was unaffected.

Conclusion Despite increasing medical complexity in our inpatients, and internal and external challenges the rise we had seen in prolonged admissions over recent years is not inevitable. It is possible to significantly reduce length of stay for these patients and simultaneously improve quality of care. Improving services for these children and young people should be a priority for paediatrics in the future and has benefits for patients, families, staff, the institution and the wider population.

G84 IMPROVING BCG VACCINATION REFERRAL OF ADMITTED ELIGIBLE NEWBORN TO 98% BY JULY 2019

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Aim The development of effective antibiotics and the BCG vaccination has significantly reduced the number of TB cases. The aim of this quality improvement project (QIP) is to improve BCG vaccination referrals for admitted eligible newborns in Hospital to 98% by June-July 2019, by raising awareness amongst healthcare professionals and improving identification of eligible newborns.

Methodology The aim and objectives were formulated using a driver diagram. A Plan-Do-Study-Act cycle was used to identify suitable changes and outcomes. Euroking database was used to create a spreadsheet with information specific for BCG vaccination eligibility and referral status. Data was collected from May 2018 to May 2019. Resources that raised awareness amongst healthcare professionals, by providing guidance for easier recognition of eligible newborns, were created by working closely with doctors, nurses and midwives.

Result The numbers of missed BCG referrals from May 2018 to Aug 2018 was 10 out of 13 (76.9%). From September 2018 to May 2019, it was 18 out of 34 (52.9%), which showed a reduction of 23.9% in missed BCG referrals. From September 2018 onwards, doctors were obliged to refer newborns for BCG vaccination.

Questionnaires were sent out in March 2019 to former and current paediatric and non-paediatric doctors. 7 out of 10 questionnaire responses were received. All of the responders found it easy to refer newborns for BCG vaccination and used the WHO list to identify high-risk countries. Paediatric trainees were informed about BCG vaccination referral during their induction, whilst non-paediatric trainees were aware of the referral via this QIP or by speaking to seniors. In May 2019, awareness was raised and random spot checks were done in June and July 2019. The number of missed BCG referrals for June 2019 to July 2019 was 0 out of 2 and 100% of BCG referrals was achieved.

Conclusion Improving BCG referrals will reduce the time, work and resources needed to chase missed BCG referrals and avoid new cases of TB. This could be achieved with easy

access to information, such as the ethnic origins of grandparents/parents of newborns, which will be added to the next antenatal book.

G85 IMPROVING CANNULATION EFFICIENCY IN LEEDS CHILDREN'S HOSPITAL (LCH)

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Background There was anecdotal evidence that the time to gather equipment for paediatric cannulation was time consuming. This had the potential to create delays in such time-critical matters as IV antibiotics within 60 minutes in suspected sepsis.

Aim To standardise cannulation trolleys across LCH to improve equipment gathering efficiency.

Method

- Questionnaire to junior doctors to determine how long it equipment gathering takes and number of cannulas inserted per shift.
- Junior doctors were timed gathering all necessary cannulation equipment on all wards
- A pilot cannulation trolley was trialled on the children's assessment unit. Adjustments were made after feedback and photographs of equipment were inserted on the trolley to facilitate appropriate stocking.
- Junior doctors were then timed gathering cannulation equipment with the new trolleys.
- A cannulation trolley champion was nominated for each ward.
- New cannulation trolleys were disseminated across all wards in LCH.

Results

- 88% of doctors agreed that 'It often takes me longer to find the equipment I need for cannulation than inserted the cannula'.
- 1–6 cannulas are inserted per junior doctor shift.
- Time taken to gather cannulation equipment at baseline 4.21 minutes. With cannulation trolleys 2.12 minutes.
- Based on 1–6 cannulations per doctor per shift, before the trolleys this would take 87–522 minutes and post-trolleys 43–258 minutes.

Conclusion Introduction of standardised cannulation trolleys has improved efficiency at cannulation preparation and has enabled speedier cannulation especially in time critical circumstances such as sepsis.

G86 IMPROVING DISCHARGE SUMMARY QUALITY IN A GREENFIELD SINGLE ROOM QUATERNARY NEONATAL INTENSIVE CARE UNIT

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Background Neonatal Intensive Care Unit (NICU) Discharge Summary (DS) provides continuity of care and ensures safe patient transition between hospital and community. Inadequate NICU DS documentation contributes to medical errors and loss of follow up. Our goal is to improve the DS quality

through use of a standard template to decrease identified deficiencies.

