Association of Paediatric Emergency Medicine

1452 SUSTAINABILITY IS FAR MORE IMPORTANT THAN ONE SUCCESSFUL AUDIT CYCLE. OUR EXPERIENCE AFTER INTRODUCING A NEW SEPSIS TRIAGE TOOL TO OUR EMERGENCY DEPARTMENT

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Background Implementing change and ensuring sustainability could be challenging in the complexity of multifactorial health care system. One successful audit cycle is not enough.

Objectives To ensure the sustainability of successfully introducing the Wessex sepsis triage tool in our Paediatric Emergency Department (ED). The patients triggering the tool require a senior review within 15mins of escalation and if sepsis was suspected by the clinician, the IV-antibiotics need to be given within 1 hour from time of decision.

Methods Regular PDSA cycles were undertaken with results shared and discussed across the disciplines. There was early and frequent involvement and feedback from the multidisciplinary staff, including regular focus groups and small group education sessions. These provided a forum to allow discussions and subsequent changes to the tool by the users themselves. Regular audits, looking at key quality indicators, were undertaken to review compliance.

Results We undertook 5 PDSA cycles between 2018 and 2020, looking at snapshot data of 3–5 days. This demonstrated a continued increase in the uptake of the tool. Prior to introducing this tool, only 33% of the total number of children who would have triggered for suspected sepsis were being identified at triage. Post introduction, this improved to 46% of children being appropriately escalated with the tool and further audits showed a sustainable improvement to 60% use.

However, we observed in our most recent cycle that there was a deterioration in the timing of the senior review (from average 2hours 17minutes to 3hours 47minute) and time of the antibiotics given (from average 1hour 13minutes to 2hours 20minutes). We suspect a recent period of considerable staff turnover may have partially contributed to this.

The most recent focus group discussion showed 90% of the group were positive about the recent sepsis tool (version 5); it is easy to follow, user-friendly and gives precise guidance. Nursing team felt more empowered to escalate care when indicated and to approach a senior clinician when needed.

Analysis of feedback acknowledged the request for training in rapid assessment and triage (RAT), particularly for non-ED staff, and the need for regular awareness and teaching for the high turnover of staff.

Conclusions By engaging our stakeholders and multidisciplinary staff, seeking frequent constructive feedback and performing regular PSDA cycles, we ensured sustainable and improved use of the newly introduced tool. This enabled staff involvement in adapting the educational sessions as well as the format of the tool itself.

We will next look more closely at why the time for senior review and antibiotics have deteriorated over time and

continue to look to getting this tool, with automatic prompts on our existing electronic system. The aim of our regular audits will continue to be to improve the appropriate identification of all children who would trigger this tool for suspected sepsis, with subsequent timely management and making any successful changes sustainable.

British Association of Perinatal Medicine and Neonatal Society

1453 BITESIZE TEACHING: LEARNING- BUT MAKE IT SNAPPY

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Background The pressures on clinical time is a well-recognised obstacle to medical teaching in a busy department.¹ The current novel Corona virus (COVID-19) pandemic has challenged this even further by placing unprecedented demands on our time and ability to deliver face to face teaching.² There is evidence demonstrating that teaching delivered in short units is well received by learners.^{3, 4}

Objectives To develop a new, quality-assured framework of teaching consisting of 15-minute virtual teaching sessions (Bite-size). They would be suitable for and accessible to all staff in a busy tertiary neonatal unit.

Methods In the first phase, teaching sessions were delivered twice weekly with a focus on establishing routine and demonstrating how to deliver the teaching. After a period of 4 weeks, a survey was sent to participants. The sessions were then continued over a 6-month period with modifications incorporating feedback from the first survey. At the end of the 6-month period, another survey was sent to the participants for their feedback on Bitesize teaching.

The sessions were open to all staff and was accessible on a virtual platform. Once completed, recorded sessions were uploaded to an online education platform.

Results The initial survey was sent to 30 participants and 10 responded (33%). As illustrated in table 1 below, there was a strong positive response to the sessions.

In order to promote inclusivity and make the sessions relevant to everyone, the sessions were delivered by various members of the team in the NICU including the c-consultants, trainees and the extended multidisciplinary team as demonstrated in table 2 below.

