British Academy of Childhood Disability

1132 UPPER LIMB SURVEILLANCE IN CHILDREN WITH CEREBRAL PALSY: A SERVICE IMPROVEMENT PROJECT

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Background Impaired ability to manipulate objects is among the main challenges for children with cerebral palsy and upper limb (UL) involvement. There is growing evidence that timely assessment and treatment of UL spasticity can improve long term functional use of the hand.

Objectives There was some evidence that current practice in our service did not include a systematic UL assessment of all new presentations with cerebral palsy, therefore a multi-disciplinary team of paediatric Occupational Therapists (OT), physiotherapists and paediatricians set out to conduct a service review. The aim of this service improvement project was to address universal access to screening, and to promote prompt access to intervention in children with cerebral palsy and UL involvement.

Methods The assessment phase involved:

1. Auditing 55 case notes of children with cerebral palsy, to identify the number of children who had received formal UL assessment over the last two years. Formal UL assessment should, as a minimum, include completion of the Ashworth scale for tone, goniometry to assess passive range of movement, posture of hand and wrist by Zancolli classification system and thumb position according to House Classification.
2. Reviewing case notes of 7 children receiving intervention because of spasticity of the UL secondary to cerebral palsy. Interventions included constraint-induced movement therapy, splinting and botulinum injection.
3. Surveying all OTs to identify perceived barriers to service delivery

Results 1. Only 30% of eligible children with cerebral palsy had had a formal UL assessment over the past two years;

2. All children receiving UL interventions achieved improvement in goal setting rating scales or SHUEE scores;

3. Nearly 30% of the of the OTs were not aware of the standardised UL assessment in use. Lack of time, training, and the complexity of the current assessment were the perceived barriers to service provision

Conclusions For this service improvement project, we identified an unmet need (only 30% of eligible children with cerebral palsy were receiving formal UL assessment) and the perceived barriers to improvement. We therefore addressed the problem by creating a simpler UL screening tool and a new referral pathway. We also provided training to OTs and set up a new database to monitor progress. We aim to close the cycle by re-assessing the situation in the future.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1133 'ARE YOU OK?'

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Background Trainee recruitment and retention are significant issues currently faced by paediatrics in the UK. In 2020, the GMC survey reported that 40% of trainees reported their work to be emotionally exhausting. Within paediatrics, symptoms of post-traumatic stress disorder have been reported in up to 81%.

The debrief process aims to provide an environment for reflection and learning, but also allows the team to process and better understand their response to a high-stress situation.

Objectives To explore paediatric trainees' views and experiences of significant events and the debrief process in the West Midlands.

Methods An online questionnaire was designed and distributed to paediatric trainees in the West Midlands region (specialty trainee grade 1 – 8). Responses were collected between 16th October and 17th November 2018. The questionnaire addressed three main areas;

1. Impact of involvement in significant events on trainees
2. Trainees' previous experience of debrief in clinical practice
3. Trainees' opinion on the use of debrief in clinical practice

Results The response rate was 46% with 118 responses analysed. Prior involvement in a significant event was perceived to have had a negative impact on 29% (n=34) of respondents. Trainees reported disruption to personal relationships, mood, energy levels and sleep following a significant event. They also reported an impact on work life; including feelings of insecurity and self-doubt, in addition to reduced confidence and self-esteem.

Previous experience of clinical debrief was described by 75% (n=89) of trainees. Of these, 57% (n=51) experienced a hot debrief, within 24 hours of the event; 35% (n=31) a cold debrief, greater than 24 hours after the event, and 8% (n=7) multiple debrief episodes. The debrief process was felt to be useful by 84% (n=75), however 20% (n=18) reported having a negative debrief experience. Reasons for this included; apportion of blame and responsibility, inability to voice concerns and emotional upset.

A majority of trainees felt that a combination of both hot and cold debrief would be most beneficial (75%, n=88), and that this should be attended by members of the multidisciplinary team, either those directly involved in the event (60%) or the wider team (35%). Over half of trainees felt that these sessions should be led by the consultant who had been directly involved. 78% (n=92) felt that a formal debrief tool would be useful.