National and Trust IPC standards. Following reported cases of MRSA bacteraemia and colonisation, and MRSA cases missed through previous routine screening regimes in our Trust, the Team has implemented mandatory routine MRSA screening for patients who fulfilled locally-defined high-risk criteria. This audit aims to determine the standard of MRSA screening for these high-risk patients on the Neonatal and Acute Paediatric inpatient wards.

Methods Patients admitted to Bluebell (Acute Paediatric) ward, the Children's Assessment Unit (CAU) or the Neonatal unit (NNU) were retrospectively identified and compared against a locally-defined set of criteria for patients at high risk of MRSA colonisation or infection. The criteria included previous MRSA infection or colonisation, transfer from or previous admission in another hospital, recurrent skin lesions or infections, and exposure to family member with known MRSA. The study began in May 2019 with data collected up to mid-October 2019. Electronic pathology records were then searched. The assumed target of MRSA testing, where appropriate, was 100%, with the Trust's IPC standard of >90%.

Results Preliminary results yielded 136 high-risk patients and 145 appropriate instances for screening. An overall screening rate of 78.6% (114/145) was noted covering all areas during the audit period. The Neonatal Unit had the highest rate of screening at 97.6% (41/42), followed by CAU at 80% (16/20) and Bluebell at 68.7% (57/83). Month-by-month analysis showed June to have the lowest rate for all areas (50.0% 8/16) and August with the highest rate (95.0% 19/20).

Conclusion The audit highlighted that compliance with guidelines is variable across areas and different months. Despite our study not being able to consider the many factors that contribute towards this, the data has identified gaps in current practice and will guide the goals on education and training of clinical staff regarding IPC guidelines, with the focus on MRSA high risk screening criteria, to ensure robust and safe practice.

G135(P) NATIONAL IMPACT OF RCPCH BEST PRACTICE GUIDE ON TIMING OF DETECTION OF CLEFT PALATE – TIME TO ADOPT SUCCESSFUL LOCAL QUALITY IMPROVEMENT INITIATIVES

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Aim Historical data show that 30% of cleft palates (CP) are not identified within 24hrs of birth, the national standard. In 2014 the RCPCH launched a Best Practice Guide (BPG) recommending a change to examination of the palate from digital palpation to visual inspection to improve detection rates.¹ We report the national impact of the BPG, highlighting regional variations, and share solutions from a local quality improvement programme (QIP).

Method Data on diagnosis time of CP for 2013–2018 were identified from CRANE database² (England, Wales, Northern Ireland) and supplemented with data from Scotland and Republic of Ireland to explore regional variations. Local data from Medway Hospital, Kent, 2010–2019 were collated for a Quality Improvement Project to improve early detection of cleft palate.

Results Nationally there has been a significant increase in detection CP <24 hrs age since the BPG: 2013–14 births (67%) v. 2015–16 births (71%) v. 2017–18 births (75–76%) [p <0.001]. Locally Medway Hospital: 30% CP (4/13) were diagnosed within 24 hrs of birth between 2010–2014. Since introducing the QIP all cleft palates (n=11) from 2015–2019 have been identified within 24 hrs of birth.³

Conclusion The timing of detection of cleft palate has improved since publication of the RCPCH Best Practice Guide. Late diagnosis remains an issue for quality of care and family experience. Local QIP can successfully sustain local detection rates at the national standard. We advocate adoption and spread of quality improvement initiatives to complement the BPG.

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G136(P) JUNIOR-LED IMPROVEMENT PROJECT: IMPROVING MORNING HANDOVERS QUALITY AND LENGTHS IN A DISTRICT GENERAL HOSPITAL WITH THE INTRODUCTION OF A HANDOVER CHECKLIST

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RCPCH worked nationally on a Situation Awareness for Everyone (S.A.F.E) toolkit that promoted safer handovers for patient safety. Due to the number of clinical areas covered and personal preferences, departmental handovers always varied in duration, structure and consistency. Key questions regarding staffing levels or unwell children would only be mentioned when issues arose.

Aim This project aimed to improve situation awareness for staff and to improve patient safety through structuring handovers to be more efficient.

Method The major invention was introducing a handover checklist to signal the start of handover covering many important aspects: staffing issues, potential risks to clinical resources – i.e. high-risk deliveries, HDU-level patients, busy emergency department and bed numbers. Start and end times were also documented.

Many iterations utilising improvement science occurred, including varying what was covered on the checklist, who fills it out and seeking departmental approval to separate midweek handovers for the neonatal and paediatric teams.

The latest checklist consists of: start/end times, staffing levels, 'Sickies'/HDU patients, any outgoing/pending transfers, high-risk deliveries, paediatric ED status, bed status, new safeguarding concerns and whether split handovers should occur.

Results The project is still running but over the first 20-week period, the checklist was filled in 80% of the time. Only 50% (41/81 documented) of handovers started at 8.30am. Monday handovers took on average 65 minutes compared to 30–35 minutes on other days. Staffing issues were highlighted