guidance of clinically extremely vulnerable group in regards to classification of children with complex congenital heart disease. Most PECs wore standard PPE (surgical mask & plastic apron) during echocardiography.

Conclusions The current pandemic has thrown in some unexpected challenges on how we deliver the paediatric cardiology services. There were great variations on how different professionals managed their work during this period. Reassuringly no increase in complaints or sudden unexpected deterioration were reported which is likely to be due to the painstaking vetting, prioritisation and diligent overview amongst our colleagues. Having a joint statement from specialist groups would be helpful in future to ensure uniformity of services and safeguarding of professionals from medico-legal challenges. There are some aspects of our work which can be delivered remotely and we need to study the pros and cons of this approach.

Paediatric Educators' Special Interest Group

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NEONATAL SIMULATION FORTNIGHT: USING SIMULATION TO IMPROVE NEONATAL RESUSCITATION SKILLS

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Background Junior doctors understandably find performing resuscitation skills a considerable source of stress (Scott et al, 2013). This is increased for those required to deliver neonatal life support but are unfamiliar with paediatrics, such as GP or foundation trainees. While resuscitation training is often incorporated into induction, research has shown that frequent reinforcement is necessary to maintain these skills (Berdin et al 1993). Previous research has demonstrated that simulation allows for faster learning and greater retention of knowledge (Knowles 2013). The implementation of an induction neonatal sim for non-paediatric doctors resulted in increased confidence in attending deliveries (Peacock et al 2016).

In our hospital, basic NLS forms part of GP/foundation trainee induction. However, as significant time may pass before these skills are utilised, we incorporated a refresher neonatal resuscitation simulation programme halfway through the rotation.

Objectives We wanted to ascertain whether the introduction of an intensive neonatal simulation programme primarily aimed at GP and foundation trainees would improve confidence and skill in neonatal resuscitation.

Methods Simulation scenarios were developed using common neonatal emergencies and local incidents. Simulation sessions were held post-handover each morning for 2 weeks. Though scenarios were primarily aimed at GP and foundation trainees, all members of the neonatal resuscitation team were involved, including registrars, SCBU nurses and midwifery team members. The simulations were facilitated by medical education fellows trained in debrief, with expert clinical input provided by Paediatric Consultants. Key learning points were themed, summarised, and shared with the team. Daily feedback was collated, and written feedback was obtained after completion.

Results Feedback was extremely positive, with juniors feeling more confident immediately after, as they were 'allowed to make mistakes in a controlled environment' and learn from them. Simulation was unanimously preferred after handover, due to improved access and minimal clinical obligations. All juniors agreed 'it was great learning' and suggested it continue for the new SHO's. Learning points included: communication, role allocation and calling for help early. We later received written examples of how simulation had positively influenced personal clinical practice. One participant reflected on a neonatal emergency, stating 'what helped me the most through this resus was remembering that I would just have to go through it the way I'd gone through it in sim'. Other positives included an appreciation for the opportunity to practice with an MDT approach and reiteration of key learning points. Main barrier identified centred on the tension between service delivery and education.

Conclusions Neonatal SIM Fortnight allowed key learning to be revisited in short, daily sessions over a 2-week period. Feedback and subsequent influence on clinical practice demonstrated the effectiveness of Neonatal SIM Fortnight via behavioural change and clinical results, as per levels 3 and 4 of Kirkpatrick's evaluation model (1959). The simulation programme has been adapted for additional use at the beginning of rotations to support new junior trainees. We anticipate that neonatal simulation fortnight will continue to improve the neonatal resuscitation skills of junior doctors in paediatrics.

Quality Improvement and Patient Safety

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IMPLEMENTING NEUROPROTECTIVE DEVELOPMENTAL PROCEDURAL TECHNIQUES IN NEONATOLOGY: EMBRACING CHANGE – A QUALITY IMPROVEMENT PROJECT

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Background Integrative developmental care in neonates promotes neuroprotective interventions for optimum neurological growth and development. Adherence to neuroprotective techniques ensures high quality individualised care during routine procedures. However, common procedures like capillary blood sampling are often done by junior doctors and nurses without proper training. This can result in inadequate sampling volumes, false laboratory results and complications such as pain and bruising.

Objectives This project aims to develop systems in place, embedding developmental care procedures in practice, to ensure safe and family integrated care in the neonatal environment.

Methods A learning pack was developed to use evidence-based developmental care practice of capillary blood sampling and lumbar puncture on the neonatal unit. Training sessions were organised to familiarise newly posted GP/FY2, speciality doctors and nurses to the developmental care techniques. YouTube videos, social media and online conferencing tools were used to disseminate and reinforce teaching and training along with competency assessments. Quality improvement methodologies such as PDSA cycles and implementation of evidence-based interventions were used to drive improvement and implement