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Paediatric Educators' Special Interest Group

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TRAINEE LED MEDICAL STUDENT TEACHING: SEVEN YEARS ON, WHAT HAVE WE LEARNT AND WHAT LIES AHEAD?

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Background Medical student education has witnessed seismic shifts over recent years, with changes to medical curricula and increased use of information technology. The declaration of a global pandemic in early 2020 has fundamentally changed the way in which medical students access their education and the impact of this will be felt for years to come. 'Paeds in a Day' is a voluntary movement led by senior Paediatric doctors from the East Midlands. Over the past seven years, we have led an annual face-to-face lecture series, covering the core contents of the paediatric syllabus for students at the University of Nottingham. This year, in response to social distancing restrictions, we hosted our lecture series online, allowing medical students across the UK and internationally to benefit from the course.

Objectives Our aim is to describe the trends in student feedback received over the last seven years and outline how we will adapt our course to meet future students' needs.

Methods A mixed-methods approach was used to analyse electronic feedback forms from April 2015 to February 2021. Trends in Likert-scale questions were quantified and for the qualitative data, a thematic analysis was undertaken to highlight key positives and identify areas for future development.

Results Between 2015–2021, we have conducted six lecture series, teaching 1281 medical students (range 53–653) and delivering between 10–13 lectures on each occasion. To date, all students consistently 'agreed' or 'strongly agreed' that the course was helpful for their paediatric revision. A handout has been regarded as a valuable addition, with 88 to 100% of students finding it useful, and a high proportion of the positive feedback analysed was related to this (5.9–15.6%). The interactive 'fill in the gaps' approach to the workbook received fewer positive comments in 2021 compared to 2015 (8% vs. 21%), with more calls for continuous prose and a document that is easier to edit on a computer. Pace, timings and organisation of the course seem to have improved, with more positive comments over time, however increased numbers of students requested for the series to be split over two days (3.4% in 2015 vs. 24.5% in 2021). Five percent of the critical feedback in 2021 was related to requests for access to the recordings, for those studying from home.

Conclusions Since 2015, we have consistently delivered a valuable paediatric revision course for medical students. By adapting our course in 2021, we created an online, open-access platform for a UK and international audience. We have learnt when the course is delivered online, it is harder to cover similar amounts of material in one day, likely related to students struggling with increased screen-time. Handouts

continue to be important adjuncts to learning, although more are accessing these electronically. To meet their future needs, we should consider sharing recordings of our presentations, producing a handout that is easier to edit on a computer and splitting the course over two days.

Quality Improvement and Patient Safety

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THE INTRODUCTION OF VIRTUAL BRIEFING AND DEBRIEFING IN A GLOBAL PANDEMIC

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Background Medicine is a high risk and safety critical field. Our general paediatrics department has inpatient numbers which fluctuate on average from 50–100 or more. Patients are not allocated a particular ward but according to availability, so there is a large geographical spread across many wards. The team comprises of approximately 30 people consisting of FY1–ST8 doctors, ANPs and consultants. Each day different members of the team may be allocated to different wards depending on rotas. The consultant for each week however is consistent.

There are minimal changes to the structure of the day however there are daily changes to patient complexities, continuity of staff and patient location within the hospital. Over a period of four years boards have been introduced to facilitate briefing/debriefing at the beginning and end of the working day. These were designed initially from feedback from the team; they have consequently been adapted and redesigned following PDSA cycles.

Briefing and debriefing had been a well-established part of the team before the global pandemic in March 2020 which universally changed the way the team approached the working day, for example working in smaller sub teams to facilitate social distancing. Due to the substantial amount of change within the team we recognised that the daily briefing and debriefing was not functioning effectively. As a project group we developed and reintroduced new ways of briefing/debriefing that incorporated the government advice surrounding social distancing

Objectives To re-introduce daily briefing/debriefing virtually having previously been embedded within the department in a face to face format pre Covid-19, to improve situational awareness including staff experience and patient safety using the five levels of care.

Methods SCOPE-Recognition of a lack of brief/debrief because of unforeseen changes in the 'normal' working day due to covid-19

SHAPE- a questionnaire was designed to obtain feedback from the stakeholders to evaluate their input regarding the briefing/debriefing (pre covid-19). Using feedback collated, our focus was to improve situational awareness and learning opportunities for brief and develop the opportunity for the team to debrief.

