risk of significant single organism growth in neonates presenting with isolated prolonged jaundice.

Quality Improvement and Patient Safety

1422 IMPROVING THE QUALITY AND SAFETY OF THE PAEDIATRIC TEAM HANDOVER

¹Sarah Barrow, ²Segn Nedd. ¹North Middlesex Hospital; ²Newham University Hospital

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Background Guidance on clinical handover states that handover of care is one of the most perilous procedures in medicine and can be a significant contributory factor to subsequent error and harm to patients if done improperly. Following a local departmental paediatric quality and safety meeting in June 2020, concerns were raised about team handover; it was often rushed and disorganised, with lack of verbal or visual aides to support a structured handover. Ultimately there was concern that salient pieces of information relating to patient care risked being overlooked or missed in handover.

Objectives The aim of this quality improvement project was to assess the quality and structure of daily paediatric team handovers from July to September 2020 on one paediatric ward.

Methods As a result of the concerns raised in the quality and safety meeting, discussion was generated amongst two paediatric trainees about current handover practice. A fishbone diagram was completed, highlighting the potential causes, and contributing factors as to why handover was deemed unsafe. The RCPCH handover assessment tool (HAT) was used to make handover assessment sheets and handover practice was assessed. Following the collection of baseline data the extent of the problem was shared with the ward doctors at another quality & safety meeting. The decision was made to add safety points to the bottom of the handover list, comprising key areas including, safety briefing, ward management, and interesting/complex cases.

Results Baseline measurement showed a median percentage compliance of 36% with safe handover points. Safety briefing points were added to the bottom of handover lists, following this intervention, reassessment of handovers showed an increase in compliance to 45%. Shortly after this there was a noticeable drop in compliance, which was felt to be attributed to a changeover of staff. An active reminder given by the senior incoming clinician to the doctor leading handover to use the safety briefing points, saw the compliance increase to 95%, with consistency. During this process, key issues were highlighted, including patients with the same forename, transfers out to paediatric intensive care and staff shortages amongst doctors and nurses. Of particular importance, patients with the same forename were moved away from each other on the ward to prevent any errors when delivering care. Using the safety handover points also generated group discussion and learning, particularly from cases transferred to intensive care.

Conclusions Assessing several factors within the paediatric team handover was an ambitious task but clearly highlighted the problem that safety points were not delivered or conveyed

in a safe or structured manner. Introducing safety briefing points at the bottom of the handover lists helped to provide a structured handover and ensured that the team were well informed when sharing the care of patients and transferring clinical responsibility. However, it was difficult to maintain consistency with the rotational nature of staff and emphasis on the use of the safety briefing points may often be needed.

Child Protection Special Interest Group

1423 THE IMPACT OF COVID-19 ON CHILD SEXUAL ABUSE REFERRALS SEEN AT AN URBAN SEXUAL ASSAULT REFERRAL CENTRE

¹Najette Ayadi O'Donnell, ²Alice Monfrinoli. ¹University College London Hospital and The Havens, Kings College Hospital London; ²The Havens, Kings College Hospital London

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Background Medical professionals working within child sexual assault and safeguarding have publically raised concern regarding the hidden harm children and young people (CYP) are exposed to during the COVID-19 pandemic lockdown. This retrospective review of cases seen at a CYP sexual assault referral centre (SARC) analyses the impact of the pandemic on case numbers, type of assaults seen and suspect demographics, and considers whether lockdown has impacted on the nature of cases referred.

Objectives To compare the impact of COVID-19 on child sexual assault cases seen at a SARC during 2020, with the non-pandemic period in 2019.

Methods Case notes were analysed between March and December 2019 and March and December 2020 for a direct comparison of the impact of lockdown and restricted activity due to the COVID-19 pandemic on case characteristics seen at a CYP SARC. Cases were seen for either a Forensic Medical Examinations (FME's); defined as cases seen within a forensic timescale or Child Sexual assault medicals (CSA); those seen outside of forensic timescale. All children seen were under 13 years of age as this is the cut off for referral into the service.

Results The analysis of cases seen by CYP SARC in 2019 and 2020 demonstrated a decrease in absolute numbers in 2020 (n=59) compared to 2019 (n=99). The mean age of cases were the same in 2019 and 2020 (6 years vs 7 years). Approximately 30% of total cases seen in either 2019 or 2020 involved an alleged perpetrator who was under 16 years of age. Further analysis demonstrated a 75% decrease in peer on peer (extrafamilial) assault seen. Conversely, the proportion of alleged perpetrator who was under 16 years old and a sibling increased to 44% in 2020 from 28% in 2019.

The nature of assaults changed from 2019 to 2020 with a significant decrease in vaginal rape from 25 cases in 2019 to 9 in 2020. There was also a decrease in anal rape from 22 cases in 2019 to 9 in 2020.

