Abstract 928 Figure 1 Three main ways professionals engage with DETECT e-pews

Abstract 928

AN EXPLORATION OF HEALTH PROFESSIONALS’ EXPERIENCES AND PERCEPTIONS OF THE CLINICAL UTILITY AND ACCEPTABILITY OF AN ELECTRONIC PAEDIATRIC EARLY WARNING SYSTEM (THE DETECT STUDY)

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Aims The Dynamic Electronic Tracking and Escalation to reduce critical care transfers (DETECT) study implemented a proactive end-to-end deterioration solution (the DETECT surveillance system) across a tertiary children’s hospital. The DETECT surveillance system, included an electronic paediatric early warning system (DETECT e-PEWS), aimed to reduce complications and emergency transfers to critical care following deterioration in hospital by screening children for early signs of serious deterioration or sepsis.

This presentation focuses on the findings from a sub-study which explored health professionals’ experiences and perceptions using the DETECT e-PEWS across a tertiary children’s hospital.

Methods Health professionals participated in single, semi-structured qualitative interviews comprised of 15 questions about their professional role and background, their experience with key aspects of serious deterioration (vital signs, raising a concern and/or responding to a child’s potential or actual deterioration) and questions about the clinical utility and acceptability of DETECT e-PEWS.

Results Fourteen HPs participated in the interviews. HPs were broadly categorised into two groups according to their use of DETECT e-PEWS. The first group use the e-PEWS to assess and document children’s vital signs: the Documenting Vital Signs (D-VS) group. The second group use the e-PEWS to review children and respond to tasks and alerts: the Responding to Vital Signs (R-VS) group. Three main themes were identified (figure 1): ‘complying with DETECT e-PEWS’; ‘circumventing DETECT e-PEWS’; and ‘disregarding DETECT e-PEWS’. These themes relate to the clinical utility and acceptability of DETECT e-PEWS and reflect how health professionals responded to and engaged with the technology.

Conclusion Speed and accuracy of real-time data, automation of triggering alerts and improved situational awareness were key factors that contributed to the acceptability of DETECT e-PEWS. Mandating use of both recording and responding aspects of DETECT e-PEWS is needed to ensure full implementation.

Abstract 930

EVALUATING AND IMPROVING TRAINEE WELL-BEING IN A TERTIARY CHILDREN’S HOSPITAL

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Aims In July 2021, Birmingham Women’s Children’s Hospital (BWCH) recruited two champions to raise the priority of trainee well-being. The project aimed to assess overall well-being using a validated measure and apply evidenced based interventions to improve junior doctor well-being and therefore the care provided to patients.

Methods Baseline well-being of junior doctors was measured using the Warwick-Edinburgh Mental Wellbeing scale (WEMWBS). We conducted a web-based survey including all junior doctors and posters containing QR codes were put up in key areas. Completing the survey gave participants the option of entering a prize draw. WEMWBS contains 14 questions with 5 responses to each. The questions are all worded positively and incorporate the feelings and functioning determinants of well-being. The responses are ‘None of the time, rarely, some of the time, often and all of the time’. Each question was then scored.

With the results of this study, we decided to act on improving the working conditions for the doctors at the hospital. Based on Maslow’s Hierarchy of needs we laid emphasis on the psychological needs as many previous interventions have focused on physiological needs.

Collaboration has been the key to our success. We have been supported by Well-being Champions from other Trusts, Chief People Officer, and Inclusion Champion from across our trust. But the most fruitful collaborations have been directly with trainees.

Our own training needs were identified, and courses attended on psychological first aid, psychological well-being and compassionate leadership.

Regular Pastoral support meetings for trainees new to training and the Trust, were initiated to provide support. Focusing on needs specific to trainees such as career advice and support with challenging situations in outside of work.

A monthly peer support meeting was trialed to give doctors an opportunity to de-brief positive and negative experiences. This has been well received and will be rolled out to the rest of the trust.

Sharing food is a great catalyst for conversation and to provide an environment where teams can bond and debrief funding was sort to provide a weekly free breakfast which has proved successful and cost effective.

Results 112 responses. All grades of doctors participated. Most of the responses were distributed midway between some of the time and often. A few were interspersed around none of the time and all of the time. Of a total score of 70 the average was 47 (Range-34-63).

