Background Emergency medications are infrequently required in district general paediatric departments, however when they are it is important for them to be given in a timely manner. Feedback from local simulation scenarios revealed that prescribing and preparing unfamiliar emergency medications was something that both medical and nursing teams felt anxious about. Regular simulation practice is therefore essential for improving patient care and safety in emergency scenarios.

Objectives The aim of this project was to improve paediatric team ability and confidence when prescribing and preparing unfamiliar emergency medications in order to improve patient care and safety.

Methods A series of 'drug drills' involving emergency medication were created: asthma (salbutamol and magnesium sulphate); sedation (morphine and midazolam); duct dependent cardiac disease (prostaglandin) and septic shock (adrenaline and noradrenaline).

Doctors timed how long it took to prescribe the medication after reading a scenario. Nursing staff subsequently timed how long it took them to prepare and administer the medication.

Participants completed an online survey after the 'drug drill' and were asked to record how long it took for them to complete the drill, and whether they felt more or less confident prescribing/preparing these medications. They were also encouraged to provide feedback and learning points to be shared amongst the team to facilitate shared learning.

In future, 'drug drills' will be repeated to assess whether our performance and confidence has improved as a result of extra practice and group feedback.

Results To date, 'drug drills' have been completed by 19 doctors and 12 nurses. Preliminary results and feedback have been positive with 100% of staff saying they felt more confident prescribing/preparing medication after completion.

As a result of the feedback received, changes have already been implemented to help staff in future. For example, we have increased the stock number of 50ml syringes in the resuscitation room as this consistently delayed drug preparation. Also, prescription and administration guidelines are now available on a tablet in the resuscitation room for ease of access.

Conclusions Staff had improved confidence after completing the 'drug drills', which is expected to translate into better performance and patient care. We aim to repeat these drills in the future to see if our prescribing and preparation times have improved, and whether we have learnt from learning points that were identified from feedback.

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WELCOME TO THE TEAM; GOING VIRTUAL

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Background Induction days are a rite of passage for all, but especially for the rotating trainee. A good induction serves many purposes: it teaches key knowledge (e.g. IT systems, safeguarding processes); sets job role expectations; ensures health and safety considerations are addressed; helps new staff feel supported and sets the tone for team relationships over the course of the job. Induction helps new staff assimilate rapidly into the team and reduces clinical risk. The case of Dr Bawa-Garba has highlighted to all, amongst other things, the necessity of a rigorous induction process.

Our face to face consultant delivered induction package had been serially updated and appeared to fulfil these various needs; feedback was excellent and trainees felt confident starting clinical work. During the COVID-19 pandemic, however, social distancing requirements meant it became undeliverable in its current format. To address this a fully digitised induction programme was produced.

Objectives To produce a self-delivering induction package that could be accessed remotely and asynchronously but that still offered an informal, personal, supportive introduction to the department. It would offer robust IT systems training, rota guidance, key safety and governance points and an 'as good as there' tour of the department to allow trainees to integrate rapidly, safely and confidently into the department.

Methods A virtual induction was produced comprising an accessible documents folder, remote intranet access, video tutorials, video clips of staff members and a virtual induction tour. Adding active participation elements in the form of automatically marked quizzes ensured documented engagement with the process. The package was reviewed by junior trainees, nursing staff, clinical support workers and consultants prior to delivery. Anonymous qualitative survey questions including confidence ratings were used to obtain feedback, in addition to open text questions.

Results 10 new trainees underwent the new induction process in two consecutive groups. Feedback was obtained from 9 individuals. All participants felt that the package prepared them well to start clinical work. The process was more efficient, taking only half a standard working day of trainee time, and an hour of consultant time (vs a full day for both) and there were positive thematic comments around accessibility and flexibility to use it as an ongoing reference whilst starting work that were unexpected benefits. Both comments and confidence ratings were superior to those from the previous face to face induction. Interestingly video introductions to the senior team were felt much more helpful than brief face to face meetings.

Conclusions It is possible to produce a virtual induction package that not only provides new starters with the knowledge required to safely start work in a new clinical area, but also develops a sense of team spirit. Although labour intensive to produce initially, the induction package is self-delivering and therefore a significant long term benefit to a department with rotations upwards of 4 times a year. Moving forward the package will be made cross-disciplinary so that all new starters in the department receive a standardised high quality programme.