positive association, using quintiles for fT3, was reported for Motor Development Index (MDI; a subtest of the Bayley's Scales of Infant Development), between Q3 vs Q4 (β 0.073; p 0.043) and for Q3 vs Q5 (β value 0.086; p 0.018).

Conclusions Thus, it is possible mothers in our cohort, who largely have optimal thyroid function and iodine intakes, are able to regulate thyroid function throughout pregnancy to meet neurodevelopmental needs. However, it is likely that minor imbalances of fT3, as indicated from our quintile analysis, may impact offspring neurodevelopment. Thus, further investigation is warranted, particularly focusing on thyroid hormone fluctuation throughout pregnancy in relation to possible associations with infant neurodevelopment.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

579 RESOLUTION TIME OF LIVER ABSCESS IN CHILDREN: DO WE HAVE AN ANSWER?

Indrasish Ray Chaudhuri, NARANG Manish. UCMS and GTB Hospital

10.1136/archdischild-2021-rcpch.80

Background The residual abscess on ultrasound after clinical resolution in children creates psychological fear among parents and diagnostic dilemma among physicians. Unlike in adults, there are no studies on resolution time of liver abscess in children.

Objectives To determine the time taken for clinical and ultrasonological resolution of abscess, and estimate the frequency of unfavourable outcomes and assess the clinico-biochemical parameters that influence the occurrence of unfavourable outcomes in children.

Methods A descriptive longitudinal study was conducted in the department of Pediatrics in a tertiary care hospital in North India in which 60 children (aged 1–18 years) with clinical features of fever and pain abdomen with a liver abscess on ultrasound were followed up clinically and by serial ultrasounds till complete ultrasonological resolution. These children with liver abscess on ultrasound were admitted and treated with intravenous antibiotics after appropriate blood tests. Percutaneous needle aspiration and/or surgical drainage (pigtail insertion/laparotomy) was attempted in children not responding to the initial conservative management or those showing signs of impending rupture on ultrasound.

Results The mean $\pm$ S.D ultrasonological resolution time was 7.9 ± 3.53 weeks whereas the clinical resolution time was 10.64 ± 4.77 days. Initial conservative management failed in 21 (37.5%) children, 2 (3.6%) children were readmitted and 18 (32.4%) children had complications. There were no deaths in our study. TLC and abscess size were the two clinico-biochemical parameters associated with the occurrence of unfavourable outcomes ($p < 0.05$).

Conclusion Clinical resolution of liver abscess in children takes an average of 10 days, whereas it takes about 8 weeks for ultrasonographic changes to resolve completely.

Quality Improvement and Patient Safety

581 NO MISTAKES! ONLY LESSONS

Nilima Singh. Mid and South Essex NHS Foundation Trust

10.1136/archdischild-2021-rcpch.81

Background Departmental Datix outcomes are not regularly shared with front line staff. They miss vital learning from errors and the opportunity to be involved in improvement. Patients suffer recurrent harm.

Objectives By the end of February 2020, 100% of front line staff will be aware of the Datix Outcomes that occurred in the previous month in the Department.

Methods

Change ideas:

- Regular emails (1–2/month)
- Rotation of leadership
- Adhoc emails from Pharmacy
- Microteach, handovers, teaching programmes
- Set up equipment, format, etc.
- Visual aid e.g. poster
- Senior trainees to join in

PDSAs:

1)

P

- Meet Clinical Governance Lead in consultant office.

D

- Share Problem statement, initial data, fish bone, aim and change ideas

S

- Lead readily recognised the issue and engaged fully. Agreed change idea email and a poster

A

- Lead discussed my project in the next clinical governance meeting and delegated the task of sharing information to Matron for more regularity.

2)

P

- Follow up with Matron in her office
- what had actually happened?

D

- Confirmed sent most recent Datix outcomes to Governance umbrella team

S

- Email still didn't reach front line staff email box. Agreed main 1 or 2 learning outcomes to go in a poster

A

- Matron to find out reasons why. Agreed to rotate task of sharing information between leads. No change in Datix outcome awareness.

3)

P

- Meeting with Clinical Governance Lead again

D

- Email formatted in the sitting. Poster reviewed and sent. 12 staff interviewed in week 1.

