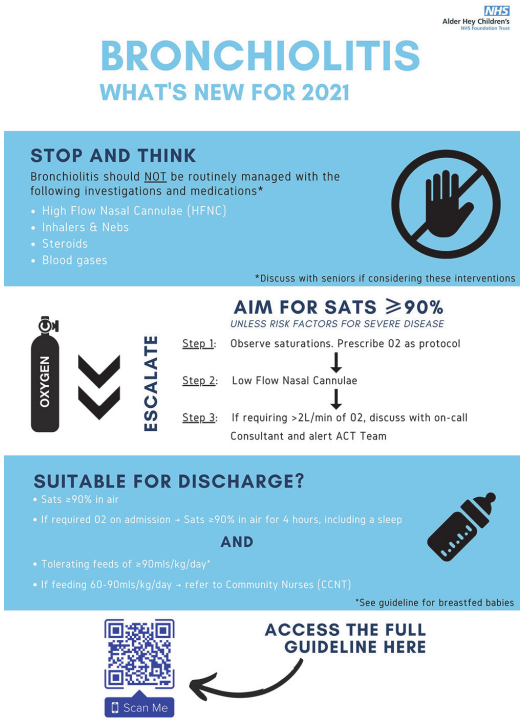
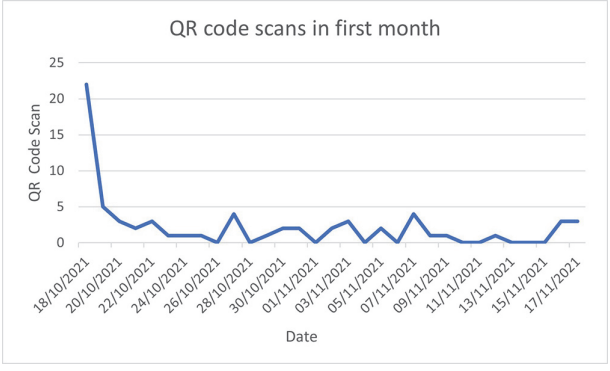
To measure the effectiveness of the infographic, we captured real-time guideline downloads via the dynamic QR code, for a month following launch.



Abstract 853 Figure 1



Abstract 853 Figure 2

Results Verbal feedback from clinical staff was very positive. From when we launched the infographic on multiple platforms throughout the hospital on 18th October 2021, to the 17th November 2021, we had 67 downloads of our guideline, with a peak on day one – see figure 2.

Whilst these numbers reflect how many individuals downloaded the full guideline, it doesn't capture those who read and saw the poster without scanning the QR code.

Conclusion We have demonstrated a successful technique of disseminating new clinical guidance.

We will need further audit data to see if clinical practice has changed since the launch of the new guideline and hence if we are meeting the standard for our general paediatric patients, during this season's surge in bronchiolitis.

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979 DIAGNOSTIC ODYSSEYS IN RARELY OCCURRING DISEASES – WHAT CAN WE LEARN?

[1]Qasim Malik, [2]Grace Mupanemunda, [2]Divya Gurudutt, [2]Deepthi Jyothish. [1]*Birmingham*; [2]*Birmingham Women's and Children's NHS Foundation Trust*

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Aims 'Diagnostic odyssey' encompasses time from initial disease recognition or symptom onset to final diagnosis as experienced by patients with rare genetic diseases and their families.

General paediatricians often encounter similar challenges in acute settings, where despite extensive investigations and specialist consultations in acutely unwell children, the diagnosis appears elusive.

Our objective is to:

1. analyse the steps in diagnostic pathways of children with rare acute medical conditions

2. evaluate the key enablers for multidisciplinary decision making

3. gain generalisable insights for improving the care journey

Methods Single-centre observational study using retrospective review of medical records and interviews with lead clinicians for children with acute presentations and eventual diagnosis of rare conditions after extensive investigations. All children were general paediatric inpatients at a tertiary children's hospital from January 2021-January 2022.

Data collected included key timelines (figure 1), investigations and critical aspects of the diagnostic pathway identified in clinician interviews.

Figure 1- see attachment

(Black N, Martineau F, Manacorda T, Policy Innovation Research unit April 2015)

Results

RESULTS (table 1) Seven children with final diagnoses of Polyarteritis nodosa, Sarcoidosis, Hepatocellular carcinoma, Familial Hemophagocytic Lymphohistiocystosis, ANCA-associated vasculitis, Systemic Lupus Erythematosus and Idiopathic serositis met the study criteria.

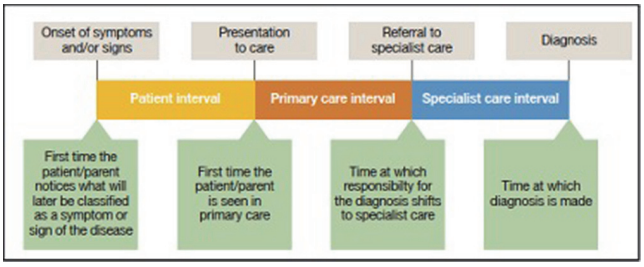
a. Timelines Median (range) for Patient interval, Primary care interval and Specialist care interval were [10 (1 - 180), 9 (1 - 257) and 18 (8 - 180)] days respectively.

