15th January 2021. This included doctors, medical students and physician associates. Given the size of the seminar room, the infection control team recommends that the total number of people in the room should not exceed 15 at any given time.

Results The recommended total number of people was exceeded on 25 discrete days (54.3%) in that period time. Moreover, chairs spaced 2m apart to ensure safe distancing were moved closer by the healthcare professionals on a daily basis. This increases the risk of spread amongst the staff. After communicating the results with all the stakeholders and staff at UHL Children's hospital, some positive changes were noticed.

Display of the poster within the seminar room and on the entrance door to the seminar room, marking the distance on the floor, communicating the results with staff and regular reminder about the need of adherence to PHE guidance helped the practice of social distancing. Since implementing this change, total number of people reduced to 9 on an average with maximum of 11 over 2 weeks period.

Conclusions Social distancing measures should be better adhered to reduce the risk of person to person transmission in a hospital setting. Participants were advised to limit the number of staff to one to two each from every ward to help minimise the number of attendees in the seminar room. Staff are being encouraged to leave after handing over jobs from their specific wards. Strict adherence to guidance with regular reminders during handovers about its implementation and reviewing PDSA cycles are key to sustain this improvement.

British Association for Community Child Health

1176 OUTPATIENT CLINICS – WHAT DO FAMILIES VALUE?

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Background Gloucestershire Hospitals NHS Foundation Trust Community Paediatrics service has reviewed the patient experience of outpatient clinics to guide the remodelling of this service. The department comprises eight consultants across two sites, serving a population of 630,000. The NHS Long Term Plan aims to reduce face-to-face appointments by one third through embracing technology. The COVID-19 pandemic has accelerated the introduction of remote clinics via telephone or video appointments in this division. Having never been routinely used, this represented a significant change in practice. Data was required regarding the aspects of the outpatient environment valued by families, to plan the organisation of future services.

Objectives To understand the patient experience of using central hospital and peripheral community clinics, and remote clinics to direct development of the service.

Methods Community paediatric patients and families were invited to complete a survey examining preferences on location, facilities, virtual vs face-to-face appointments and MDT working.

Results 1990 surveys were distributed and 265 were completed, representing a 13% return. 87% of respondents stated their child had ADHD or Autism, or a learning disability.

Appointment preferences 58% of respondents reported that proximity to home was the most important factor in determining clinic location of choice; time out of school to attend appointments was frequently mentioned. Parking and appointments at the same site as other facilities such as radiology and blood testing was mentioned in 43% and 27% of answers respectively. 20% of wheelchair users reference accessibility in addition to the factors above.

Virtual Appointments 70% of those who had attended a video appointment stated they were happy for appointments to be run in this way, compared to 39% of those who had not. 55% of those who had attended a telephone appointment stated they were happy about appointments being run in this format, compared to 40% of those who had not.

Patient reported advantages of virtual appointments included convenience and reduced travel time. A lack of physical examination, technical problems and a reduction in child engagement in the appointment were concerns mentioned by respondents.

MDT working 80% of respondents had not attended a multi-disciplinary clinic. 87% of those who had attended reported it to be helpful.

Conclusions The majority of respondents identified their child as having ADHD or autism, or learning difficulties. The NHS Long Term Plan and RCPCH State of Child Health Reports highlight the need for greater focus on the needs of these young people.

Proximity to home and parking remain the most important factors in determining preferred clinic location. The number of patients who were happy to have video appointments was higher in those who had experienced these already, suggesting they were more successful than expected. A smaller difference was seen for telephone appointments. MDT working was popular amongst those who had experienced this.

Both remote appointments and MDT working are modalities of consultation that should be considered when developing the Community Paediatrics service, using models of working that are closer to that outlined in the NHS Long Term Plan.

Quality Improvement and Patient Safety

1178 APPLICATION OF NICE BRONCHIOLITIS FLUID THRESHOLDS TO INFANTS ADMITTED WITH ACUTE BRONCHIOLITIS

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Background Feeding support is the most common reason for bronchiolitis hospital admission. NICE bronchiolitis guidelines recommend an assessment of hydration status (including >12 hours since last wet nappy) and feed volume thresholds (<50% or <75%), taking into account risk factors (prematurity, congenital heart disease, < 3 months of age). There are no data to support these recommendations.

Objectives To apply NICE bronchiolitis recommendations to children with clinical bronchiolitis admitted to hospital to describe the (1) frequency and method of assessment of hydration status on admission, (2) volume of feed at admission and discharge from hospital, and (3) impact of NICE guideline risk factors on these assessments.

