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ESTABLISHING A SATELLITE SIMULATION SUITE ON THE NEONATAL INTENSIVE CARE UNITGabrielle Simpson, Kathryn Martinello, Amy Gilbert. *Great Ormond Street Hospital*

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Introduction In situ simulation has long been considered the most favourable method of delivering immersive simulation. It allows candidates to rehearse clinical scenarios in a familiar environment and takes into consideration systems testing which can highlight potential latent safety threats. In situ simulation can further develop candidates' technical skills and contribute to team building and communication skills.

In a high intensity environment such as neonatal intensive care (NICU), being prepared for rapid deterioration in acutely unwell patients is a necessity. Great Ormond Street Hospital NICU is a level 3 teaching unit with a high turnover of medical and nursing staff, and thus building key team working relationships can be challenging.

Methods A manikin from the Clinical Simulation Centre (CSC) was loaned to the NICU and a satellite simulation suite was established in a NICU cubicle. The manikin is stored in a portable cabinet to allow ease of movement throughout the unit. The suite was stocked with expired consumables to minimise waste and provide the necessary equipment needed for clinical scenarios.

We developed a curriculum and regular weekly schedule factored into the unit's daily demands. This allows the clinical staff to pre-allocate candidates and ensures equal opportunities for clinical staff to attend.

Results We faced some challenges initially including identifying the ideal time and ensuring staff engagement. After overcoming these challenges, the programme has become well established. Staff are better engaged with the programme and timings are integrated into the unit's culture. Scenarios have been written to address patient safety incidents and identified knowledge gaps.

Discussion Despite facing initial challenges of staff engagement and incorporating the programme into the unit's culture, the satellite suite has been a huge success and has impacted on ward culture and patient safety.

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HANDOVER RELATED ANXIETYSevasti Konstantinidou, Nikita Patel, Jayaram Sivaraj, Manal Dhaiban, Dylan Wills, Stavros Loukogeorgakis, Ceri Jones. *Great Ormond Street Hospital*

10.1136/archdischild-2020-gosh.93

Background Handover is a vital clinical skill to transfer information to ensure continuity of care for patients. However, handover can be stressful with significant effect on clinicians. It is important to acknowledge participants well-being and level of expectation. This project aims to assess and address handover as cause of anxiety for the clinical team.

Methods We have conducted a quality improvement project assessing the impact of handover to participants well-being, utilising a verified questionnaire. Following the results, changes were implemented to provide a standardised structure to handover, providing a framework and expectation for the process with an aim to improve clinicians' satisfaction and quality of handover.

Results Twenty questionnaires were initially completed regarding handover. Most of the participants felt that handover was

a source of anxiety. Seventy-five percent of the consultant respondents felt anxiety related to time pressure and the need to attend to clinical and nonclinical responsibilities. The majority (66%) of the registrar respondents had anxiety related to leading and receiving handover. The junior team appeared to be the group less effected by handover. Following recognition of this and implementation of improvements, reported anxiety was reduced to 20% among all team members.

Conclusions We have identified the handover as a stressful period of the working day. The reason for anxiety is very interesting as it varies for different members of the team. Initial interventions had positive effect on participants. We aim to continue assessing, teaching 'handover communication skills' and refining handover process to improve mental health linked to handover.

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GERMLINE MOSAICISM – WHEN A RARE DISEASE RECURS¹Tanya Lam, ²Shamima Rahman, ³Ajith Kumar. ¹Clinical Fellow, Clinical Genetics, GOSH; ²Professor and Honorary Consultant in Mitochondrial disorders, GOSH; ³Consultant, Clinical Genetics, GOSH

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Rare autosomal dominant and X linked genetic disorders are often caused by new mutations. Both parents are healthy in these instances and they are counselled that the risk of recurrence in their future children is likely to be low (usually less than 1%). However, in some of these families, one parent may have a mutation confined to some cells including testicular or ovarian cells (germline or gonadal mosaicism). Whilst rare, germline mosaicism may significantly change the risk of recurrence in future offspring, with implications for genetic counselling. We review families who have multiple affected children due to germline mosaicism, discuss conditions in which germline mosaicism is more common and a current study that aims to stratify risk using NGS (Next Generation Sequencing) on multiple cell lines in both parents.

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ASPIRANT NURSES – THE JOURNEY OF WELCOMING A NOVEL ROLE INTO THE NURSING FAMILY AT GREAT ORMOND STREET HOSPITAL (GOSH)Kate Prosser. *Great Ormond Street Hospital*

10.1136/archdischild-2020-gosh.95

Aim As part of the national response to Covid-19, emergency legislation was passed allowing final year nursing students to undertake paid placements to support the NHS. This paper describes the approach taken by the Nursing Workforce Team to facilitate the successful introduction of this novel, nationally recognised role to GOSH.

Approach Collaboration with internal and external stakeholders including North Central London Capital Nurse Returner Bureau, GOSH Nursing and Non-Medical Education Team (NNMET), Higher Education Institutions (HEIs), Health Education England (HEE), and GOSH Human Resources (HR) in order to divide and agree on actions to enable us to host as many Aspirant Nurses as possible.

