Abstract G108(P) Table 1

Number-	Jan'13-Dec'13 (1 year)	Mar'16-Feb'19 (After PNJ pathway) (3 years)
Of referrals	222	166(55/year)
Attending clinic	182	137(46/year)
Investigated	88	51(17/year)
With pathological cause	0	5 (1 biliary atresia, 2 G6PD deficiency, 1 congenital hypothyroidism, 1 still under investigation)

Conclusion PNJ referrals declined by 75% following implementation of the pathway. Number of infants investigated reduced by 80%; whilst still effectively and timely identifying serious pathology. It meant 167 less clinic appointments and 71 fewer infants investigated per annum.

Recommendation PNJ pathway improved service-efficiency whilst effectively identifying serious pathology. Most importantly, it is community-based, family-friendly and a safe approach to PNJ management. NICE should consider adopting this approach.

G109(P) TRANSFORMING EDUCATION AND TRAINEE EXPERIENCE USING QUALITY IMPROVEMENT

^{1,2}H Zhu, ^{1,2}I Ng, ²R Tresman, ^{1,2}S Cooke, ^{1,2}E Routh, ²A Roberts, ²J Morris. ¹Community Paediatrics, Evelina Children's Hospital, London, UK; ²General Paediatrics, Kingston Hospital, Kingston-Upon-Thames, UK

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Aims Problem statement: Paediatric trainees expressed dissatisfaction with local training on the GMC survey. This led to poor morale, trainees feeling disadvantaged and less equipped to provide excellent quality of care.

This project aimed to improve quality of paediatric training by promoting a supportive learning environment and proactively sharing learning experiences from July 2018 to August 2019.

Methods Our problem analysis involved the 2018 GMC survey and qualitative local questionnaires. We identified key areas for improvement; teaching attendance, rota design and use of feedback. Our process measures were evidence of shared learning and our outcome measures were trainee satisfaction in the 2019 GMC survey. Change ideas were implemented by a team of Education Champions comprising junior doctors and consultants. Education governance was improved by teamwork, transparency and shared consultant responses to all areas of trainee feedback. Protected teaching sessions and clinic opportunities were built into rotas, including monthly half-day education symposia for Registrars.

Results Learning points were discussed at Monday handovers, led by the night team and on-call consultant. PDSA cycles showed positive uptake on run charts, with a median of 3 learning points shared weekly on WhatsApp, sustained for 3 months through frequent reminders by champions. However, this dropped in number during holidays and increased locum cover.

Monthly education summaries sharing local learning were emailed, with excellent stakeholder feedback. These improved morale and engagement in teaching by celebrating the range

of local and national training provided. Education whiteboards were used to educate on monthly topics, update trainees of upcoming educational opportunities, display quality improvement projects and share learning points.

The GMC Training Survey showed improvement in all areas and overall trainee satisfaction increased from 70% to 82% from 2018–2019. Improvements in local teaching (increased from 53% to 68%) and handover (65% to 80%) were particularly encouraging.

Conclusion This project demonstrates how the model for improvement can be used to systematically improve education and trainee experience. Using multiple modes of communication for regular sharing of learning can embed education into a busy working day and improve trainee satisfaction. Ongoing PDSA cycles and champions are required to sustain further improvements in education and trainee experience.

G110(P) KEEP CALM AND INTUBATE (USING CHECKLISTS ON THE NEONATAL UNIT TO REDUCE ANXIETY AND INCREASE SAFETY OF NEONATAL INTUBATIONS)

N Audhali, I Gregory, G Nair, R Singh, J Oleksiewicz, P Kalaivanan. Paediatric Department, Whipps Cross Hospital, London, UK

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Aim Intubation on a DGH Neonatal Unit can be risky and stressful for a new registrar. We know that intubations in non-specialist centres have greater risk of adverse events, and evidence for use of safety checklists, is well established. We aimed to improve safety and staff confidence in delivery of care on our neonatal unit by launching a safety checklist for this and other invasive procedures. This would function as an aide memoire for the performing clinician, support good team-working, empower assistants to help and to raise concerns when appropriate.

Methods Taking a quality improvement approach, we set up a team of doctor and nurse champions to develop, pilot and embed our safety checklist. We started with a preliminary staff survey of doctors and nurses via survey monkey and paper questionnaires. We developed checklists for intubation, central line, long line, lumbar puncture and chest drain using NHS England's template. These were made widely available and launched via staff seminars, handover bulletins, and posters. At 3 months post-launch we carried out a Quality Peer Review to assess staff response to the checklists. Audit data for intubation, and central, and long lines were collected at 6 months to review quantitative take up of the checklists.

Results Preliminary survey responses: 19 respondents, most (n=15), thought intubations safe but some (n=4) thought they were only somewhat safe or not safe. All respondents (n=19) thought checklists would make intubation on the unit safer, and most, (n=18) thought they would make documentation easier. 24 hour Peer Quality review data: themes reflected staff perception's that checklists improved team working, reduced stress, and increased safety of invasive procedures. Our preliminary 6-month audit data showed: 15 intubations of which most (n=13) had checklists correctly used, 24 central and long lines of which most (n=22) had checklists. We will continue to collect and analyse data for the next year. Checklist use has been adopted into departmental induction this September.