Methods 317 children aged <12 months admitted with bronchiolitis to an acute paediatric medical ward between 01.10.2019 and 31.01.2020 (269 had diagnosis at time of ED review). From a retrospective review of medical records we noted documentation of clinical hydration, last wet nappy, fluid intake and percentage fluid intake (documented or calculable) at admission and discharge. Where available we calculated agreement between medical paediatric (MP) and emergency department (ED) assessments.

Results Included infants were <3 months of age in 46% (146/317), preterm 17% (53/317) and had other high risk co-morbidities 13% (40/317).

At admission 264/269 infants (98%) MP and 172/269 (64%) ED reviews were documented. Last wet nappy, fluid intake and calculated percentage of fluid intake was observed in MP review for 190/264 (72%), 168/264 (64%) and 27/264 (10%) of infants and ED review for 107/172 (62%), 97/172 (56%) and 28/172 (16%). Fluid intake was documented or calculable in 155/264 (59%) MP and 94/172 (55%) ED, and for 149/269 (88%) bottle fed, 22/71 (31%) breast fed and 5/28 (18%) mixed fed babies. On admission NICE fluid threshold <50%, was identified in 69% (114/165), 50-<75% in 19% (31/165) and ≥75% in 12% (20/165). Age <3 months, but not other risk factors, appeared to impact clinical decision making for fluid intake and admission.

108 of 139 infants (78%) had reason for admission documented as feeding support and/or suction and/or observation with 36% (38/107) needing hydration support and 40% (43/108) an admission <24 hours.

Discharge fluid intake was median of 79% daily requirement for all infants (calculable in 230/317), and higher in any risk factor (82% vs 71%). The majority, 56% (129/230), were ≥75%, with 10% (23/230) discharged at <50% intake, predominantly term infants without risk factors. Re-admission rate in this group was 9% (2/23), in line with the whole group, 9% (29/317).

Conclusions In acute bronchiolitis documentation of fluid intake is frequently absent, particularly in breast fed infants. Many infants are admitted with fluid intake <50% of requirement, often for <24 hours. Acute care requires improvements to fluid volume calculation, particularly for breast fed infants. Some low risk infants breaching NICE thresholds may be able to be supported in the community.

Quality Improvement and Patient Safety

1180

THE GREAT ESCAPE: A QUALITY IMPROVEMENT PROJECT TO STREAMLINE THE PAEDIATRIC DISCHARGE

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Background Pressure on safe and timely discharges of paediatric inpatients is greater than ever before. With rising numbers of hospital admissions for children in the UK (up by 3%

between 2014/2015 and 2019/20)^{1,2} and the COVID associated risks of a hospital stay.

There is minimal pre-existing data outlining the discharge experience for paediatric inpatients. The discharge process is an essential component of patient safety with respects to communication with primary care, medication information and effective follow up. Efficient processes improve patient flow and experience as well reducing patient complaints.

To evaluate current practice data was collated from The Royal Alexandra Children's hospital in order to implement strategies to improve discharge processes. The discharge process ordinarily comprises of initial discharge decision making by the clinical team, writing of a discharge summary to include follow-up arrangements and preparation and provision of TTO's (To Take Out's – referring to medications provided on discharge).

Objectives The aim of this quality improvement project was to collect data from different sources to identify how best to improve discharge processes for paediatric inpatients. Data gathered was used to highlight areas for improvement and propose strategies for change.

Methods Firstly quantitative data was gathered by means of a survey to nursing staff, this survey addressed time breakdowns for discharge processes and assessed specific reasons for delays along a single patients journey.

Questionnaires were also given to families to assess patient experience. An opportunity was given to provide feedback surrounding communication, and to suggest improvements. Finally a gap analysis was performed to design interventions in order to address identified gaps.

Results There were 45 respondents to the survey. We established that 62% of patients identified as appropriate for discharge left within 3 hours of the decision being made.

Prompt discharges were found to be as a result of:

- Early Pharmacy screening of TTO's
- Timely preparation of discharge summaries and TTO requests reducing wait times for arrival of TTO's to the ward or nursing staff collecting TTO's from Pharmacy themselves

Delays included:

- Medication related issues
- Delayed decision making
- Inefficient communication
- Technical issues (including ward staff being unable to print Discharge summaries or printer errors)
- Need for repeat observations prior to discharge
- Delay in transport arrival

Reassuringly, 92% of parents felt they were clearly informed with regards to their child's discharge time.

In order to improve communication between nursing, medical staff and patients:

- TTO sticker for patient notes to raise awareness of planned discharge and alert clinician to prepare discharge paperwork, communicate to patient and nursing staff likely discharge times.
- 'TTO completed column' on the patient whiteboard for doctors highlight when TTO completeTo address technical issues:
- Designated TTO tray where printed TTO's can be stored for nursing/pharmacy teamTo train staff:
- Poster and training in effective TTO completion to aide speed of medication ordering and screening