supported the carer to tell their story of own experiences. The positive and negative emotions were mapped along the journey. The encounter timeframe was 20 minutes. Feedback on the discussion was subsequently collected.

Results Negative feelings were predominant at the beginning of relapse. Modifiable triggers of negative feelings included: repeating past medical history and accessing prednisolone prescriptions. Treatment initiation was the main timepoint positive feelings emerged. The important role of specialist nurse was emphasised. The parent's trust in network communication was evident. Feedback on this exercise was that the parent felt heard and optimistic that improvement work is done. The unintended benefit was the invaluable learning experience for the interviewer.

Conclusions Access to nephrotic syndrome nurse specialist and to prednisolone prescriptions were identified as factors affecting the patient journey. Emotional mapping is a useful tool for understanding patient perspective, as well as a powerful learning experience for trainees.

British Society of Paediatric Endocrinology and Diabetes

1760

HYPOGLYCAEMIC EFFECT OF CLARITHROMYCIN IN AN ADOLESCENT WITH TYPE 1 DIABETES MELLITUS

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10.1136/archdischild-2021-rcpch.836

Background A 15 year old girl required a significant reduction in Insulin detemir dose on commencement of Clarithromycin for treatment of acne.

Objectives A case report describing a significant reduction in insulin detemir dose in order to self manage recurrent mild hypoglycaemia on starting oral Clarithromycin for acne, with no change in overall glycaemic control.

Methods A 15 year old girl with established type 1 diabetes described at routine review she had required to lower her insulin detemir dose by 33% (13 units), after starting oral clarithromycin 500mg daily for treatment of acne over the 3 months prior to the review. She has experience recurrent mild self-managed hypoglycaemia until lowering the dose. Her short acting insulin dose was unchanged at 33 units per day. There were no other changes to her medication, clinical condition or lifestyle. Routine screening tests according showed no abnormalities including recent negative coeliac screen.

Results The patients' glycaemic control was similar over the 6 month review period between reviews. HBA1C 48 & 54 mmol/mol. 2 week average blood glucose (Xpert BM meter) prior to each review was 8.3 & 8.8 mmol/l (SD 3.2 & 3.3 mmol/l). Mild Hypoglycaemic event had resolved with dose reduction. No serious hypoglycaemic events requiring 3rd party intervention or admission had occurred.

Conclusions This case demonstrates clear potential for clarithromycin treatment to require close monitoring of blood glucose control in patients on insulin detemir. Literature review showed few similar case reports and non in Children and young people. The effect appears to be due to clarithromycin and insulin detemir both being highly protein bound and the former able to displace the insulin increasing free insulin levels. Clinicians should be aware and counsel their patients and

their carers of this important potential interaction between 2 common paediatric medicines.

British Association of Child and Adolescent Public Health

1761

THE POVERTY PANDEMIC: START SEEING, SCREENING AND INTERVENING

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Background Before the COVID-19 pandemic, 4 in 10 children local to North Middlesex Hospital lived in poverty. Recent job losses, rising debt, bereavement and deteriorated mental health, all inevitably increase hardship. Poverty increases the risk of chronic diseases, mental illnesses, accidents and trauma. Surprisingly, families living in the west of Enfield and Haringey live almost 15 years longer in good health than those in the east!

Objectives We challenged our paediatric staff to start seeing poverty as a chronic health problem and not just a moral issue. By screening for poverty, as we do other health risks, we can identify and intervene for vulnerable families and offer them essential help.

Methods In July 2019 we explored paediatric doctors' awareness of the social determinants of health. Using quality improvement methodology we built upon our pilot project in Kingston Hospital. Barriers to screening and possible questions were discussed. Education sessions, email communications, text reminders and leaflets were shared regularly with paediatric staff. Surveys were planned to monitor staff progress and record families being signposted.

Results Barriers to screening for poverty included a perceived lack of time, inexperience, being unaware of resources and inadequate privacy during clinical assessments. In October 2019, only 10% of staff surveyed routinely screened for poverty. 13% felt they had sufficient knowledge of where to signpost families in need and 22% recalled giving social help in the preceding 3 months.

To improve these rates we devised change ideas:

- screening questions co-designed with parents,
- '123 fight inequality' leaflets of practical resources co-produced,
- presentations and workshops with local parents who had suffered hardship.