S

- 0% saw poster- not signposted in email. 8/12 (66%) aware of Datix outcome. 4/12 unaware (2 newly joined GPVTS + 2 oncology)

A

• To adapt the method of communication. Make poster available

4)

P

• To use visual aid (poster)

D

• Poster printed and displayed in team room, handover room, staff room and kitchen. 8 staff interviewed (Week 2).

S

• 5/8 (62%) of staffs had seen the poster. They liked the simplicity but would like it to be colourful. Total staff awareness 87% (7/8)

A

• Improvement seen. To adapt

5)

P • Departmental presentation

D

• Spread awareness of this QI and the outcomes so far and plans for future. Note audience's change ideas and comments

S

• Well received by 7 senior departmental consultants. Lots of discussions on sustainable change ideas

A

• Sustainability yet to be tested. Email sent to all consultants with run chart and discussed/agreed change plans

Results During 5 PDSAs between January 2020-February 2020, front line staff's awareness of Departmental Datix Outcomes reached up from 0% (none) to 60% to 90%.

Conclusions

Learning & Reflections:

- Stakeholder's attention and interest is crucial.
- It is relatively easy to make a change but more difficult to sustain the change.
- Don't give up on reaching a rate limiting step. Think laterally...what else can I do to bring the desired change?

Future?

- Looking positive: many more PDSAs can be tested: microteach, Grandovers, monthly teachings, etc.
- Reporting of Datix may increase as a secondary outcome
- Audit

AND

- Life is too short to learn from our own mistakes. So we must learn from others.
- Minimising errors means minimising suffering for patients.

Quality Improvement and Patient Safety

585

LIFE DOESN'T STOP TEACHING...NO STOPPING LEARNING!

Nilima Singh. *Mid and South Essex NHS Foundation Trust*

10.1136/archdischild-2021-rcpch.82

Background Since 23/03/2020, at a time of social isolation, uncertainties, crisis in service provision due to Covid-19

Pandemic causing great disruptions, Departmental teaching programme, running 4–5 times per week, was at a halt until unknown period. This meant no teaching for trainees through the teaching programmes, less connectivity between team members, low morale within the team.

Objectives After a gap of 5 weeks, main objecting of starting once a week remote teaching on 30/04/2020, was to reinstate teaching and training opportunities in a safe and enjoyable manner and also boost team morale by 'staying connected with each other'.

Methods PDSA included:

1. Gaining agreement from stakeholders in the Department.
2. Selecting a secure portal to run the teaching sessions remotely. We chose a portal that Trust was already using or higher management meetings.
3. Testing the portal one to one and then sharing the information with rest of the team.
4. Creating a teaching and training 'chat group' on the same secure portal for ease of communication.
5. Delivering first lecture by Organiser to 'break the ice' since technology was new to many.
6. Modifying the existing teaching rota to roster most trainees and including MDT sessions such safeguarding peer-review meetings, etc
7. Organiser helping with a trial run for a few minutes before the actual teaching session to avoid last minute issues or delay.
8. Constant development based on feedback from each teaching session until it became a 'norm' within the department by 6 weeks.

Results Improved morale within the team. Some of the verbal and written feedback included 'it gave a sense of togetherness', 'positivity', 'enthusiasm', 'something to look forward to every week'. 'more interesting than face to face', 'less daunting', 'thoroughly enjoying'.

Variation in attendance pre-covid (9–22) minimised to fairly constant attendance (15–22).

Number of trainees attending without obligation when off work varied from 1–4 during each session.

Those working in low risk areas or shielding completely, participates and attended more enthusiastically.

After six weeks, from 16/06/2020, frequency of teaching programme increased to two times a week.

Additional unexpected benefits were:

- A trainee on maternity leave joined in remotely with a month old baby in her hand and she continued to do so afterwards until return to work.
- A Greatix project was launched successfully for the department, without any undue delays waiting for face to face sessions.
- Sharing of teaching material or feedback was almost instant after the teachings through the chat group whereas with face to face this wasn't a regular practice.

Conclusions Remote teaching has a lot of potential to be part of our regular educational programmes, even when the current Pandemic is over.

It can be an established way of 'keeping in touch' days for trainees away on maternity leaves or away from clinical area for any other reasons.