Conclusions The decrease in cases seen at the SARC from 2019 to 2020, given the restrictions of lockdown is unlikely to be surprising. The NSPCC report a decline in calls from adults with concerns regarding child sexual abuse. The 75% decrease in peer on peer assault is likely to reflect the

decrease in socialisation and interaction of young people during this period but worrying is the increase in the proportion seen who were defined as under 16 years of age and siblings. The impact of lockdown, restrictions on movement of young people outside the home and the increase use of the internet with its potential exposure to pornography are all hypothesis to explain this trend. However, further analysis of data is required over a longer time span to see the real impact of the pandemic on CYP.

Despite the decrease in absolute numbers, there remains concern of the hidden harm experienced by children and young people and every effort made to have support in place for disclosure.

Paediatric Critical Care Society

1425

PICU MOBILE APPLICATION FOR PARENTS: INSIGHTS FROM THE PARENT CONSULTATION QUESTIONNAIRE

Rufaro Ndokera, Christine Pierce, Samiran Ray, Esther Rose, Katie Dettmer, Emily Cantrell.
Great Ormond Street Hospital

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Background During a child's stay on PICU, parents receive a significant amount of information. This includes both medical and practical information. Until this point, information has been provided in paper form and informally by ward staff. During a particularly stressful time, parents may struggle to retain such information and in its paper format, it is not always easily accessible.

The Great Ormond Street Hospital (GOSH) parent support group highlighted that a mobile phone application (app) providing information during their child's PICU stay would be helpful.

Objectives To inform the desired content for a PICU information app, we surveyed parents of past and present patients.

Methods A paper questionnaire was designed by the authors. The questionnaire was distributed to parents on GOSH PICU during a 3 week period in 2019 and disseminated at a past patient event.

Results Thirty-three of the 40 distributed questionnaires were completed (82% response rate). Thirty-two (97%) of parents said they would use a PICU app. Information about bedside equipment 32 (97%) and medications 29 (87.9%) were the most important content for parents. Information about specific conditions 24 (84.8%), the hospital 28 (84.8%), the surrounding area 26 (78.8%) and research undertaken on ICU 20 (60%) were also sought.

The majority of parents would want to use the app to communicate with the clinical team in addition to the usual face-to-face contact. Twenty-four (75%) of parents would value a diary feature and the majority 30 (90.9%) would consider using the app to stay in touch with PICU following discharge.

Conclusions Parents would like access to a unit specific intensive care app to use both during their child's stay and to maintain contact following discharge. Parents would like the app to both provide information and allow them to communicate with their clinical teams. The ability to document their child's PICU journey was also of note.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1427

HARNESSING STAFF VALUES TO CATALYSE WORKPLACE CHANGE. TOWARDS 2040, NHS NET-ZERO

¹Nadia Audhali, ²Florence Wedmore, ²Anna Moore, ¹Charlotte Monro. ¹Whipps Cross Hospital; ²Royal London Hospital

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Background The climate health emergency is a problem that disproportionately affects children, and our response to it as paediatricians has lagged behind some of our young patients.

While we are simultaneously part of the problem, and one of the strongest advocates for child health, we have a duty to act. Reducing carbon emissions from healthcare remains a huge challenge with ever bolder targets; NHS to reach Net zero by 2040. For this to happen we need innovative thinking, and support at every level to succeed, which means engagement of every one of us.

By connecting against a shared adversity, as we have seen through the healthcare response to Covid, we can motivate each other to deliver extraordinary things.

Objectives To form a Trust-wide staff group of paediatric doctors and nurses, alongside HCPs from other specialities, with a passion for tackling climate change. We knew our Trust took these issues seriously but understood that our leaders faced competing pressures. By offering to help, we could help provide solutions and focus. Our aim was to use our voice, to result in greater reductions in operational carbon, better staff engagement, and education of staff and patients. A secondary aim was to promote staff wellbeing by taking action together, and creating a sense of connection, belonging, and hope around this shared value.

Methods The Green at Barts Health staff group formed, and launched itself by presenting to the Board. Members were recruited by webinars, grand-rounds, regular meetings. Members shared a passion for sustainability and tackling climate change, and many hours of voluntary time were contributed towards the shared goals. We established stakeholder networks, used quality improvement methods, along with advocacy and relationship building.

Results 80 staff were recruited across 3 sites, including 10 paediatric clinicians.

Advocacy work led to a quarterly Green Forum, with Board level representation, and key stakeholders to advance the Trust's green agenda.

In response to influencing during this forum, our Trust has agreed to declare a Climate Emergency.

Our paediatric education stream has delivered departmental teaching to colleagues on climate change and air pollution. Play therapist members have taken part in National Clean Air Day, working with paediatric inpatients to create air pollution/clean air images for the newsletter.

Quality improvement has resulted in collaboration with external partners, Centre for Sustainable Health (CSH) in development of their toolkit calculating CO2 emissions savings from switch to online vs face to face outpatient appointments.