Conclusions There had been some initial hesitancy to use new system and availability of probes in all delivery areas. Simulation sessions for staff training and provision of spare probes in the emergency resuscitation kits have facilitated use. Hypothermia during transport is an identified area to improve.

British Paediatric Respiratory Society

692

THE DIFFICULT ASTHMA MULTI-DISCIPLINARY CLINIC: SILVER LININGS OF THE COVID CLOUD

¹Lydia Roberts, ²Wanda Kozłowska. ¹School of Clinical Medicine, University of Cambridge; ²Department of Paediatric Respiratory Medicine, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust

10.1136/archdischild-2021-rcpch.146

Background An estimated 5–10% of children with asthma have problematic severe asthma, defined as asthma which is poorly controlled (chronic symptoms, episodic exacerbations, continued requirement for short-acting β agonists) despite a daily dose of at least 800 μ g budesonide or equivalent for 6 months or longer. Such patients should be referred to a specialist difficult asthma team in a tertiary care, in order to facilitate systematic specialist assessment and a multi-disciplinary approach to management.

Objectives As with most outpatient services, the delivery of paediatric difficult asthma (DA) clinics was disrupted by the COVID-19 pandemic. Teams were required to restructure clinics and operating procedures, in order to optimise patient care despite the restrictions on face-to-face appointments. This study aimed to assess the impact that the COVID-19 pandemic had on the initial assessment of patients referred to the paediatric DA clinic at a tertiary care, specifically in relation to being seen by the appropriate multi-disciplinary team (MDT) members and having relevant investigations completed.

Methods The electronic notes database was interrogated to provide a list of children and young people with asthma referred to the paediatric DA clinic between 1/9/2016 and 31/12/2020. In total 144 patients were identified, and their electronic medical records were retrospectively reviewed. Patients were considered to have been seen 'pre-COVID' if their initial appointment in the paediatric DA clinic occurred prior to 23/03/2020, and considered to have been seen 'post-COVID' if their initial appointment was on or after 23/03/2020.

Results Of the total 144 patients, 130 were initially seen in the paediatric DA clinic pre-COVID and 14 were initially seen post-COVID. In the post-COVID group, fewer patients had fractional exhaled nitric oxide (FeNO) (71%) and spirometry (57%) as part of their initial work-up. In the pre-COVID group, 85% had FeNO measured and 96% had spirometry. This was in contrast to the proportion of patients having a physiotherapy and psychology assessment; in the post-COVID group, 64% had physiotherapy review and 50% had psychology review following their difficult asthma referral, compared to 52% and 26%, respectively, in the pre-COVID group. The wait for initial specialist assessment after being seen in the DA clinic for the first time was also reduced in the post-COVID cohort. The median wait for physiotherapy and psychology assessment decreased from 91 and 180 days in the pre-COVID group to 70 and 35 days, respectively, in the post-COVID group.

Conclusions Unsurprisingly given strict restrictions on in-person appointments and aerosol generating procedures, assessment of FeNO and spirometry was lower in patients first seen in the DA clinic post-COVID. However, improvements were seen in relation to physiotherapy and psychology assessment in the post-COVID group, as the physiotherapist and psychologist were able to attend more DA clinics to see new patients at their first appointment. This highlights that changes to working in response to the COVID-19 pandemic can actually help to streamline services and promote early input from the wider MDT when managing patients with problematic severe asthma.

Association of Paediatric Emergency Medicine

695

IMPROVING THE TRIAGE ORDER FOR PAEDIATRIC PATIENTS – A COLLABORATIVE QUALITY IMPROVEMENT PROJECT

Stephanie McCallion, Rachael Nixon, Natalie Bee. Royal Hospital for Children Glasgow

10.1136/archdischild-2021-rcpch.147

Background The Royal Hospital for Children (RHC) in Glasgow is the busiest paediatric emergency department in the UK with over 70000 attendances a year. With increasing attendances yearly and added system pressures due to COVID, we reviewed our triage system. In previous winters approximately only a third of the sickest patients presented by ambulance. The current system allows patients brought by ambulance to be triaged first, resulting in those brought by car waiting.

Objectives To develop a Scottish Ambulance Service (SAS) arrival flow chart to be used by ambulance staff to improve getting the right patient triaged at the right time. By utilising the flowchart, patients needing immediate triage or treatment must be identified, whilst identifying those safe to wait in time of arrival with patients brought by other modes of transport.

Secondary aims were to identify data for a group of patients that could potentially wait for triage without the SAS team.

Methods We developed a Flow Chart to be used by ambulance staff with 2 outcome arms – immediate SBAR handover and triage with nursing staff (urgent), or wait for triage by time of arrival (non-urgent), based on red flags, observation parameters (national PEWS) and clinical concern. Red flags were exclusion criteria for subsequent completion of the chart and indicated the need for urgent triage. Following a 2 week pilot study in September 2020, all SAS arrivals notes were reviewed in conjunction with their flow chart outcomes.

Results A total of 183 patients arrived by ambulance (10%). 71.6% of patients had a completed triage form or appropriate use of red flags/stand by status. 13.0% were stand by calls, 26.7% had red flags, 20.6% were classified as urgent and 39.7% as non-urgent.

Review of all cases showed that patients subsequently triaged as category 1 and 2 had attended by car and patients of low acuity triage categories had attended by ambulance.

Use of the flow chart showed that zero patients subsequently triaged as category 1 or 2 were classified as non-urgent by use of the flow chart.