Despite these and regular communications to staff, poverty screening rates worsened during the pandemic. In October 2020 we re-launched Connected Communities (CC) and the provision of support workers within the hospital. Staff reported feeling empowered knowing that practical help would be given. A poverty screening guideline was drafted with case studies and recommended screening using framing like:

'Since the pandemic we know more parents are finding it difficult to pay bills/debts, afford food or find employment, - do you?' Or asking 'do you worry that your housing is affecting your child's health?' We delivered teaching together with CC support workers in February 2021.

In March 2021, 43% of doctors and nurses surveyed reported they had screened the last patient they saw; 79% were aware of resources and; 67% had signposted someone to help in the last 3 months. From zero introductions to Connected Communities in October 2020, a staggering 95 parents have been screened and recommended to contact our support workers. Only 23 have engaged so far and they have received help with housing, finances/benefits and citizenship. Ten do not speak English but will be supported to access advice.

Conclusions Tackling health inequalities takes commitment.

By seeing, screening and intervening, we help reduce stigma and identify vulnerable families. Our close partnership with Connected Communities increased staff confidence and increased introductions. More work is needed to determine why only 23/95 parents take up the offer but language barrier, parental expectations or clerical factors may contribute.

Association of Paediatric Emergency Medicine

1765

PAEDIATRIC EMERGENCY DEPARTMENT MULTIDISCIPLINARY IN-SITU SIMULATION PROGRAMME FOR THE COVID-19 PANDEMIC

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10.1136/archdischild-2021-rcpch.838

Background During the pandemic there were significant changes to our Emergency Department (ED). For example there was the creation of 'Red' (Patients requiring aerosol generating procedures or suspected COVID-19 patients) and 'Green' (low risk of COVID-19 patients) resuscitation and majors areas and complete relocation of the Paediatric ED to the Adult Clinical Decisions Unit. There were also significant changes to paediatric emergency protocols.

We established an on-going programme of simulation within the multidisciplinary teams managing children in the ED to enable the dissemination of these changes.

Objectives

Our aims were

1. to create a face to face Paediatric Emergency Medicine Simulation package that could be delivered during a pandemic
2. disseminate changes in protocols and geography within the Paediatric ED and wider ED
3. collect feedback from simulation participants
4. use this feedback to improve our programme

Methods In-situ simulations involving the acute on-call teams with real arrest calls were planned weekly. 6 participants could sign up to simulation teaching, but all other participants were 'unaware' of the simulation taking place.

Departmental leads were informed of training dates to minimise clinical disruption. Additional Personal Protective Equipment was sourced and debriefs were run in large spaces following social distancing rules. Advanced Life Support Group recommendations regarding the running of courses during a pandemic were followed.

We collected feedback from participants using electronic questionnaires.

Results 4 in-situ simulation mornings were held during July and August 2020. Participants included paediatricians, ED nurses and doctors, the trauma team, PICU and anaesthetics.

All participants found the simulation a positive learning experience with 81% of participants rating the sessions 'excellent' 36% rating the sessions 'very good' and 9% 'good'.

93% of respondents felt more prepared to manage children in ED during the COVID pandemic.

Conclusions We have shown that face-to-face simulation training is still possible during the pandemic, by ensuring social distancing rules are followed and sourcing PPE. Our simulation sessions allowed sharing of geographical & protocol changes and provides a model for shared learning within the paediatric ED. We have shown the majority of participants have found it a useful learning experience.

We have continued to run these simulations throughout the Pandemic from October 2020 into March 2021, focussing on new trainees rotating into our hospital and departments. We would hope in the future to ensure that this programme is sustainable and would like to include a larger teaching faculty, particularly including more nurses and resus officers.

British Association for Community Child Health

1768

THE POVERTY PANDEMIC: START SEEING, SCREENING AND INTERVENING

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10.1136/archdischild-2021-rcpch.839

Background Before the COVID-19 pandemic, 4 in 10 children local to North Middlesex Hospital lived in poverty. Recent job losses, rising debt, bereavement and deteriorated mental health, all inevitably increase hardship. Poverty increases the risk of chronic diseases, mental illnesses, accidents and trauma. Surprisingly, families living in the west of Enfield and Haringey live almost 15 years longer in good health than those in the east!

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