Overall, evaluation of human factors to identify potential barriers to follow up has significantly reduced errors and improved patient safety.

REFERENCES

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G94(P) IMPROVING CANNULATION EFFICIENCY IN THE CHILDREN'S HOSPITAL

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Aim To introduce standardised cannulation trolleys across the Children's Hospital to decrease time spent gathering equipment.

Method A questionnaire was sent to junior doctors enquiring about cannulation practices across the wards in the Children's Hospital. Junior doctors were then timed gathering the necessary cannulation equipment on all of the paediatric wards. A pilot standardised cannulation trolley was trialled on the children's assessment unit, and junior doctors were timed gathering equipment with the new trolleys. Adjustments were made to the equipment layout after feedback from staff, including photographs of equipment inserted into the trolley drawers to facilitate appropriate re-stocking. Standardised cannulation trolleys were disseminated across all wards in the Children's Hospital. A cannulation trolley champion was nominated for each ward. Random stock checks have been performed.

Results In the baseline survey 88% of doctors agreed that 'it often takes me longer to find the equipment I need for cannulation than inserting the cannula'. 1–6 cannulas were inserted per junior doctor per shift. The time taken to gather cannulation equipment at baseline was 4.21 minutes on average, the maximum time was 10 minutes. After the trial of the cannulation trolley on the assessment unit it took 2.12 minutes. This is an initial reduction of 50%. A second spot audit of the cannulation trolleys has been undertaken. All wards had well stocked cannulation trolleys and it now takes 58 seconds to gather everything needed for cannulation. If we scale this up and have on average 20 doctors working during the daytime, and each doctor sites 1–6 cannulas per shift, 84.2–505.2 minutes were spent gathering cannulation equipment compared to 19.3 minutes to 116 minutes currently.

Conclusion In an era of less staff and the need to improve efficiency, this simple implementation has hugely decreased the time spent preparing to cannulate, a common junior doctor job. This has enabled quicker cannulation especially in time critical circumstances such as sepsis.

G95(P) DRUGGLE: A PRESCRIBING SAFETY QUALITY IMPROVEMENT PROJECT

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Aim Prescription errors are common on paediatric wards and have the potential to cause significant harm to children and young people. We introduced a regular intervention - a prescribing safety huddle called the 'Druggle' that aims to a)

increase the awareness of prescribing errors among doctors and nurses; b) improve prescribing and reduce errors and c) create a safe and positive prescribing culture.

Method We have presented a monthly 'Druggle' at our Clinical Risk Meetings, where prescribing errors are discussed and learning points identified. These interactive sessions also involve prescribing quizzes created by our pharmacist. We have collected regular feedback from the multidisciplinary team to enable us to continually improve the 'Druggle'. Data has been collected on prescribing errors on our paediatric ward, over 10 day periods in October 2018 and June 2019, before and after the introduction of the 'Druggle'.

Results We noted a decrease in prescribing errors from 187 to 126.

Abstract G95(P) Table 1

Type of error	October 2018	June 2019
No date	10	19
No route	1	0
No dose	1	7
Incorrect dose	3	3
No dosing per kg when required	4	1
Incorrect frequency	2	0
Allergies not checked at the top of the drug chart	4	1
Allergies not checked for each prescription	86	40
Prescriber has not signed or documented their name	3	2
Antimicrobial Indication not documented	39	28
Antimicrobial Duration not documented	34	25

Feedback from the MDT allowed us to alter the content of our 'Druggles' to focus on learning from reported prescribing related Clinical Incidents and to develop the idea of introducing a prescribing safety newsletter. It has also helped us to tailor prescribing teaching in induction for new doctors joining the department. We have recently incorporated a pharmacist-led daily drug huddle in our board rounds.

Conclusion Regular prescribing interventions like 'Druggles' could be a valuable tool to improve safety and reduce prescribing errors. Regular feedback can continuously improve and develop these interventions.

G96(P) INNOVATING AND LEADING CHANGE: A PRACTICAL GUIDE TO IMPLEMENTING A REGIONAL ST1 TEACHING COURSE

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Aims The RCPCH requires that all three written exams be passed by the end of ST3 (level 1) training. Failure to do so prevents trainee progression. However, many trainees struggle to pass examinations on first sitting. In response, in 2014 we set up an exam preparation course that readied trainees for the FOP and TAS examinations within the first 6–12 months of training.

Methods A pre and post course online questionnaire (5-point Likert scale) was sent to all trainees after the 2019 course. It evaluated trainee confidence in passing the exam and