G127(P) SNAP AND SHARE – A NOVEL APPROACH TO MEDICAL EDUCATION

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Background Junior doctors rotate between different specialties to gain a breadth of experience but may have little experience in the specialty they are working in and therefore feel less confident and may present a risk to patient safety. Innovative ways of maximising learning from teaching opportunities are needed to improve knowledge and confidence.

Aims

- Increase confidence of junior doctors in managing common paediatric problems
- Maximise learning from each teaching opportunity and share with as many juniors as possible

Methods During their general paediatrics rotation, junior doctors have three morning teaching sessions a week; simulation, consultant-led and case-based discussions. We introduced a 'snap and share' proforma to summarise key learning points and further resources from each morning teaching session. They were photographed and shared on the junior doctors' WhatsApp group.

Results Trainees reported a mean 40% increase in knowledge and confidence of the topic after receiving the 'snap and share' material.

Conclusion

- The 'snap and share' model is effective for engaging trainees in learning and improving confidence in topic material
- Sharing learning in this way maximises learning opportunities in paediatric trainees in this department

G128(P) 'ASSESSMENT TO TREAT RATHER THAN ADMISSION TO ASSESS': ESTABLISHING A PERMANENT PAEDIATRIC ASSESSMENT UNIT AT A DISTRICT GENERAL HOSPITAL

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Aim A quality improvement Paediatric Assessment Unit (PAU) pilot creating a consistent model of 'assessment to treat' rather than 'admission to assess'. To establish a permanent PAU at a district general hospital (DGH). Specific aims included improving quality of care, reducing unnecessary admissions, improving patient experience, increasing primary care access to senior advice and bringing paediatrics services in line with an 'integrated front door' approach.

Method Historically, paediatric assessments and admissions had the same care pathway at our DGH. Local CCG analysis indicated that children were twice as likely to be admitted compared to other regional units with separate PAU facilities. A funded 3 month pilot PAU ran from January- April 2019. The pilot ensured that senior decision making took place at the point of referral, triage and review.

Results 434 children attended during this time. Of these, 122 children were assessed and subsequently admitted (28%) and

312 were treated and allowed home (72%). Proportion of patients waiting to receive a clinical decision greater than 120 minutes fell from 46% to 10%, with significantly more children receiving a clinical decision within 60 minutes, exceeding RCPCH standards. Improved advice to primary care: 31% calls given specialist advice, decreasing admission/referrals to outpatients. Consultant Connect answer rates increased from 54% to 83%, with 56% patients avoiding an unnecessary visit to hospital. 100% children screened for sepsis with significant improvements for children requiring antibiotics within one hour. There were less reported patient/carer concerns with positive patient experience. Staff experience was universally positive with improved working environment, structure and morale. Trainee exception reporting reduced. GMC Trainee Survey results improved by two quartile positive shift for workload: highlighting good team work and supportive working environments. This model supported achievement of Standard 2 'Facing the Future' standards and was recognised in the NHSI cross county review of paediatric services.

Conclusion The qualitative and quantitative outcomes were presented to our Trust, A&E delivery board and the STP business planning teams. The business case was successfully supported for funding a permanent PAU from January 2020. A PAU alongside ED remains the long term ambition for an integrated front door/acute paediatric assessment hub.

G129(P) ISOTONIC MAINTENANCE IV FLUIDS IN INFANTS UNDER 3 MONTHS AS PER NICE GUIDANCE: A CLINICAL AUDIT

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Aims

- Audit the type of IV fluid prescribed against NICE recommendations
- Monitor incidents of hypo- and hypernatraemia

Methods Data were collected from the electronic patient record system (EPR). All fluid prescriptions and electrolyte tests were analysed during three data collection periods:

- First Audit Period, with promotion of local (NICE-based) guideline
- Second Period, before introduction of EPR IV fluid prescription 'power plan'
- Third Audit Period, after introduction of EPR power plan

We looked at EPR records of patients who had incidents of sodium abnormalities to determine whether they could have been iatrogenic.

Results A total of 568 fluid prescriptions were analysed. Data in the first audit cycle showed only 40% of fluid prescriptions were isotonic and the rest were hypotonic. Whilst on IV fluids, there were 12 patients with hyponatraemia, 11 of whom were on hypotonic fluids.

These findings were disseminated to general paediatric and paediatric surgical teams, and the local IV fluid guideline was promoted. On the EPR prescription system, a 'power plan' was introduced, which makes isotonic maintenance fluids the default option.

Data in second audit period, before the fluid prescription power plan had been implemented, showed that 51% of IV maintenance fluids were isotonic. This increased to 88%, after the power plan was introduced.

Across both the second and third audit periods, there were 2 infants who developed hyponatraemia after receiving maintenance IV fluids. One was on a mixture of TPN and isotonic fluid, the other was on hypotonic fluids. There was only one incident of hypernatraemia (146), which occurred while on 10% dextrose infusion.

