Conclusion All patients received a first line antibiotic in line with Trust guidance, although no patients had confirmed intracranial infection. Pus samples did not alter antibiotic choices in this small cohort. This suggests, in our population, most patients can be safely managed with co-amoxiclav as first line therapy.

G146(P) EFFORTS TO INCREASE EARLY DETECTION OF OBESE AND OVERWEIGHT CHILDREN IN GENERAL PEDIATRIC CLINICS

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Aim Lack of attention to the pediatric Body Mass Index (BMI) by the physician during outpatient visits decreases the early detection of obese and overweight children visiting the clinic for reasons other than increased weight and subsequently delays starting active management. The aim of this project was to promote early detection and management of patients with a BMI above or equal to 85th percentile for age and gender (High BMI).

Methods Several Plan Do Study Act cycles were implemented:

- Education all physician and the nursing staff regarding measurement of BMI in children
- To choose the 'office visit' template on Cerner (electronic medical record) so that the BMI is automatically built into the physician note
- Nursing Staff identified Patients with high BMI during vital signs check and placed a reminder next to the patient's room number to alert the treating physician about patient's high BMI status
- High BMI Patients were provided with an educational pamphlet on diet management and referred to dietician

Results

Conclusion The recognition of BMI is the first step to early detection of pediatric obesity. Through simple sustained efforts we were able to improve the management of High BMI children by improving counseling and dietician referral to above 75% in the last quarter of 2018. We intend to

follow the patients detected to be overweight and obese in these clinics to see if simple measures like family counselling and dietician referral have resulted in BMI reduction over time.

G147(P) SUSTAINED ENHANCEMENT OF TEAM LEARNING TWO YEARS AFTER IMPLEMENTING A SIMPLE INITIATIVE

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Background We identified significant challenges to longitudinal team learning in the Acute Receiving Unit of our quaternary paediatric hospital. These included shift work, trainee rotation and a high service demand. We hypothesised that a regular 'Learning Points' email would be a simple and cost-free way to address this. Since establishing this departmental project in 2017 we have sought to improve and expand throughout the hospital.

Aims Our key aims were to:

- Inspire and enhance team work and learning – both within and between departments
- Promote evidence-based practice
- Promote a culture of quality improvement and patient safety, highlighting local and national initiatives.

Methods Regular emails were compiled by a small group of paediatric trainees. Content included interesting cases, clinical teaching, quality improvement and patient safety information. An initial electronic survey in January 2018 yielded positive feedback and identified areas to improve. Subsequently circulation was widened to include staff from other departments (consultants, senior nursing staff, paediatric ST1-8, GP and FY trainees). Contributions were invited from recipients. The email template was updated and changed to PDF form to enable e-portfolio use. A follow-up electronic survey was disseminated in July 2019 to re-evaluate our intervention. This included space for free-text comments. Questions included:

- Do you find the learning points email a useful learning resource? If so, can you explain what the key benefits of it are?

Abstract 146(P) Table 1 Percentage of patients with documented BMI in physician's notes

Pre-intervention	2017 1st Quarter	2017 2nd Quarter	2017 3rd Quarter	2017 4th Quarter	2018 1st Quarter	2018 2nd Quarter	2018 3rd Quarter	2018 4th Quarter
47.3%	81%	88.1%	87.9%	77%	85%	87.5%	78.7%	91.6%

Abstract 146(P) Table 1 Percentage of patients with High BMI who received counseling and dietician referral

Pre-intervention	2017 1st Quarter	2017 2nd Quarter	2017 3rd Quarter	2017 4th Quarter	2018 1st Quarter	2018 2nd Quarter	2018 3rd Quarter	2018 4th Quarter
33.3%	54.7%	43.3%	44.6%	65.3%	63.3%	45.3%	48.3%	76.6%

- Do you feel that reading the learning points email has influenced your practice?
- Would you recommend reading the learning points email to a colleague?

Results There were 26 respondents out of 111 (response rate 23%). 100% found the email a useful learning resource and 100% would recommend it to a colleague. 96% felt the emails had influenced their practice. 62% 'always' read the emails, 38% 'usually' and 0% 'never'. Themes identified amongst open question responses included: improved team spirit, practical knowledge, continuous professional development, quality improvement, patient safety, applicability, and use for trouble-shooting.

