Objectives To evaluate the parental and clinician's level of satisfaction in telephone consultation that has taken place during the lockdown period.

Methods Telephone survey was conducted on all out-patient telephone consultation in our Paediatric Department from 14th April to 29th May 2020. The Telephone survey was anonymous. It was conducted by 2 clinicians retrospectively between June and July 2020. The Telephone Survey consisted of 14 questions, which are mixtures of ratings on a 5-point Likert Scale, Yes/No questions and open suggestions. Simultaneously, an anonymous online survey was sent to our clinicians conducting the consultations to evaluate their level of satisfaction.

Results 144 Patients met our inclusion criteria and their parents were contacted by phone. We eventually contacted 100 patients. Over half (71%- 97%) declared that they 'Strongly agree' or 'Agree' regarding 'Consultation experience', 'Communication and Information', 'Technical Quality', 'Efficiency, 'Convenience' and 'Prescription system'. 27 clinicians responded to the on-line survey. The clinician level of satisfaction had been mixed. Although most our clinicians were willing continue with telephone consultation, over half of our clinicians (60%) had disagreed that the clinical assessment via telephone consultation had been adequate.

Conclusions This pilot study provided evidence of satisfaction with telephone consultation in a Paediatric Department of a large UK Teaching Hospital. Additionally, other comments and suggestions from parents and clinicians were a valuable source of feedback that should be considered in future service development.

Paediatric Educators' Special Interest Group

1171

REMOTE 360 VIRTUAL SIMULATION- CAN YOU 'DO SIM' COMPLETELY ONLINE?

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Background Simulation is resource heavy in terms of time, space, equipment, and faculty, with limitations on the number of people you can deliver each session to. During the COVID-19 pandemic, social distancing makes face to face simulation more challenging.

After working with a local healthcare VR team through a return to training project¹, we explored benefits and acceptability of remotely debriefing 360° videos of simulated paediatric emergencies. Remote debrief has been used successfully in the past to train teams² and faculty³. However, its use in the context of 360 content is still novel. The theory being that because the participant is an 'active observer' this would bring a more immersive experience.

Objectives We were keen to assess whether this novel method of experiencing simulation teaching was engaging, immersive and safe.

Methods Using 360° content filmed at Royal Devon and Exeter hospitals, we ran a remote virtual simulation session over MS Teams video conferencing platform in local and regional paediatric teaching sessions.

After a quick but vital pre-brief we asked the learners to watch a pre-filmed scenario (www.youtube.com/watch?v=1SqvH6TA_Kw).

We guided them to interact with the video, directing their view in the 360° media to whatever interested them. This was followed by a debrief using a modified 'standard' simulation debrief structure.

We collected feedback on its acceptability and similarity to face to face simulation.

Results Between April 2020- March 2020. 9 Sessions around 130 learners, 60 gave feedback. Sessions were embedded in local, regional (South west) and international (Wales) teaching.

Group sizes ranged from 6 to 40 learners. Levels ranged from medical students, foundation doctors, trainees and Paediatric consultants. Sessions were accessed on phones or computers at work or home.

Feedback was globally positive 100% 'would do it again'.

Qualitative feedback was rich and promising:

- 'more life-like than expected'
- 'safer than real sim as I didn't feel judged'
- '360 element meant you had a different perspective'.

Interestingly for some sessions we had more senior grade learners than our usual simulation sessions – this directed debriefs towards the non-technical learning which was discussed more than the medical learning.

The debrief often led to learners sharing stories of clinical encounters and it did not seem to matter that they did not actively participate in the simulation.

Additional positives include:

- Easy accessibility for anyone to view 360 video (no need beyond normal consumer technology).
- No need for additional faculty or manikins.
- Relatively quick and engaging to run remotely.
- Larger groups can be engage (and fit in a room) than standard simulation.

After presenting this work in 2020, other hospitals have taken our pre-made scenarios and have used them for their own virtual sessions.

Conclusions We recommend remote 360 sim with debrief as a fantastic adjunct to standard simulation. The modality is low cost, well received and a safe method of providing people with an experience of emergency scenarios. This is enhanced though a supportive debrief.

The experiences have helped establish some 'best practices' for this evolving modality, which we are keen to share.

British Association of General Paediatrics

1172

UMBILICAL GRANULOMAS: A PINCH OF SALT DRIES IT UP

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Background An umbilical granuloma is an overgrowth of tissue that usually occurs when the umbilical stump has fallen off. It occurs commonly in the neonatal period usually after Day 15 of life. Parents usually describe a fleshy mass and persistent cumbersome discharge from the umbilical area. The potential risk of omphalitis and necrotizing fasciitis means that it is important umbilical granulomas are identified and treated

appropriately. Silver nitrate was previously the first line of treatment of this condition in our local hospital. However, it is associated with various problems which include burns to the surrounding skin and need to be applied by a trained health professional.

