Method Small cycles of change included uploading updated plans to the local intranet portal, educating staff on how to find the plans using a 'how to' guide, education and posters placed around the wards. Effectiveness of the change was evaluated by time taken by medical staff to find a PAC-Plan using a hospital identification number.

Results After 3 small cycles of change there was a fall of 83% in median time taken to access the PAC-Plan from 4 minutes 55 seconds to 50 seconds.

Conclusion A significant reduction in time taken to find PAC-Plans using the existing intranet system was achieved through a combination of correctly uploading PAC-Plans, and training staff. Further work would be to ensure this system is sustained.

By ensuring appropriate logins and access to the NHS portal, any member of the palliative care team will be able to securely access PAC-Plans from any location across the region.

G89(P) IMPROVING PRIMARY CARE ASSESSMENT OF FEVER IN CHILDREN UNDER FIVE

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Aim In a busy GP surgery with 4897 registered patients, this project aimed to review and improve the assessment and management of pyrexia in children under five. As recommended in NICE's guidance, all children presenting with a feverish illness should have their temperature, heart rate, respiratory rate and capillary re-fill time assessed and recorded.

Methods Using the Plan-Do-Study-Act (PDSA) quality improvement methodology, we reviewed consultation notes of all children under five to identify relevant cases and assess our performance. We designed a 'Fever <5' SystemOne template that allowed clinicians to complete prompts for vital signs when assessing relevant patients. We presented our findings and template at a practice meeting and reviewed consultation notes for relevant patients to assess whether our performance has improved in an one month period.

Results Our practice achieved 100% on the measurement and recording of the vital signs recommended by NICE when assessing children under five with recorded tympanic temperatures of 38 degrees or above; however, there was room for improvement. When assessing children under five presenting with a history of fever, the vital signs were only recorded 46% of the time. After the template was introduced and results shared at a practice meeting, we re-audited relevant patients in a one month period. This time, the four vital signs were measured and recorded 85% of the time.

Conclusion Feverish illness is a cause of parental concern. Not only is pyrexia one of the commonest reasons for a child to be taken to a doctor, it is often indicative of underlying infections, which remain the leading cause of death in children under five. As such, comprehensive assessment in primary care is vital. As pyrexia can often be variable in children, and parents often give paracetamol or ibuprofen prior to attending the surgery, it is important to include children with a history of fever in this population. With the introduction of a succinct and simple electronic template, we hope to improve our practice's assessment of children under five presenting with fever.

G90(P) MANAGING ACUTE PAEDIATRIC PAIN: A JOINED UP APPROACH

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Objectives Managing pain in children presenting to hospital should be a high priority for staff in the emergency department (ED) and on the children's ward. Many factors influence the quality of this provision. Following an audit of pain management in children with fractures, the Royal College of Emergency Medicine (RCEM) identified potential improvements in the care of children presenting to District General Hospitals having sustained a fracture. As part of a department wide focus on pain management and closer links being forged between paediatrics and ED, this project aimed to assess staff confidence in paediatric pain management as well as patient experiences in ED and on the paediatric ward.

Methods An electronic survey, alongside face-to-face discussion, was used to ascertain staff confidence levels, prior training and potential ideas for innovation in paediatric pain management. Alongside this a paper survey was sent to 50 families whose children were either seen in ED or admitted to the ward with a fracture. The feedback was analysed in a focus group involving medical and play specialist staff. We plotted the course of the patient journey constructing a driver diagram.

Results The primary drivers included medicines provision, training and ability and a reassessment process. This culminated in change ideas such as: access to a distraction box in ED, increased awareness of play specialist availability, formal training in both departments and the development of a pain pathway tool.

Conclusion Amongst other systems changes and wider education advances an acute paediatric pain tool was developed. This tool has been designed to be used initially at triage and then throughout an admission. The tool includes pain scores and guidance on pain management depending on the score and injury pattern. This tool has been reviewed at the paediatric clinical governance meeting and we are exploring its introduction aiming to evaluate the effect of the tool on staff confidence and patient experience after six months.

G91(P) CONTACTLESS HEART MONITORING USING MMWAVE RADAR – A RESEARCH STUDY

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Introduction Significant burns and skin damage are caused by the probes of the pulse oximetry devices that are used to measure the pulse rates and oxygen saturations in neonates and children. The Royal College's 'Paediatrics 2040' Project aims to look at new innovations and technologies to improve the care of children. Hence we researched one such technology.

Aims To investigate a novel method of 'non-invasive' heart rate monitoring using mmWave radar sensing technology.

Methods To utilise and evaluate Texas Instrument's IWR1443 mmWave radar sensor (similar to radar, but uses short wavelengths for high resolution). A frame of transmitted signals,