Conclusion This simple initiative demonstrates success and longevity in promoting a culture of team learning, quality improvement and patient safety in our hospital. Relatively low survey response rate is acknowledged as a limitation of our evaluation method.

G148(P) SAFE AND TIMELY STEPDOWN FROM AN INTERNAL PICU: A PATIENT SAFETY PRIORITY BUT ONE FULL OF CHALLENGES

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Background Children recently discharged from Paediatric Intensive Care units (PICU) are likely to have on-going complex medical needs and are at significant risk of deterioration. Local and national standards are in place to ensure that these children are reviewed in a safe and timely manner.

Aims This Quality improvement Project (QIP) assessed the internal 'step-down' process of patients from the PICU to the paediatric wards with intention of improving communication and documentation between these two teams.

Methods Retrospective audit of PICU discharge communication, documentation and time to ward review for all patients discharged during October 2018. Novel 'PICU discharge summary' and 'Verbal Handover' templates to be used the on local patient management system (PMS) were devised following consensus between PICU and paediatric consultants. Re-audit of PICU discharge data was performed after the new templates were in routine use.

Results Discharge data was reviewed for the 35 children discharged from PICU to the ward in October 2018. 31 cases were studied in the second audit cycle (September 2019). Table 1 compares key differences after implementation of the changes. Table 2 compares timing of PICU discharges between the two audit cycles.

Conclusions Introduction of a PICU verbal handover template for the hospital PMS significantly improved verbal handover from PICU to ward teams in our trust. However mean time

Abstract G148(P) Table 2

Time of PICU discharge	% Discharges Oct 2018	% Discharges Sept 2019
Morning (0900–1200)	9 (3)	10 (3)
Afternoon (12:00–16:30)	49(17)	58 (18)
Out of hours (16:30–08:30)	42 (15)	32 (10)

to ward review following PICU handover remains sub optimal. Most patients are discharged from PICU during the afternoon or out of hours, this may explain the lengthy time to ward review as these times are likely busier and with less staff. Further QIP involving multidisciplinary teams to improve PICU discharge planning would be beneficial.

G149(P) PROVIDING INDIVIDUALISED FEEDBACK TO IMPROVE THE RATES OF PRESCRIPTION ERRORS

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Background The incidence of medication errors is higher in the paediatric population, who require dosing based on age, weight and body surface area. These errors might cause significant harm and could be prevented through improved prescribing practices.

Aim To reduce the rates of paediatric prescription errors in one hospital by providing doctors with individualised feedback when an error is made.

Methods When a pharmacist identifies a prescription error, the prescriber is sent feedback about this error and how it should be corrected. The most common errors are recorded and emailed to the whole team. If a doctor has made one significant or three non-significant errors, they are required to complete the RCPCH prescribing e-learning. Doctors are informed of this initiative during induction.

To evaluate this project, drug charts were audited four times between 2018–2019. Data was collected on both chart and prescription errors. Univariate and bivariate analyses were conducted using chi-square, Fischer exact tests, Wilcoxon rank-sum test and two-sample tests of proportions.

Results 52 drug charts were audited in 2018 and 47 in 2019, with a mean of 3.68 prescriptions per chart. Generic drug names were used 71.43% (n=70) of the time. 100% of prescriptions were signed but 38.14% (n=37) were missing a bleep number. Illegible handwriting was not associated with any errors observed (p>0.1). There was significant improvement in use of generic drug names (p<0.05), dosing errors (p<0.005), use of correct units (p<0.005) and documenting the indication for antibiotics (p<0.05). There were no significant changes in legibility, documentation of allergies, patient details, bleep numbers, or errors in medication frequency or route. (p>0.05).

Conclusions The data show improvements in the prescribing error rates following the introduction of individualised feedback. However, as some doctors left and some joined the hospital during the time-frame audited, it is not possible to definitively show that the improvements are secondary to this initiative.

To improve the project and encourage good practice, we have begun notifying doctors following excellent prescribing.

Abstract G148(P) Table 1

	Oct 2018	Aug/Sept 2019
Number PICU to ward discharges	35	31
% Discharge summary completed	100 (35)	100 (31)
% Cases verbal handover documented	37 (13)	84 (26)
Mean time to ward review (hours)	4.3	5.5