SHIFT- Developing new tools using virtual systems to enable brief/debrief to occur in a timely and safe way. Education and training was provided for members of the team. Engagement from the whole team was essential for briefing and debriefing to be sustainable.

SUSTAIN- briefing/debriefing virtually has been embedded within the routine of the working day. However, ongoing PDSA and feedback from the ever changing team updates and changes are occurring

Results We measured qualitative data for 2 months after the introduction of virtual briefing/debriefing. Some examples were 'helps with team morale' and 'worthwhile but would be better if we could do it as a whole team'.

Conclusions The process of virtual briefing/debriefing has been well received by the team with improved situational awareness, learning and education while creating an open space for debrief and reflection. As patient demographics and numbers change, we continue to make adaptations to our process with repeated feedback. Team engagement when implementing change has been key to its success.

British Association of Perinatal Medicine and Neonatal Society

1071 IS LOW PLATELET COUNT AT START OF MEDICAL TREATMENT FOR PATENT DUCTUS ARTERIOSUS (PDA) LIGATION A PREDICTOR OF REQUIREMENT FOR SURGICAL LIGATION?

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Background Previous research has suggested that platelet count could be important in patent ductus arteriosus (PDA) presence¹ and possibly closure.²

Objectives To understand the characteristics of patients with a PDA, and identify if platelet count at the start of medical treatment for PDA is a predictor of failure of treatment and need for surgical ligation.

Methods We reviewed all babies from our unit who had medical or surgical treatment for a PDA over a 1-year period (1st April 2019 - 31st March 2020). This was a retrospective review of the BadgerNet database and clinical notes.

Results We identified 26 babies who underwent successful medical treatment, and 6 babies who required a surgical ligation. This analysis excluded a baby with PDA/VSD where data was incomplete. Table 1 shows a comparison of the two groups. Those who had successful medical treatment had greater median gestational age (27 vs 25+4 weeks) and higher birthweight (888grams vs 605grams, $p < 0.05$). More male babies required ligation ($n = 5$, 83% male), but this was not statistically significant. There were no statistical differences in antenatal steroid administration or in timing of first course of medical treatment (median 5 vs 4.5 days respectively). We also reviewed platelet count at the start of first medical treatment. The platelet count was significantly higher in the group who had successful medical treatment compared to those who went on to surgical ligation (median of 235 vs 119, $p < 0.05$).

Conclusions Previous research has found that low platelet count during medical treatment is associated with failed medical treatment.² Our findings differ: Platelet count at the start of treatment was associated with failed medical treatment and requirement for PDA ligation. Other characteristics of babies who required surgery for a PDA were observed. On average they were male, 25+4 weeks gestation at birth and 604 grams

Abstract 1071 Table 1 Comparison of surgical ligation and successful medical treatment

	Surgical	Ligation	Successful Medical Treatment	Statistical	
Variable	Range	Median	Range	Median	Significance
Gestation at birth (Weeks +Days)	23+2 - 27 +6	25+4	23+2 - 30+0	27+0.5	NA
Birthweight (Kg)	0.485–1.053	0.605	0.600–1.462	0.888	** $p=0.009$
	Number	Percentage	Number	Percentage	NA
Gender					
Female	1	16.7	10	38.5	$p=0.424$
Male	5	83.3	16	61.5	NA
Antenatal Steroids					
Complete	6	100	19	73.1	$p=0.322$
Incomplete	0	0	4	15.4	NA
None	0	0	3	11.5	NA
	Range	Median	Range	Median	(Medical Treatment vs Ligation)
Median Age at First Medical Treatment (days)	3–16	4.5	2–21	5	$p=0.386$
Platelet Count at First Medical Treatment ($10^9/L$)	43–277	119	89–536	235	* $p=0.043$

in birthweight. Could we avoid exposing these babies to the risks and delays of medical treatment and do surgery more directly? These data are also useful for counselling parents and managing expectations of clinicians. Further research into this group specifically and may highlight a more tailored medical treatment strategy that might be successful.

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Paediatric Critical Care Society

1073 RARE CASK GENE MUTATION WITH CEREBELLOPONTINE HYPOPLASIA AND TETRALOGY OF FALLOT – END OF LIFE CARE CONSIDERATIONS IN PICU

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Background CASK gene mutation is very rare and is associated with microcephaly, cerebellar and pontine hypoplasia (MICPCH).

Objectives It is essential to understand the life-limiting nature of the genetic mutation and the role of End of Life Care considerations, including family support. We would like to describe our experience in providing care for a child with the