

workshops were well received and improved confidence levels amongst paediatric trainees. The sessions were easy to implement and could viably run on a routine basis, to enhance understanding and participation in research, which is essential for maintaining an environment fostering research and innovation.

## Paediatric Educators' Special Interest Group

### 478 SCAFFOLDING SUPERVISION AT A TERTIARY CHILDREN'S HOSPITAL: CAN INTRODUCTION OF A TOOLKIT STREAMLINE CLINICAL SUPERVISION MEETINGS?

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**Background** Supervision, both clinical and educational, has been identified as an area for improvement locally, by Health Education England, and in the General Medical Council National Training Survey. This was explored in 2018 through a survey completed by paediatric trainees and supervisors at our regional tertiary paediatric hospital, identifying factors relating to poor supervision, including poor preparation for meetings and limited time. When further exploring preparedness for becoming a supervisor in senior trainees, we identified that most senior trainees feel additional training is required prior to taking on supervisor responsibilities. We have subsequently designed a toolkit to make elements of supervision more streamlined.

**Objectives** To identify if a toolkit can streamline clinical supervision meetings by suggesting discussion points aligned with standard outcomes.

**Methods** We designed a toolkit to streamline elements of supervision meetings derived from local and national documentation on supervision.

Paediatric trainees were divided to tier 1 (ST1-3) or tier 2 (ST4-8), and allocated to receiving the toolkit or not, along with their clinical supervisors.

Surveys were completed before and after the induction clinical supervision meeting and collected anonymously.

**Results** Initial survey:

- 43 paediatric trainees were identified; 13 at ST1–3 level and 30 at ST4–8 level
- 25 responses were received from trainees (toolkit, n=11; no toolkit, n=11; not disclosed, n=3) and 20 responses were received from supervisors (toolkit, n=12; no toolkit, n=7; not disclosed, n=1)
- Trainees expect to discuss post-specific details (learning opportunities, expectations of the trainee), review their existing experience and portfolio, and career progression
- Trainees report moderate confidence in their knowledge of the RCPCH curriculum (56%) but experience frustration with use of the ePortfolio and Kaizen
- Experience of supervisors was skewed, with median experience of 3 years
- 11/20 supervisors had attended training on supervision within the past year, and 9/20 supervisors had attended training on Kaizen and the new RCPCH portfolio

- However, 6/20 had never attended training
- Supervisors highlighted issues with resource, such as lack of appropriate meeting space, and the capability of local networks to access Kaizen

Follow-up survey:

- 4 trainees and 8 consultants in the toolkit group responded; all used it.
- 2 trainees identified that the toolkit allowed discussion of a topic that would otherwise not have been covered, such as career planning

*'It was helpful - however my current supervisor is very organised anyway! Would have been even more useful if you had a supervisor not aware of portfolio requirements.'*

- 3 consultants identified that the toolkit enabled discussion of topics that otherwise may not have been covered, such as rota issues and career planning:

*'Gave useful baseline structure; enabled me to focus on aspects of trainee's development I hadn't previously considered'*

**Conclusions** Our toolkit for streamlining supervision meetings was well-received, useful and encouraged discussion of topics that may otherwise not have been covered.

Barriers to effective supervision may be structural, such as navigation of ePortfolios and physical space for meetings. Further qualitative research is needed to explore improving the process of supervision locally, particularly with increasing acceptance of virtual meetings.

We aim to expand this pilot to be evaluated regionally.

## RCPCH Trainees Committee

### 479 QI PROJECT: IMPROVING LESS THAN FULL TIME TRAINEE (LTFT) ROTA DEVELOPMENT AND APPROVAL IN HILLINGDON HOSPITAL'S PAEDIATRIC DEPARTMENT

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**Background** LTFT trainees often find starting new rotations stressful due to conflicts associated with their rotas.

In May 2019, 37% of Paediatric junior doctors at Hillingdon Hospital were working LTFT. Only 20% of these trainees felt supported with their rotas. Many of our LTFT trainees were unsure how to calculate their hours, which frequently resulted in proposed rotas being sent back and forth to medical staffing, delaying their approval. The survey found only 50% of LTFT trainees were confident or very confident when calculating their hours and only 60% were confident or very confident when calculating leave.

**Objectives**

1. To clarify and simplify the process of developing and confirming LTFT rotas.
2. To improve rota support for LTFT trainees.

**Methods** We surveyed all LTFT junior doctors in the Paediatric Department and presented the results at a departmental meeting. We identified areas of difficulty and met with the medical staffing and payroll teams, the Consultants responsible

for the rotas and the Consultant Champion for LTFT working. Together we agreed to update our department's practice in line with the most recent guidance from the RCPCH and BMA.

