Aims The RCPCH has published the Trainee Charter and the Training Toolkit outlining the standards of training, trainees can expect of their training units. The aim of this audit was to conduct a quality improvement project by surveying adherence of regional units with training guidance as perceived by trainees and college tutors and to sample examples of good practice in the School of Paediatrics in Yorkshire and the Humber.

Methods A survey questionnaire was designed using recommendations from the above guidance. Additional questions in relation to training and requesting examples of good practice were added. There were 47 questions, which were distributed to college tutors in three separate phases (college tutor group). The questions (apart from those relating to trainers only) were also circulated in a single phase to volunteer trainees at each hospital with apnoea in the car arrived at PAU within 3 mins of apnoea. O/E-no HR or breathing, bleeding from nose and mouth, pale looking, mottled, CRT 5 sec, CPR started and connected to monitor showed asystole. Immediate cardiac arrest call was activated. Intubated, cannula inserted, 2 doses of adrenaline given IV, Bolus of normal saline 10mls/kg thrice, partial septic screening done and covered with triple antibiotics amoxycillin, gentamycin and cefotaxime. After 10 mins of resuscitation baby responded. Given vitamin K and transfused with O negative blood and FFP. Blood gas showed mixed metabolic and respiratory acidosis and hence connected to ventilator started on morphine, maintenance fluids, ionotropes, morphine infusion and transferred to tertiary centre. In tertiary centre admitted for 11 days, extubated to CPAP on day 5, weaned to high flow on day 6, RA on day 9. Ionotropes for 1 day, acyclovir, vitamin K for 9 and 6 days respectively. Neuroprotective measures followed.

Results NPA for RSV positive, covid 19 PCR negative, blood c/s, CSF c/s and CSF PCR for bacteria and viruses negative, X ray chest consolidation upper lobes bilateral, CT angiogram subsegmental consolidation and possible intraparenchymal haemorrhage. Initial Echo pulmonary hypertension and repeat Echo normal. MRI Brain - hypersensitivity in posterior putamina. Deranged coagulation profile. APTT more than 180, PT 16.2, INR 1.4.

Conclusion RSV positive bronchiolitis with all complications can mimic bacterial sepsis and its clinically difficult to differentiate between viral and bacterial septic shock. As this baby’s blood C/S was negative only positive thing was RSV in NPA. We have to consider this case as RSV BRONCHIOLITIS with fulminant septic shock with pneumonia, DIC, Pulmonary Haemorrhage leading to Asystole. Management of bacterial and viral Septic shock is pretty much the same except in certain cases we may have to use antivirals drugs when indicated.
next step will be to publish these more widely to all stakeholders to drive further improvement in our training units.

Thank you to everyone that helped.

REFERENCES
1. Trainee Charter, Royal College of Paediatrics and Child Health
2. Trainee Toolkit, Royal College of Paediatrics and Child Health

A537 HANGING ON THE TELEPHONE – WITH APOLOGIES TO BLONDIE
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Aims There is a general perception about time to contact medical services and automated messages to navigate, with hardly any mention of children. Previous work1 showed that of 537 general practices contacted, 440(81.9%) had automated messages. When present, the mean(95% confidence interval of mean) length was 54.1(51.6-56.6) seconds. With 290(65.9%) mentioning Covid, but only 5(1.1%) practices mentioned children.

We assessed the length of time it took NHS Trusts to answer the telephone, the length of automated messages and whether they mentioned Covid or children.

Methods Using the A-Z 'Acute (Hospital) trusts' directory on the NHS Choices website, the main contact number for each NHS Trust was obtained. Numbers were dialled once after 5pm from the same mobile and network provider. We recorded how many times it rang before answered, whether there was an automated message or not.

Where there was an automated response, characteristics were assessed, including: length, male/female/computerised voice, use of voice recognition, menu choice, references to Covid, instructions provided for urgent situations, and mentions of children.

Results Of 225 NHS Trusts listed, 46(20.4%) of numbers were effectively unobtainable, with 22 providing a short message to call back within office hours. The remaining 179 NHS Trusts, 57.5% had a number specifically dedicated to that NHS Trust, the rest directed callers to one of their hospitals.

When numbers functioned they were answered in mean 1.7 (2.2-3.1) rings. Automated messages were in 146 NHS Trusts. Hospitals with automated messages answered in 0.6(0.57-0.68) rings, around 2 seconds. Without automation it took 6(5-7) rings, which was statistically significantly longer, around 20 seconds.

The mean length of automated messages was 44(26-48) seconds:
• 57.5% were human voices, and 37.7% computer generated
• 78.1% were female voiced
• 96.4% of computer generated messages seemed female
• 59.6% of messages did not offer any interactive elements
• 12.3% offered voice recognition
• 28.1% offered menu choices
• 59.6% did not triage calls, but were used to welcome the caller, mention covid visiting, or both
• 83.6% placed callers in the operator queue after the message

• 51.4% referred to Covid, instructing the caller regarding symptoms or visiting
• 8.2% offered instructions for urgent situations other than covid
• Only 4.1% of trusts mentioned children, 83% of which were about visitor rules for child inpatients

Conclusion The NHS Choices directory needs updating. NHS Trusts with automated messages will answer faster, but automated switchboards require a longer wait before people will interact with a human, as while the telephone is answered in around 2 seconds (0.6 rings) there are still about 44 seconds to wait until the caller gets to a human.

Hospital messages are shorter than primary care ones.1 Children are not part of most NHS trusts responses. Qualitatively most messages were not helpful.

There is a shocking lack of voice recognition despite the wide use of voice recognition software in many spheres of life.

REFERENCE

868 HANDOVER- A POTENTIALLY PERILOUS PROCEDURE?
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10.1136/archdischild-2022-rpoch.743

Aims The aim of this study was to assess the number and quality of paediatric ward handovers taking place in a busy district general hospital. The goal was to assess the efficacy of handover and identify any factors potentially impacting adversely on the hand-over experience.

Methods Data was collected over a 30-day period from 05/10/20 – 03/11/20. The data was collected using ‘audit sheets’ completed by the ward tea. The audit sheets included sections on:
• Time of handover (morning, post-ward round, afternoon and evening/night handover)
• Safety brief
• Duration of the handover
• Location handover took place
• Number of interruptions

Results A total of 66 handovers were audited over the 30-day period, i.e. approximately 59% of the total number of handovers that would have been expected during this time.
• 80% of the handovers in the audit were morning handovers where the night team hand over to the daytime team.
• Afternoon handovers were the most poorly documented (only 10 documented total).

All handovers took place on the ward or in clinical settings, in large part due to COVID 19 restrictions centred around social distancing and space availability.

All documented handovers were timely, taking 30 minutes or less with appropriate numbers of people present including the consultant and senior nursing staff.

17 interruptions were documented, of which one was urgent, 56% of non-urgent interruptions occurred during the evening handover with the night team. All interruptions by the ED department occurring during the evening sessions.

Conclusion The data collected showed that most handovers are effective and performed well, however nothing is perfect!