Salt treatment was introduced to our local hospital as the first line treatment for umbilical granulomas. Salt is thought to be effective due to its desiccant properties. The salt is applied and monitored by our outreach nursing team after the diagnosis is confirmed. Salt is applied to the area for 30 minutes after it has been cleaned. Further application of salt is done by the parents twice daily after they have been trained. On the 4th day of treatment, the granuloma is assessed by the team at home. No further treatment is required if it has resolved completely. In cases of treatment failure, further treatment with polyurethane and silver nitrate is considered as per local policy.

Objectives A retrospective audit was undertaken to demonstrate the effectiveness of salt therapy as the first line of treatment for umbilical granulomas.

Methods A review of the case notes of the infants treated for umbilical granuloma between January 2019 and November 2020 in our trust was done. A proforma was created reviewing what treatment the infants received.

Results A total of 6 infants received salt treatment as the first line of treatment for their umbilical granulomas during the review period. The umbilical granulomas resolved completely with salt treatment after a 3 day course of salt application. No infant during our study period required second line treatment.

Conclusions Our audit has demonstrated that salt treatment is an effective, environmentally friendly, inexpensive and easily available first line treatment for umbilical granulomas with no reported side effects.

British Association of Perinatal Medicine and Neonatal Society

1173 DOES TRANSPORT TIME TO OFFSITE MICROBIOLOGY AFFECT TIME TO POSITIVITY OF BLOOD CULTURES IN INFANTS SCREENED FOR EARLY ONSET SEPSIS?

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Background Screening babies for early onset sepsis represents a high proportion of neonatal antibiotics use. Due to historical concerns about the delays in transportation of blood cultures from our District General Hospital to off-site microbiology services, antibiotics are currently continued until the automatically generated report of 'no growth' appears 36 hours after incubation begins in the microbiology lab. Consequently, it was predicted that babies were having multiple doses of unnecessary antibiotics, and a prolonged stay, without ascertaining whether there was a significant delay in reporting of positive blood cultures caused by transport off-site.

Objectives To determine whether the transport time to offsite microbiology affects the Time To Positivity in blood cultures sent from a District General Hospital NICU.

Methods Blood culture data from 1/1/2015–13/05/2020 was obtained, and analysed for indication for antibiotics, CRP

values, bacteria isolated, whether the bacteria was clinically considered a contaminant, and time elapsed from culture being taken and antibiotics commenced to phone call to NICU informing them of a positive result. Finally, NICE guidelines for discontinuation of antibiotics at 36 hours (well baby, low initial suspicion of sepsis, reassuring CRP trend) was retrospectively applied to the true positive blood cultures taken for early onset sepsis, to ascertain if any neonates would have inappropriately had their antibiotics stopped due to transport time to offsite microbiology.

Results 2113 blood cultures were sent over the 5 year period studied, of which 37 were positive, 14 were considered 'true positives', and 6 were true positives from infants screened for early onset sepsis. 5/6 (83%) flagged as positive at 36 hours from being taken, and 6/6 flagged at 48hrs from being taken. The single outlier was a baby who was intubated, cooled and transferred to a tertiary centre. Both CRP values in this child were >10. In early onset sepsis screening, the negative predictive value of a negative culture having further growth after 36hrs was 99.8%.

Conclusions If the NICE guidance for discontinuing antibiotics in early onset sepsis were followed, and antibiotics were stopped 36 hours after commencing in well appearing babies with a low initial suspicion of sepsis, with two CRP levels less than 10, and with blood cultures that have not flagged as positive by 36 hours from starting antibiotics, there would have been zero cases of missed bacteraemia in five years. The concerns about the impact of transport time are unwarranted, and lead to poor antimicrobial stewardship practices. Based on previously gathered data on the number of inappropriate extra antibiotic doses given to these babies, in a centre with 2500 live births/year, this has the potential to save £1700/year in drug costs alone, and could reduce the length of stay by 12–24 hours for 116 low risk babies per year.

Quality Improvement and Patient Safety

1175 SOCIAL DISTANCING IN THE SEMINAR ROOM OF A CHILDREN'S HOSPITAL – A PROSPECTIVE QI ANALYSIS OF PRACTICES AND RECOMMENDATIONS

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Background SARS-CoV-2 can be spread when people have close sustained contact. This means spending more than 15 minutes within two metres of a covid-positive person as it spreads through droplets from sneezes and cough. To that effect, Public Health England recommends social distancing, that is, maintaining a distance of at least 2 metres between people of different households. In cases where a 2m distance is not possible, additional measures such as wearing a face covering and having adequate ventilation should be ensured.

Objectives The objective of this audit was to look at social distancing measures among healthcare professionals during the morning paediatric handover in the seminar room at our Hospital and to identify areas of improvement so as to prevent the spread of the infection among hospital.

Methods A daily head count was carried out at the morning handover in the seminar room from 1st November 2020 to