Abstracts

Objectives The aim of this quality improvement project was to review the interagency safeguarding referrals completed at a district general hospital before and after the implementation of the project's initiatives. The quality of the referrals was evaluated based on the accuracy and clarity of documented information. The project also focused on evaluating how long after the patient encounter the referrals submitted. These were assessed against Working Together for Safeguarding Children 2018 and the NICE Clinical Guideline CG89 Child Maltreatment: when to suspect maltreatment in under 18s.

Methods During the first cycle, sixteen interagency referrals (IAR) submitted in March 2020 through the local electronic records system were retrospectively reviewed using a previously devised proforma from 2016. Following analysis, the electronic IAR on the local care records system was modified by simplifying the questions and specifically asking about concerns and outcome if no action were taken. Healthcare professionals were presented with the initial results and received an education session about using the form. In the second cycle, nineteen IAR forms were retrospectively reviewed in August 2020.

Results Nursing staff and junior doctors completed majority of the forms. In March 2020, 75% of the forms used clear language with no medical jargon and this improved to 100% of the forms submitted in August 2020. In terms of accuracy, school's and family members' details were commonly missing. In March, school name was documented in 25% of referrals and following intervention this improved to 37%. There was an increase in accuracy of completing parent and carer details which increased from 75% to 83% as well as documentation of communication needs of the child and family, increasing from 81% to 95%. In addition, there was a significant improvement in the clear documentation of concerns from 38% in March to 79% in August. The description of the risk to the child if no action was taken, also improved from 13% to 26%.

Prior to interventions, all forms were completed within 48 hours of patient encounter and 63% within 24 hours. After the interventions were implemented, 94% of the forms were submitted within 24 hours. The only exception was a delay in a form submitted following repeated missed attendances which raised safeguarding concerns.

Conclusions These interventions facilitated the social care team in risk-stratifying patients and optimising management of safeguarding in children. Completing a re-evaluation has also significantly increased the accuracy of the forms submitted following repeated missed attendances which raised safeguarding concerns.

References
investigation or prescription, local options could be implemented to reduce need to travel.

Virtual urgent care is feasible, safe and acceptable for clinicians and carers of infants, children and young people. Based on the range of presenting complaints seen during the trial, a significant proportion of attendances to our type 1 PED could be effectively managed through this model.

Association of Paediatric Emergency Medicine

THE BREAKS BOARD – AN INITIATIVE TO EMPOWER STAFF TO COORDINATE AND TAKE THEIR BREAKS IN A BUSY CHILDREN’S EMERGENCY DEPARTMENT

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Background Tired doctors make mistakes and excessive workload is a key driver to burnout, creating exhausted, cynical and ineffective individuals. The RCPCH, RCEM and BMA recognised this, designing a framework for managing fatigue and stipulated rest break entitlements according to hours worked.

But how does this translate to the realities of a busy emergency department (ED)? Despite written and verbal encouragement about break entitlements, doctors reported challenges to the timely access to all entitled breaks. With additional pressures of a global pandemic, we recognized the importance of having a well-rested workforce. We therefore set out to identify and address challenges our ED staff were facing in taking breaks.

Objectives To introduce a break-system that ensures doctors have a 30-minute break for every 4 hours worked in a Children’s Hospital ED.

Methods We undertook a 36-week project using plan-do-study-act (PDSA) cycles. Each intervention was evaluated to assess the time required to coordinate each break (see table 2). It did however demonstrate that the taking of a 2nd break in a 10-hour shift is still a challenge, requiring further attention.

Results Introducing a formalised break system via a break(s) allocation board resulted in a greater percentage of time staff reported taking both their first and second break, and reduced the time required to coordinate each break (see table 2). It did however demonstrate that the taking of a 2nd break in a 10-hour shift is still a challenge, requiring further attention.

Conclusions The Breaks Board initiative reduces time required for staff to coordinate their breaks, increases people taking their breaks, and is felt by the majority to be a helpful breaks system.

British Paediatric Respiratory Society

EVALUATION OF AVAILABILITY OF SPECIALIST PSYCHOLOGICAL SERVICES FOR PAEDIATRIC CYSTIC FIBROSIS PATIENTS IN DISTRICT GENERAL HOSPITALS AND TERTIARY CENTRES

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Background Cystic Fibrosis (CF) is a life-limiting genetic disorder. Given the chronic, progressive and disabling nature of CF, it is well recognised that living with CF can have an emotional and psychological impact. A significant number of CF patients report experiencing stress, anxiety, low mood and difficulties in managing their treatments. The morbidity and mortality factors pose cognitive, emotional and behavioural challenges for many children with CF and their families. NICE (National Institute of Clinical excellence) guidelines recommend that the specialist cystic fibrosis multidisciplinary team should include Specialist Clinical Psychologist (SCP) who have specialist expertise in managing psychosocial problems in children and young people with CF.

Objectives We conducted an online national survey across England to evaluate the services available for psychological assessment of CF patients in District General Hospitals and Tertiary Paediatric Respiratory Centres.

Methods We contacted paediatric tertiary centres (n=21) and District General Hospitals (n=33) CF specialist teams across England. A questionnaire exploring current psychologist services was emailed to them.

Abstract 1387 Table 1

<table>
<thead>
<tr>
<th>Reported average</th>
<th>Percent of time 1st break taken</th>
<th>Percentage of time 2nd break taken</th>
<th>Time taken to coordinate each break</th>
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<tbody>
<tr>
<td>Pre-Initiative</td>
<td>90%</td>
<td>32%</td>
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<tr>
<td>Post-Initiative</td>
<td>97%</td>
<td>51%</td>
<td>2.2 min</td>
</tr>
<tr>
<td>Improvement</td>
<td>7%</td>
<td>19%</td>
<td>2.3 min</td>
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</tbody>
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