presenting with accidental poisoning to our two emergency departments.

Methods We performed a retrospective analysis of all children less than 5 years old and presenting between July 2016 and July 2018 with an accidental poisoning to the emergency departments at the John Radcliffe Hospital, Oxford, and the Horton Hospital, Banbury. Children with either deliberate, food or unknown poisoning were excluded. As an audit, the study did not require ethical approval.

Results Among 214 children with accidental poisoning (median age of 2 years, 52.3% male), LDCs were the commonest cause (27 cases, 12.6%), followed by paracetamol (15, 7%) and carbon monoxide (10, 4.7%). There were 103 different substances recorded, with personal care products forming the largest group (110, 51.4%) followed by medications (57, 26.6%).

Most children were asymptomatic (173, 80.8%). The commonest symptom was vomiting (22, 10.3%). A quarter had an ECG performed (47, 22%) and 31 (14.5%) children had a blood test. All children were discharged from the emergency department after a period of observation.

Conclusion LDCs were the commonest cause of accidental poisoning in young children presenting to our emergency departments. Healthcare workers should engage with industry to make packaging of LDCs safer to prevent continued presentations by young children with LDC poisoning.

G228(P) ABSTRACT WITHDRAWN

G229(P) USING SIM TO ADDRESS THE NEEDS OF THE 'FORGOTTEN TRIBE'

S Mullen, P Martin, L Loughins, N Wetherup. *PED, RBSCH, Belfast, UK*

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Aims Adolescents make up approximately 19% of the UK population with treatment received split between paediatric and adult services. Research has noted that adolescent attend ED, often as a first preference for illness/injury. The aim was to enhance local knowledge and skills regarding adolescent care with an emphasis placed on emergency presentations.

Methods We developed a one-day teaching programme consisting of mixed teaching modalities (lecture, case-based discussions and simulations). The learning objectives were tailored to the curriculum for paediatric and emergency medicine trainees with input from local experts in adolescent health. A multi-disciplinary faculty facilitated including clinicians from paediatric emergency medicine, emergency medicine, paediatrics, CAMHS (Child and adolescent mental health services) and a speciality organ donation nurse.

A total of eight high fidelity simulations were developed and delivered by faculty covering adolescent trauma, DKA, intoxication, the aggressive adolescent, HEEADSSS (psychosocial) assessment, confidentiality, capacity and utilising the Mental Health Act. Amateur actors were employed to play the roles of patients/parents to enhance fidelity.

Results There were 36 participants who attended with 86% (n=31) completing the pre-course questionnaire and 95% (n=34) completing the post course questionnaire. An increase in confidence and knowledge was seen across all domains for

all trainees, with an average overall improvement of 30%. The greatest increase in confidence was noted in managing an aggressive adolescent with verbal de-escalation (55.8% vs 82.1% pre and post), managing an adolescent refusing treatment (43.9% vs 80.6% pre and post) and psychosocial evaluation using the HEEADSSS assessment tool (26.2% vs 81.8% pre and post). Feedback was universally positive. Comments included 'Relevant and interactive, learned so much' and 'fantastic course. Covered areas I didn't know I was lacking in.' Delayed feedback at 3 months showed sustained confidence across all areas and evidence of new skills learned being used in clinical practice – in particular use of the HEEADSSS assessment. All candidates would recommend the course to colleagues.

Conclusion This project is an excellent showcase of how we can bring a group of clinicians from various different backgrounds together to drive improvement for a vulnerable group of patients.

G230(P) CAN UTILISING OUT-PATIENTS SPACE IMPROVE SERVICES OFFERED IN A PED?

S Mullen, T Oman, E Dalzell, A Fitzsimons, B Bartholome, H Jahn. *PED, RBHSC, Belfast, UK*

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Aims The PED that has seen a 10 000 increase in attendances over the last 5 years with no increase in space to accommodate this. This led to issues with patient flow, poor morale and increase in waiting times. Our aim was to utilise out-patient clinic space to run a minor illness and injury area for emergency department attendances.

Methods This initiative utilised fracture out-patient clinic and staffing with middle grade paediatric or emergency staff. In addition, this service was staffed by a band 3 receptionist, an enhanced nurse practitioner and a band 5 nurse. The clinic runs on the three peak days of the week (Monday, Tuesday and Friday) between 17:30 to 22:30.

Results 404 patients were seen over 31-days, averaging 13 patients per day. A survey was completed by 52 patients/parents. 98% reported that this was an appropriate area to be seen with another 98% stating that the Winter pressures clinic was beneficial. They rated their experience as 4.1 out of 5 (mean).

Comparison between this year (2018/9) and previous (2017/8) demonstrated a reduction in average time in ED of 11 minutes per patient for all category four and five patients despite significantly higher numbers.

The comments from parents supported the use of this initiative; 'A+E was a nightmare, overcrowded and not a nice environment. Minor unit is quiet and less stressful for the baby and parent', 'Getting moved to the other emergency department today was for the better'. Staff have been very supportive of this service. Comments acknowledged the ability to provide a more efficient service to those of a lower triage category. The service was also found to be beneficial to the higher acuity patients in the ED allowing them to be allocated to a treatment room quicker and prioritising staff to see them in a more efficient and timely manner.

Conclusion The use of an out-patient clinical space is an appropriate area to manage minor illness and injury in the emergency department. It has improved flow, reduced waiting times and is acceptable area for patients and staff.