Outcome Throughout May and June 2020, GOSH welcomed 65 Aspirant Nurses in total, 62 of whom had Junior Band 5 Staff Nurse conditional offers with us for September 2020. This resulted in us being able to supplement the workforce over the challenging months of the pandemic, while supporting a smooth transition into their Junior Band 5 Staff Nurse roles in the autumn.

Conclusion The benefits of this novel approach included:

- A smooth transition of Aspirant Nurses in to their next phase of employment as registered nurses
- Prevented disruption to the teams and rosters
- Supported continuity of care for patients
- Reduced the risk of attrition
- Having already completed induction, they did not require a supernumerary period on commencing in their Junior Band 5 Staff Nurse role
- Inclusion in workforce numbers throughout this period and immediately from when they commenced in post as Junior Band 5 Staff Nurses on the 28th September supported safe staffing and Care Hours Per Patient Day (CHPPD) data.
- Promoted GOSH as a good employer
- Reduced the impact on HR and payroll by reducing additional workload

96 USING QUALITY IMPROVEMENT METHODOLOGY TO ELIMINATE HARM TO GOSH PATIENTS THROUGH STANDARDISED DEVICES AND ENHANCED RESOURCES

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Background In 2019 GOSH identified variations in urethral catheter insertion and urinary catheter care. Datix highlighted this contributed to 28 potentially avoidable patient safety incidents in the previous 18 months. Lack of standardisation across the Trust was due to factors including; misbelief around female nurses catheterising males, patients having NG tubes inserted and multiple brands Trust-wide.

The aim Eliminate harm to ureteral catheterised patients.

Methods Supported by the Quality Improvement team, a Steering committee was formed from stakeholders Trust-wide. Reviewing incidents to identify themes and interventions, using the Model for Improvement (QI Tool), three work streams were established.

1. Standardised pathway for catheter care: Developing clinical practice guidelines for Urinary Catheterisation, standardising electronic documentation across the MDTs and introducing an escalation pathway.
2. Standardised trust training package: Quick reference posters, FAQs, Insertion videos and a Resources hub for quick/easy access. Facilitating 'Train the trainer study day' to improve overall nursing/medical knowledge.
3. Standardised devices: Standardised brands and devices then developing a device size reference guide.

The Project Plan kept focus on the aim and monitored time-dependant tasks.

Measurements; Catheter related incidences, Urology referrals for catheterisation (normal anatomy) and nursing staff knowledge on catheter cares.

Results Completed - Workstreams 1&2, with a clear pathway, standardised electronic documentation, Trust-wide training package and a suite of resources. Workstream 3 still in progress, with an agreement to consolidate to two preferred devices

Discussion Our success is based on multidisciplinary working, using QI methodology and tools (Driver Diagrams) to identify primary drivers and simultaneously make decisions on how to improve care for catheterised patients.

*Covid has impacted results but initial findings support our prediction that access to resources increases knowledge and skill, resulting in an impact on incidents.

Conclusion Staff now have all the resources needed to provide excellent care for catheterised patients.

**No ethical clearance needed

97 PAEDIATRIC INTENSIVE CARE RETRIEVAL – FAMILIES' EXPERIENCE OF THEIR CHILD'S JOURNEY TO INTENSIVE CARE

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Background Each year, nearly 5000 critically ill children and young people (CYP) are transported by paediatric intensive care retrieval teams (PICRTs) from general hospitals to UK paediatric intensive care units (PICUs). Great Ormond Street Hospital (GOSH) accepts the greatest proportion of patients annual (circa 600) most retrieved by the GOSH based retrieval service CATS (Children's Acute Transport Service). Our study aimed to understand the experiences of families whose child used these services including those who were transferred using CATS.

Methods Parents of transported CYP were approached while in PICU and invited to participate in the study, which included filling out a questionnaire about their experience of their child's journey.

Results 24 (of 25) UK PICUs located in 21 NHS Trusts participated, 4558 CYP were identified as eligible for the study over a recruitment period of 12 consecutive months (January 2018–2019); 2838 consented (response rate of 62%), 2133 completed questionnaires were received (73.5% of consenting parents) and 1796 (84.2%) questionnaires related to unique transfers by the 9 specialist PICRT in England and Wales, 16% of responses were received from patients transferred into GOSH. Most families reported the overall experience and quality of care as 'excellent' (n=1574; 87.6%; n=1615; 89.9% respectively) but a small proportion of families reported feeling confused about what was happening during transport (n=193; 10.7%), felt the transport team did not listen to them (n=27; 1.5%), and did not understand answers to questions asked (n=37; 2.1%).

Conclusions Service development is helped by understanding when and why experiences are sub-optimal and while quality of care delivered by PICRT appears to be almost universally perceived as 'excellent' families' experience is impacted by communication and could be improved through individualised –tailored– communication.

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