Between August 2021 to October 2021, we conducted a survey using the Warwick Edinburgh Mental Wellbeing Scale to measure the wellbeing of Postgraduate doctors in training and received 112 responses where most of the responses fell between some of the time and often. The average score was 47 out of 70 (figures 1 and table 1).
ABRAMHAM MASLOW'S HIERARCHY OF NEEDS:

Abstract 930 Figure 1  Abrahams maslow’s hierarchy of needs

Conclusion The WEMWBS survey results showed that most Trainees are in the median range of happiness quotient. The key lessons learned are that wide collaboration is the key to success with early trainee involvement. Surveys can provide a wealth of information but should be validated for their specific use. High completion rates can be achieved through incentives and ensuring access to the survey is widely publicised in multiple formats.

The journey of improving well-being of junior doctors has just begun and we seek to build on success to create a culture of well-being.

921 MRI BRAIN SCAN REQUESTS DURING COVID PANDEMIC IN A DISTRICT GENERAL HOSPITAL

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10.1136/archdischild-2022-rpch.749

Aims Remote outpatient consultations during the COVID pandemic have been found to be feasible and safe but has led to concerns of increased reliance on urgent requests for imaging including MRI brain scans. We aim to study the requests for MRI brain scans during the pandemic period compared to the pre-pandemic period.

Methods MRI brain scan requests on all children between 0-16 years in a district general hospital during the pandemic period (P) (March 2020-August 2021) were compared to pre-pandemic period (PP) (September 2018-February 2020). Apart from one consultant (consultant A) who was shielded and did only remote telephone and/or video outpatient consultations, the remaining consultants (consultants B) were flexibly working with combination of face-to-face examinations (F2F) and remote consultations. All children who needed an ‘urgent scan’ (to be done within maximum 14 days) had to have a F2F examination before scan request was made. ‘Routine scan’ requests (to be done within maximum 6 weeks) either followed from remote consultation or after F2F. Consultant A requested only routine scans during the period P. All significant scan abnormalities on MRI brain scans were noted.

Results During period PP the total scan requests were 467; urgent scans were requested in 29% children (32% requests in children <12 years). Urgent scans were done within a mean of 5 days (0-14 days); significant abnormalities in these urgent scans were seen in 23% cases. During period P total numbers of patients seen were 13794 (consultants B) and 2217 (consultant A) respectively. Total number of scan requests were 453 (397 consultants B and 56 consultant A). Urgent scan requests were total of 176 (44.3%) with 108 (61.3%) requested in children <12 years. 34 (19.3%) urgent scans showed significant abnormalities. Urgent scans were done in average of 3.6 days in 147 children but were done after 14 days (average 28.6 days) in remaining 29 (16.5%) children with urgent scan requests. Significant scan abnormalities were found in 6 children in whom the urgent scan was delayed. No significant abnormalities were seen on routine scans asked by consultant A. Mean routine scan request per total number of patients seen were 2.9% (consultants B) and 2.5% (consultant A) respectively.

Conclusion Significantly more urgent requests for MRI scans were made during the pandemic period especially in children under 12 years. Extreme parental anxiety about presenting symptoms during the pandemic may have significantly contributed to the increased urgent requests. This may have also contributed to a delay in getting urgent requests and delay in diagnosis in 6 children.

Similar total levels of routine scan requests in the two periods, P and PP, suggest that remote consultations have not increased the requests for MRI brain scans. There was no significant difference in the average number of routine scan requests in the 2 groups, Consultants B and Consultant A. In addition the scan requests following remote consultations appear to be safe with similar significant scan abnormalities seen in the two periods.

Parental reassurance and adherence to recommended guidelines may help in reducing urgent scan requests especially in younger children.

940 IN-SITU SIMULATION IN THE PAEDIATRIC EMERGENCY DEPARTMENT: IMPROVING PATIENT SAFETY, ENCOURAGING TEAMWORK AND DELIVERING EDUCATION

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Aims We want to improve the quality and safety of patient care within the paediatric emergency department (PED). We want to be able to deliver education, encourage teamwork and communication, and identify and act upon clinical risk seen in the PED. We look to use in-situ simulation to address these issues.