Abstract 1453 Table 1 Positive feedback from initial bitesize sessions. There was emphasis on the relevance, as well as the practical and interactive nature of the sessions

Comment	Percentage of responses mentioning comment
Practical	23
Interactive	23
Relevant	15
Interesting	15
Straightforward	8
Accessible	8
Quick	8

Abstract 1453 Table 2 The different roles of the Bitesize presenters. The MDT included nurses and nurse educators, a pharmacist, a Speech and Language therapist, physiotherapist and breastfeeding support specialists. Presenters who delivered more than one session were counted once.

Consultant	5
Trainee	12
MDT	8

The response was positive even after 6 months. When asked what they liked about Bitesize, 78% (n=11) highlighted the brevity of the sessions.

Participants were asked if they would like Bitesize to continue (if staying in the NICU) or to be initiated in their new department (if rotating) and 100% (n=14) said that they would.

Conclusions Bitesize teaching is a valuable technique for delivering concise and relevant teaching in a busy department. The brevity promotes inclusivity of different team members and encourages the virtual participation fostered in the current pandemic climate.

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Association of Paediatric Palliative Medicine

1454 MEDICATION ACCESS AND SUPPLY ISSUES AS A BARRIER TO GOOD SYMPTOM MANAGEMENT: HOW BIG IS THE PROBLEM?

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Background The number of children living with life limiting conditions (LLC) has increased over the last 17 years with a current prevalence in the UK of 66.1 per 10000. Care of these children is complex, requiring care in a number of settings including district and tertiary hospitals, hospices, communities and family homes from a number of professionals – specialist doctors, general practitioners, nurses, pharmacists as well as parents and carers. Differences in access and supply of medications across settings, as well as differences in confidence in prescribing unlicensed or off label medications, not to mention lack of effective communication between individuals and institutions, can lead to delays in delivery of needed symptom management.

Objectives To identify and quantify access and supply issues for patients receiving care from a specialist palliative care team at a tertiary centre and to consider the impact of these

issues on patients, their families and professionals, as well as ways in which problems could be ameliorated.

Methods Identification and review of all instances of medication access and supply issues for patients referred to a tertiary palliative care team between February 2020-August 2020 (inclusive) through chart review, reporting and discussion at the weekly multidisciplinary team (MDT) meetings, daily on call handovers and via telephone requests to the team. Access and supply issues were coded by type (e.g. availability, prescribing, dispensing), location (e.g. community, local hospital, tertiary hospital and national) and patient consequences (e.g. change in location of care, delay in receipt of medication).

Results 102 patients were referred to the tertiary palliative care team over the study period. 87 symptom management plans (SMPs) were written for 58 patients. 14 patients (24% 14/58) patients had documented difficulties with medication access and supply. This issues occurred across all service providers, but were most common in the community and local hospitals. Common issues identified were:

- Lack of ability to source drugs locally (e.g. ketamine, gabapentin, lansoprazole, diamorphine, aprepitant)
- Difficulty or inability to prescribe medications in the community
- Incorrect preparations dispensed
- Delay in prescribing medications for symptom management
- Issues with ongoing supply for non-formulary medications

Resolving these issues took a significant portion of palliative care team members time. More significantly, however was the impact on patients. Notably two patients required emergency readmission to hospital for symptoms which could have been managed effectively at home had there not been access and supply issues.

Conclusions Medication access and supply issues affect a significant number of children with LLC and can impact effective symptom control and place of care. Next steps to address these issues include: education program for professionals involved in care of children with LLC focused on medications commonly used in paediatric palliative care, need for timely/anticipatory prescribing and effective collaborative working amongst professionals in a variety of settings where these children are cared for.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1455 USING A PATIENT REPORTED EXPERIENCE MEASURE (PREM) TO ASSESS THE EXPERIENCE OF CARERS IN PAEDIATRIC INTENSIVE CARE DURING THE COVID-19 PANDEMIC

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Background In April 2020, in response to the emerging COVID-19 pandemic, NHS England recommended limiting visiting to hospital inpatients, with resultant changes to our hospital policy of open visiting limiting visits to a single carer. In addition, changes to the way healthcare professionals interacted with carers had to be implemented, such as remote