We wrote a guide summarising LTFT training in our department. This included a timeline of events leading to a trainee's rota being confirmed, typical average hours, nights and weekends a trainee would work based on their training percentage, and information on calculating leave.

We developed a spreadsheet to make it easier to develop slot share rotas. It is prepopulated based on the training percentage and automatically calculates the average hours and numbers of each different shift each slot share partner works. It has enabled more complex slot shares for example three LTFT trainees sharing two rota slots.

A LTFT trainee representative management role was introduced from August 2019. They contact each new LTFT trainee prior to their rotation, act as a point of contact for queries, and signpost trainees to other resources and support networks when needed.

After these changes were implemented a repeat survey was carried out to assess their impact on trainees' experiences.

#### Results

1. Initially, 50% of LTFT trainees were confident or very confident at calculating their total hours. After our changes this increased to 75%.
2. In 2019, 20% of LTFT trainees felt supported with their rota development. After our changes, 87.5% of trainees felt supported or very supported.
3. 75% of trainees found the LTFT guide and spreadsheet helpful or very helpful. 80% found the LTFT representative role very helpful and 20% found it helpful.

**Conclusions** The largest improvement was that LTFT trainees felt much better supported. There were also improvements in LTFT trainees' confidence in calculating their hours and leave.

In addition to the improvements assessed by our survey, the changes we made led to fewer rota gaps, and less 'doubling up' of two slot share partners working the same shift, which has benefitted the whole Paediatric Department.

## British Association of General Paediatrics

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### '3 IS THE NEW 4' – A QUALITY IMPROVEMENT PROJECT FOR 2–5 YEAR OLDS WITH WHEEZE AND EARLIER DISCHARGE. WHY WAIT 4 HOURS?

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**Background** The current British Thoracic Society (BTS) guideline (SIGN 158, 2019) states that children with wheeze or asthma can be discharged when stable on B-agonists every 3–4 hours (hrs). Anecdotally, standard UK practice is B-agonists every 4hrs before discharge. There is limited published evidence to support the BTS guideline (SIGN 158, 2019) which references 2 studies from 1999 (n=63) & 2003 (n=359). These have debatable relevance to current practice as these children were discharged home on nebulisers, an uncommon UK practice.

**Objectives** Implement a change in practice to discharge children aged 2–5 years from our paediatric assessment unit (PAU) and ward deemed well by a clinician 3hrs after their last inhaled B-agonist.

**Methods** Children referred via PAU and either discharged or admitted were reviewed monthly 01/12/18 – 31/01/20. Any child treated with B-agonists with a respiratory attending complaint of 'cough', 'wheeze', 'asthma' or 'upper respiratory tract infection' was included in analysis. Initial treatment is standardised to burst therapy for all (3 x 10 puffs or 5mg nebulised salbutamol x 20 minutes apart) with clinician review after this and hourly until discharge. The percentage of children discharged 3hrs after their last B-agonist was plotted on a run chart with the median calculated pre-intervention (December 2018 – March 2019). Re-presentations within 72hrs via the Emergency department (ED) or PAU were recorded. Interventions included posters in ED, PAU & ward, along with a formal data presentation (July 2019). Illness severity, oxygen requirement, medications used and direct ED discharges were not recorded.

**Results** There were 7279 PAU attendances over the study period with 271 included in analysis. Median age was 3yrs with an interquartile range (IQR) 3–4yrs. Discharge from PAU 3hrs post B-agonist treatment increased from baseline median 46% to 100% by December 2019. A definitive shift in practice (PAU) occurred from April 2019. Ward discharges did not show a consistent shift in practice likely due to confounding factors (low patient numbers, staff clinical practice/preference and patient acuity). Re-presentations within 72hrs were low (n=8). Discussion around discharge 3hrs post B-agonists began in early 2018 with some clinicians possibly become 'early adopters' as the pre-intervention median is above 0% (46%), suggesting a shift in practice occurred before formal intervention. No data is available before December 2018 due to record storage issues and prevents deeper analysis of when the shift occurred.

**Conclusions** We successfully implemented a change in practice such that the proportion of children discharged from PAU at 3hrs (rather than 4hrs) after B-agonist treatment increased over the study period to near 100%. This practice follows current national guidelines; we recommend other institutions consider adoption of this practice.

## British Association of Perinatal Medicine and Neonatal Society

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### MAINTAINING PRETERM ADMISSION TEMPERATURES IN AN ERA OF DEFERRED CORD CLAMPING AND DELIVERY ROOM CUDDLES: A QUALITY IMPROVEMENT PROGRAMME

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**Background** Admission hypothermia is an independent risk factor for death in preterm babies. During implementation of deferred cord clamping at preterm birth, we had experienced an increase in the rate of admission hypothermia. We have also implemented a policy of improving the quality of immediate care by encouraging cuddles in the delivery room, which