Pandemic-related delayed access to healthcare were reported by 57% (4/7). 75% (5/7) had more than 1 unscheduled medical attendance prior to final admission.

b. Investigations Blood count, inflammatory markers, blood cultures, Mantoux, IGRA, vasculitis screen, ultrasound abdomen and echocardiography in 100% (7/7) patients, lymph node biopsy, bone marrow studies and MRI scan in 75% (5/7)], Whole Exome Sequencing (WES) in 57% (4/7) and PET scan in 14% (1/7).

c. Critical aspects:

- Regular joint multidisciplinary bedside assessments
- Clarity on roles and accountability between teams
- Supportive environments enabling constructive critique recognising the potential for conflict
- Vigilance on pitfalls of heuristics and bias
- Revisiting clinical and diagnostic co-relations (a negative biopsy may require repeat tissue sampling, if discordant to presentation)
- Value of new generation genomic tests including WES
- Clear and transparent communication with patient and family
- Supporting families and empowering them to work in partnership with clinical teams
- Peer support and debrief for clinical teams (feeling of inadequacy and increased emotional burden was common)



Abstract 979 Figure 1

Conclusion Our study illustrates the diagnostic odyssey associated with a challenging heterogeneity of uncommon childhood diseases, which has adverse implications for patients, professionals and resource utilisation. While pandemic-related delayed access to care played a part, in-hospital time to diagnosis accounted for significant delays. One in 17 people (7% of UK population) will be affected by a rare disease during their life, making it imperative to equip generalists with skills to manage these diagnostic complexities. We conclude that embedding efficient multi-disciplinary working, increasing the awareness of uncommon conditions, use of advanced diagnostic tools as well as training in cognitive biases and debiasing strategies are requisite strategies for improving patient journeys.

973 REDUCING THE TIME TAKEN TO PRESCRIBE MEDICINES FOR PICU PATIENTS TRANSFERRED TO THE GENERAL PAEDIATRIC WARD

Jennifer Browne. *Evelina London Children's Hospital*

10.1136/archdischild-2022-rcpch.189

Aims Children returning from intensive care to the ward can wait up to five hours for time sensitive medication to be prescribed and given. Essential medications are delayed. Children can deteriorate or experience pain in that time. Parents are distressed. Incidents occur.

The aim of this project was to improve the efficiency of prescribing critical medications for children who are admitted to the General Paediatric ward from Paediatric Intensive Care, in a large tertiary Paediatric Hospital. A target of one hour was initially set as a time for prescriptions to be completed within.

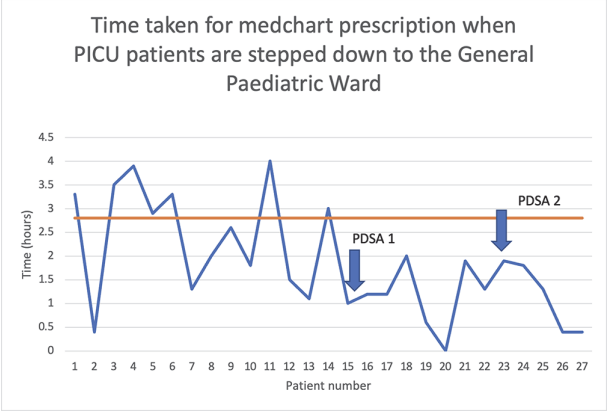
Methods Data was collected retrospectively for all General Paediatric patients transferred to the ward, initially over a 2-month time-period. Time to prescribe was the chosen outcome measure. All diagnoses were included. The handover list was used to identify patients. Medchart and enoting were used to determine timing of transfer and prescribing time.

A series of PDSA cycles was used to test different change ideas. The first was to increase awareness of the problem. This was done by sending emails to all ward doctors and adding it to the nursing 'big 5' for it to be highlighted at each handover. The second involved introducing the attendance of a doctor at the nurse to nurse handover when the patient arrived on the ward.

Results A total of 14 patients were included in the initial analysis. The longest time for prescription to be completed was four hours. Median time to prescribe was two hours 48 minutes. At PDSA cycle 1, awareness was increased amongst both doctors and nurses. Subsequently, eight further patients were stepped down to the ward. Longest time for prescription was one hour 54 minutes, shortest time was 36 minutes. At PDSA cycle 2, doctor presence at nursing handover was introduced. Longest time to prescribe was one hour 54 minutes and shortest 24 minutes (see figure 1).

Data is being further analysed to determine the impact of factors, such as timing of transfer and presence of ward pharmacist on subsequent prescription times.

Run chart demonstrating changing time for prescription to be completed with each PDSA cycle



Abstract 973 Figure 1

Conclusion Increasing awareness of the time it takes to prescribe amongst both doctors and nursing staff reduced the time for prescription to be completed. This effect was immediate, however not sustained. Doctor presence during nursing handover further decreased the time to prescribe. Further data is required to determine if this effect is long-lasting. It is likely that repeat reminders will be required to maintain this effect, particularly as ward staff frequently change. Important work for the future will be to link with the Intensive Care team to increase the sphere of influence and to establish safe times for transfer to avoid error. Other changes ideas to test include; PICU facilitating prescriptions, the General Paediatric team attending PICU to prescribe and a dedicated pharmacist for PICU prescriptions. Incidents should also be looked at to determine if there has been a reduction in medication related errors.