Conclusion The prescription of isotonic solutions has increased significantly since the EPR power plan for paediatric fluid prescriptions was introduced. This had a much greater impact than trying to encourage guideline adherence alone.

There is little published evidence on the safety of isotonic fluids in young infants. We have not observed any significant hypernatraemia since the increase in isotonic fluid usage.

G130(P) EVALUATION OF A YEAR OF DEBRIEFS IN A TERTIARY CHILDREN'S HOSPITAL AS PART OF A NEW FRAMEWORK OF STAFF SUPPORT

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Aims After a series of difficult resuscitations and serious incidents, we developed a new debrief pathway as part of a broader staff support programme.¹ We report 12 month evaluation of this pathway.

Methods The debrief pathway includes: an immediate huddle after the event, a personal 'check in' within 48 hrs with a supervisor/line manager, and a debrief facilitated by a senior psychologist 1–3 weeks later. 71 debriefs were held over a year (52 group, 19 individual), the majority (67) delivered by the same psychologist. After each debrief, participants completed a semi-structured questionnaire and the Miller (2007) group outcomes scales.

Results Feedback from over 200 participants representing the full range of the MDT was collated. The overwhelming majority valued debriefs as demonstrated by the percentage of high scores (scoring 8, 9 or 10 on a scale 0–10) on Miller group outcomes: 90% rated debriefs overall highly; 86%, 89% and 95% rated highly respectively on Goals, Approach and Relationship with group/facilitator. If the immediate huddle and 48 hour follow up occurred, the debrief flowed more smoothly. Additionally, attendees appeared better adjusted and there were fewer requests for individual support.

Themes that emerged from the qualitative feedback include the importance of talking in a safe space, listening to different perspectives and that sharing emotional reactions improved their psychological wellbeing. Other themes include that debriefs help staff to recognise existing support and consider offering support to colleagues. Many staff reported debriefs had helped them remain in work or return to work after incidents. The analysis identified 'the protective power of staff support' - knowing that management sanctioned debriefs made people feel cared for by the hospital, and that debriefs improve working practice by providing the space to reflect on situations.

Conclusion Staff value debriefs following incidents. We found a staged approach to holding debriefs useful. This

fits with a recent review reporting significant benefits from early trauma interventions when part of a wider package of support (Richins et al., 2019). We conclude that our debrief pathway, where debriefs are normalised and routine, plays an important role in the psychological wellbeing of our staff.

REFERENCE

1. The development of the staff support programme is discussed in more detail in another presentation.

G131(P) THE ROLE OF VIRTUAL CLINICS IN REDUCING DEMAND FOR CLINIC CAPACITY—A PILOT STUDY FOR ANTENATALLY DETECTED HYDRONEPHROSIS PATHWAY AT A DISTRICT GENERAL HOSPITAL

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Aims To evaluate the use of telephone consultation 'virtual clinics' as an alternative to traditional face-to-face clinic in effectively managing the increasing demand for outpatient clinics. A pilot for antenatally detected hydronephrosis follow up service.

Methods Data from renal clinics at a district general hospital over one year was reviewed and information collected from patient electronic records.

Results There were 232 renal clinical appointments. 140/232 appointments were face-to-face (60%) and 92/232 appointments were virtual (40%). The DNA rate for face-to-face encounters was 10/140(7%) and for virtual clinics (no answer to telephone calls) was 4/93(4%). Antenatal hydronephrosis related referrals accounted for 85/232 appointments (36.6%), of which 38 were new referrals. 57/85 of all appointments for antenatal hydronephrosis were virtual (67%) and 28 were face-to-face (33%). The first appointment for all 38 of these patients was virtual (100%). 5/38 patients were referred to tertiary services (13%). 13/38 patients were discharged after the 1st contact (34%). Of those that needed further local follow up, 16/20 patients were followed up by virtual clinic (64%). Of the 16 followed up virtually only 2/16 went on to require face-to-face clinic at a later date (12%).

Conclusion The incidence of antenatal hydronephrosis is around 1:200 with 50% normalizing on postnatal scans. This patient cohort places considerable demand on outpatient capacity and parental and clinician time for scans and appointments. Antenatal hydronephrosis related appointments accounted for over a third of all renal clinic appointments. The use of virtual clinic has significantly reduced the number of face-to-face clinic appointments needed. Only 12% of patients referred went on to require face-to-face appointments, potentially freeing up outpatient clinic capacity and clinical time. It also has implications for parents in terms of visits for appointments and time off work. The DNA rates were better for virtual clinics than face-to-face appointments (4% vs7%). Transforming the way that outpatient consultations are delivered can improve patient and clinician experience, as well as allowing better management and reduction in demand. It may also offer significant opportunities for making financial savings for organisations.