Conclusions  Wellbeing is multi-faceted and as such is difficult

to measure. We have measured markers for engagement in

our project rather than wellbeing per se.

There was a low response rate to our survey, though those

who did respond were very positive. This is likely to be a

confounding factor of the motivation of responders being

those who are ‘engaged’. From the survey results we have

reduced the frequency of emails to weekly, and have acted on

suggestions for content.

Overall our project has been well received and has raised

the importance of staff wellbeing within our department.

Quality Improvement and Patient Safety

LEARNING FROM DEATHS – STILLBORNS, CHILDREN

AND YOUNG PEOPLE

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NHS Foundation Trust; 2Imperial College Healthcare NHS Foundation Trust

Background Structured judgement reviews (SJR) are designed

to help acute hospitals learn from retrospective mortality

reviews. ‘The process ensures a traditional, clinical-judgement

review method but in a standardised format with a view to

identify and make improvements in quality of care.’

Trained reviewers score six phases of care from admission to

end-of-life care. They also make explicit written comments

about care for each phase. At the end of the review, a subjective

‘avoidability of death judgement score’ is made, the scoring

system is as follows:

• Score 1 definitely avoidable

• Score 2 strong evidence of avoidability

• Score 3 probably avoidable (more than 50:50)

• Score 4 possibly avoidable but not very likely (less than

  50:50)

• Score 5 slight evidence of avoidability

• Score 6 definitely not avoidable

‘The result is a relatively short but rich set of information

about each case in a form that can also be aggregated to pro-
duce knowledge of clinical services and systems of care.’

The trusts ‘Learning from Deaths Policy’ mandates that all
deaths amongst children, young people, 16–25 year olds and
stillbirths undergo an SJR.

Aim To highlight learning from avoidable and unavoidable
deaths amongst stillbirths, children and young people <25
years old, over an 18-month period across the trust.

Methods Review cases that underwent a SJR, over an 18
month period from July 2017 – December 2018. The trust
SJR secure database was used to capture the data. In cases
were the ‘avoidability of death score’ was 3 or less i.e.
suggesting the death may or was avoidable – the cases were
reviewed in detail. In cases were the ‘avoidability of death
score’ was 4 or above, the recommendations and key learning
points were reviewed.

Results 3154 cases underwent a SJR. 171 deaths occurred in
the sub-group we analysed. The structured judgement of
avoidability of death in the cases are detailed below:

Conclusions The data seemed to mirror itself – problem areas
identified in avoidable cases, scoring 1–3, conversely were
highlighted as areas of good care in unavoidable deaths, scor-
ing 4–6. These areas have been stratified into two key themes
with learning points highlighted below:

• Patient assessment and management:
  o Know and use local guidelines
  o Identify and respond to problems early
  o Involve seniors
  o Involve the multidisciplinary team

• Communication:
  o Adequate documentation
  o Clear communication

• Of results
  o Overcoming ‘language barriers’

• With patient and family regarding problems
  o Parental involvement, discussion and support
  o Future planning

REFERENCE
1. Royal College of Physicians. Using the structured judgement review method - A

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Medicine

PAEDIATRIC CARDIAC ARRESTS – A DESCRIPTIVE AUDIT

REPORTING CARDIAC ARRESTS PRESENTING TO A

TERTIARY PAEDIATRIC EMERGENCY DEPARTMENT

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Children’s Hospital NHS Foundation Trust – Emergency Department

Background The 2018 Out-of-Hospital Cardiac Arrest Out-

comes Registry saw 530 paediatric Out of Hospital Cardiac
Arrests (OHCAs) in England, with a survival to discharge rate
of 12.1%. It is widely reported that paediatric OHCAs have
poor outcomes, with downtime being a strong prognostic
determinant for survival to discharge. This audit will retro-
spectively describe local patients attending a tertiary paediatric
emergency department (ED) presenting after undergoing a car-

Objectives

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<td>Strong evidence avoidable</td>
<td>Probably avoidable</td>
<td>Possibly avoidable</td>
<td>Slight evidence avoidable</td>
<td>Definitely not avoidable</td>
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<td>4</td>
<td>3</td>
<td>8</td>
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<tr>
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<td>-</td>
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<td>2</td>
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<td>32</td>
</tr>
<tr>
<td>16–25</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>16</td>
<td>18</td>
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