• 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)

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’ 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 for prescription 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.

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.

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.

Abstract 973 Figure 1