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

confidence with RCPCH question style. In addition, open-ended questions sought to identify problems with the teaching programme and barriers to attendance.

Results All trainees reported improved confidence in their ability pass their exams and answer MCQ style questions. Trainee confidence in passing the FOP/TAS exam improved from 51.8% pre-course to 87.2% post course. Trainee confidence in answering RCPCH exam style questions improved from 48.2% pre-course to 100% post course.

Areas identified as requiring course improvement included:

- Teaching style: non-interactive power point, limited MCQ practice
- Course timing: trainee exhaustion from 4-day course run consecutively
- Funding: reliance on sponsored lunches.

Discussion Over the last 6-years, by analysing trainee feedback and working together with the head of school, we have been able to develop a unique course, which provide a high-quality teaching to prepare trainees for their FOP/TAS examinations. One of the key contributors to our success was changing the course teaching style. Power points were replaced by interactive one-hour case based discussions, paired with best of five and extending matching questions. Problems with accessibility were addressed by holding the course immediately prior to the trainees starting their training programme. This maximised trainee attendance rates as it has avoided the needed for study leave applications. Furthermore, breaking the four-day course up by running it either side of a weekend has ensured trainees are energised and productive. Sponsored lunches required trainees to engage in presentations during their breaks. The top slicing of the study leave budget has allowed us to provide food and drink, giving the trainees a much-needed rest.

G97(P) A QI PROJECT TO INTRODUCE POINT OF CARE CRP TESTING FOR ASYMPTOMATIC BABIES RECEIVING ANTIBIOTICS ON THE POST NATAL WARD

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Aim To see if point-of-care (POC) rather than laboratory C-reactive protein (CRP) testing on the postnatal ward (PNW) leads to earlier discharge for asymptomatic babies >37 weeks gestation who have been screened and treated for sepsis based on risk factors alone.

Method Babies > 37 weeks gestation receiving antibiotics for sepsis risk factors on the PNW were prospectively identified from the daily medical handover list. The trust sepsis risk factors are maternal group B streptococcal infection, prolonged rupture of membranes > 18 hours and suspected maternal sepsis. Babies were excluded if clinically unwell. In our trust all babies meeting the threshold for screening and treating for infection have a full blood count, CRP and blood culture at birth with antibiotics administered afterwards. A second CRP should be performed at 18–24 hours of life. Babies who remain clinically well with the second CRP being <10, will stop antibiotics prior to the 48-hour blood culture result and be discharged back to midwifery care. We investigated whether these babies had their second CRP performed at the correct time and if they were discharged earlier with using the POC CRP testing.

Results

	Cohort 1- laboratory 2nd CRP	Cohort 2- POC 2nd CRP
Number of babies	35	19
Most common reasons for antibiotics	Maternal pyrexia/ sepsis	Maternal pyrexia/ sepsis Prolonged rupture membranes
Birth CRP<1	97%	100%
Average length of time (hours) between 1st and 2nd CRP (target 18–24)	25	24
% with 2nd CRP<10, suitable to have antibiotics stopped	63%	53%
Average time taken to stop antibiotics after CRP result (hours)	8	5
Total number unnecessary antibiotic doses given	8	5
Average time of discharge to midwifery care after 2nd CRP result (hours)	16	15.5

Conclusion Babies receiving POC CRP testing on the PNW had their antibiotics stopped slightly sooner and were discharged to midwifery care slightly earlier, however these differences were slight. They did not go home sooner as many required further midwifery care, most commonly feeding support. We anticipate that as our teams become more familiar with the POC CRP testing less babies will receive unnecessary doses of antibiotics and will return to midwifery care sooner.

G98(P) ABSTRACT WITHDRAWN

G100(P) HOW DO WE ENCOURAGE A CHANGE OF BEHAVIOUR AROUND COLLEAGUES TAKING BREAKS?

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We relaunched our HALT (are you Hungry, Angry, Late or Tired?) campaign with poster and enhanced communications. To change behaviour around break culture more was needed.

Aim To increase colleague wellbeing by improving the percentage of colleagues taking a break.

Methods As part of our wellbeing conference we ran a HALT workshop. Including some background information around the positive benefits of taking a break, barriers and enablers to taking a break. We captured baseline data at beginning of the conference and collected post conference data. Ongoing data collection to see if changes have been sustained.

Results 91 colleagues attended our workshop. We asked on a Likert style scale how energised they felt from low – high to 9 low energy levels. At the beginning of the shift 3/9 (range 1–7) and at the end 5/9 (Range 1–9).

Barriers and enablers to taking a break were at organisation, team and individual level. Environmental factors included 'no staff room', 'always connected to technology'. Workload