Aims

- Increase use of a standardized template for DS to >90% in 6 months
- Improve quality of DS to >85% in 6 months
- Achieve the state of no deficiencies in the DS to >80% in 6 months.

Methods

Study Design: Prospective PDSA (Plan, Do, Study, Act) cycle-based Quality Improvement Project.

Study Setting: 54 bedded quaternary level NICU, Doha, Qatar.

Study Period: January 1, 2019 to December 31, 2019.

Phase 1: January to May 2019: Pre-intervention phase: Conducted an anonymous DS survey and audit and provided education on improving DS qualities in several team group meetings

Phase 2: June to August 2019: Intervention phase: Designed new DS template and implemented in daily care along with other interventions bundle

Phase 3: September to December 2019: Post-intervention phase: Regular monthly audit or quality check and feedback

Definitions Template: A structured DS processes and framework.

Quality: The standard of the DS measured with apriori outcome measures.

Deficiencies: Missing or inaccurate required information on DS documentation.

Results

Abstract G86 Table 1

Outcome measures (mean%)	Pre-Intervention	Intervention	Post Intervention
	Jan to May 2019	June to Aug 2019	Sep to Dec 2019
Use of standard DS template	10	85	90
Quality of DS	40	75	85
No deficiencies in DS	50	85	95

Conclusion The NICU DS quality improvement project initiative achieved the goals of improved DS quality, increased use of a standardized template for DS, and decreased the deficiencies in DS. Going forward, we plan to continue with regular audits to maintain DS quality.

G87

IT'S A 'DRUGGLE': REDUCING DRUG ERRORS AND DISSEMINATING LEARNING

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Aims Our aim was to improve team awareness of medication errors on the general paediatric ward by June 2019. We hoped that this would:

- Improve safe prescribing;
- Reduce medication errors.

Methods An audit revealed frequent and serious administration and prescribing errors on the general paediatric ward. Over a

half were administration errors and a third were prescribing errors.

Other trusts have implemented discussions around drug errors known as a 'Druggle'. We have replicated the idea but adapted it to make it relevant to our trust.

A multipronged, multidisciplinary intervention was planned using a PDSA approach which included:

- implementing a weekly Druggle, to be attended by the multidisciplinary team (MDT). The purpose of our Druggle is to review all the drug errors and near misses from the previous week with discussion and action points on how to reduce the likelihood of the errors recurring;
- dissemination of learning points from the Druggle;
- restructuring the paediatric prescribing induction.

Outcome measures:

- weekly attendance at the druggle;
- dissemination of learning;
- restructure of the paediatric prescribing induction;
- total number of drug errors (as recorded on Datix).

Results Our run chart demonstrates that a steady increase in attendance at the Druggle, now maintained at 100% for a number of months. There was a temporary fall in attendance when there was a change in the staff leading the project, which resolved with new leadership.

Learning is disseminated at nursing huddles and highlights in the monthly governance letter.

The paediatric prescribing induction has been restructured to test basic paediatric prescribing skills and prescriptions to be successfully completed on the electronic prescribing system.

There has been a sustained reduction in drug errors over time with an overall 24% reduction in administration and prescribing drug errors comparing the 8 weeks pre and post-intervention.

Conclusions Drug errors are trending downwards with nearly a quarter reduction in errors. This project is particularly valuable as the education is ongoing and weekly action taken.

There were several challenges and areas for learning: finding a convenient location and time; MDT involvement in planning and implementation; encouraging pharmacy to take ownership and the need for a project lead to ensure sustainability.

G88(P)

ADVANCING ACCESS TO ADVANCE CARE PLANS

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Introduction The Paediatric Advance Care Plan (PAC-Plan) supports families in exploring understanding of the multi-agency response to death. This record of conversations helps support families and clinicians to make decisions during often fraught and difficult circumstances at the end of life. In practice its effectiveness is often restricted because in times of crisis it cannot be found.

The aim of this quality improvement (QI) project was to improve access to PAC-Plans a) for out-of-hours medical staff in our local district general hospital, where such crises might occur, and b) by the Paediatric Palliative Care team from across the region.