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 ineffectve individuals. The RCPCH, RCEM and BMA recognised this, having designed 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 reported percentage of time breaks were taken and time required to coordinate breaks. Qualitative data was collected to inform interventions and subsequent cycles.

PDSA Cycles

1. P Survey designed: quantitative questions to identify baseline; qualitative questions to identify barriers, ideal time to take breaks, and staff suggestions

D Staff surveyed

S Results analysed

A Intervention 1: Introduction of the ‘breaks board,’ which facilitated allocation of break slot(s) at start of shift. Launch accompanied by creation of guideline for use and staff

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.

88% of people reported the breaks board helped them coordinate and take breaks. Staff reported that it ‘has been an excellent initiative’ ensuring ‘the team are proactive about everyone having their break.’

Our future work will focus on ensuring the longevity of the change, by creating a culture change in order to get the ‘whole team to fully adopt it.’ For the next cycle we plan to do this by introducing break champions or seniors who encourage ‘everyone to put their times at huddles/handovers.

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 recommends 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.
Results 5/21 tertiary hospitals and 14/33 DGH participated in this survey. Of the 19 (n) responses, 5 (26%) were tertiary hospitals and 14 (74%) were DGH.

All respondents from the tertiary hospitals revealed they had availability of Specialist Clinical Psychologist (SCP) who participated in all CF meetings including MDT (Multi-Disciplinary) and Annual Reviews.

3/14 DGH (21%) had availability of SCP locally who saw patients in CF Annual reviews and MDT meetings.

In another 3/14 DGH (21%), CF patients had no access to SCP either locally or in tertiary hospitals. These patients were referred to CAMHS locally for psychological concerns or a Diabetes Psychologist if patient had Cystic Fibrosis Related Diabetes (CFRD).

In the remaining 8/14 DGH (58%), CF patients had no access to SCP locally but out of these, SCP from tertiary hospitals visited CF clinics in 2 DGH. CF patients from the remaining 6 DGH visited tertiary hospitals to access psychological services.

Conclusions From the analysis of the results from the online survey, we concluded that very few DGH have local SCP services. Where SCP services are not available, patients have to rely on tertiary hospitals or local CAMHS services. It is known that patients with long term physical health problems are likely to have mental health problems. NHS England highlights that prevention of mental health problems is the most cost-effective service that can be provided. Hence, it is recommended that all children and young people with CF should have access to psychological services so that they benefit from early psychological intervention and improved health outcomes through improvement in wellbeing. Our survey indicates that there is an unmet need to develop psychological services within DGH. A major limitation of this survey is the low response rate which we attribute to the work and capacity pressures from COVID-19.

British Association of Perinatal Medicine and Neonatal Society

1390 DOCUMENTATION AROUND THE COMMENCEMENT OF THERAPEUTIC HYPOTHERMIA FOR HYPOXIC-ISCHAEMIC ENCEPHALOPATHY (HIE). A QUALITY IMPROVEMENT PROJECT

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10.1136/archdischild-2021-rcpch.609

Background Healthcare Safety Investigation Branch (HSIB) have begun to investigate infants who have been ‘cooled’ for HIE in England. This triggered an audit of iCLIP electronic records for infants cooled Jan 2020 to Jan 2021 at St Georges University Hospital (SGH), London. Perinatal HIE has a significant risk of long term neurological and developmental sequelae. 1–3.5/1000 births in the UK have perinatal asphyxia severe enough to cause neonatal HIE. SGH is a level 3 unit receiving infants from level 1 and 2 units in the network. Infants must meet cooling criteria A, B and C. Criteria A is pH <7.0 or BE >-16, Appgar <5 at 10 mins, ongoing resuscitation at 10 minutes. Criteria B signs of moderate to severe encephalopathy including altered consciousness plus hypotonia, abnormal reflexes, weak or absent suck or clinical seizures. Criteria C based on aEEG for a minimum of 30 minutes showing intermittent or continuous seizure activity, abnormal or suppressed activity. Without intervention, risk of death or severe disabilities in survivors of moderate to severe HIE is 25% and 75% respectively. With therapeutic hypothermia, mortality and disability has reduced but it remains an area of interest for quality improvement and litigation.

Objectives An audit to identify gaps in the documentation around commencement of therapeutic hypothermia in infants with HIE. This will enable the team to highlight areas that need to be developed to allow more robust documentation in the future; improving patient safety.

Methods Infants identified from Badger system from Jan 2020 to Jan 2021. iCLIP entries were examined for; maternal history, delivery details including CTG, resuscitation, cord gases, first gas, neurological examination, Cerebral Function Monitoring (CFM), time of cooling, seizures, medication and reasons for re-warming if occurred.

Results 18 infants were cooled in 12 months. 33% were transferred from level 1 and 2 units. One was cooled out of cooling criteria as had borderline blood gases but went on to develop seizures. Two infants were <36 weeks, three had cooling commenced more than 6 hours of age from birth due to changing neurology, one rewarmed early due to diagnosis of chromosome disorder. One patient died after re-warming. 27% had no maternal history documented, cord pH not mentioned in 27% of cases, 22% had no resuscitation note, 27% did not have the age in hours documented at commencement. 11% of patients had no neurological examination documented prior to cooling. 5% did not have CFM results documented.

Conclusions Audit identified good documentation around infants who were cooled outside of cooling criteria. Some deficits were identified in the documentation around the maternal history, resuscitation, neurological examination at the time of commencement of therapeutic hypothermia. These results alongside the HSIB investigation have prompted an update of the HIE Guideline, triggered departmental teaching and production of an electronic pro forma for iCLIP. We aim to start a pro forma to improve and standardise documentation around commencement, during and after cooling.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

1391 THE MAGNITUDE OF PICKY EATING BEHAVIOUR AND ITS IMPACT ON CHILD HEALTH IN PRESCHOOL CHILDREN IN FOUR PRIMARY HEALTH CARE CENTRES IN KHARTOUM CITY 2020

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