Methods By introducing monthly in-situ simulation we run a 15-minute scenario with a 15 minute debrief of how it went. We involve many different allied health professionals from ED, paediatrics and other specialties. We acquire feedback with learning points and use this to improve future simulations.

Through in-situ simulation training 1. We are able to provide education and training to junior staff, which can be disseminated to the rest of the team
2. We are able to involve multi-disciplinary teamwork as well as involve different specialities in the training process, promoting interprofessional learning
3. We are able to implement and ‘test’ new guidelines and policies
4. We are able to witness any human or environmental factors, such as access to medications in the drug cupboard in resus, and act upon this.
5. We can provide an environment to test out new devices such as transport vapotherm
6. Enable to act upon clinical risks and incidences
7. Identify common learning mistakes or beliefs and correct this through simulation summaries that are shared amongst the team.

Results Examples of simulations covered and their outcomes
1. Asthma – was able to test and introduce the new flow chart and witness accessibility issues in making up magnesium IV.
2. Bronchiolitis – we were able to assess how to use the transport vapotherm and identified difficulties in setting it up leading to more training on it
3. Congenital Cardiac disease – we were able to introduce a new version of Prostin and educate the nursing team on how to make it up and administer
4. Major trauma – we identified we had no major haemorrhage protocol in paediatrics so this has been designed.

Feedback Subjectively participants have said their knowledge of the conditions increased by 40% and they feel more confident managing these conditions. Participants were able to give 3 learning points from each session with roughly 60 participants per year being involved.

Going forward
Based on feedback we have received we have designed further in-situ simulations based on recent critical events including preterm delivery, head injury with coagulopathy and anaphylaxis.

Conclusion In-situ simulation has been shown to improve patient care in the paediatric emergency department through a multi-faceted approach leading to better teamwork, delivery of education and improved patient safety.

Aims Nurse-led asthma clinics have been consistently evidenced to improve the quality of asthma care and reduce hospital admissions in children. Birmingham has greater childhood asthma prevalence and higher emergency admissions for paediatric asthma compared to the rest of UK.1 As part of an organisational approach to optimise paediatric asthma care, Advanced Nurse Practitioners (ANP) led a service improvement project to set up a nurse-led asthma clinic within the general paediatric service

Methods Plan, Do, Study Act (PDSA) cycles methodology was used, with two paediatric ANPs leading the project team which included three general paediatric consultants with a respiratory interest. Stakeholders, including clinicians, outpatient services and secretarial team, were involved to process map the project. Initial patient selection was from consultants own follow up waiting list and with the inclusion criteria of being above 2 years of age with a diagnosis of asthma or wheeze. Clinic template initially was 4 patients with 45-minute time slots, covering asthma education, inhaler technique checks, peak flow/lung function assessment, asthma control tests, clinical assessments and nurse prescriptions. Consultant supervision & discussion post-clinic promoted on-going ANP professional development. Evaluations and amendments were made along the way using PDSA methodology. (Figure 1) Patient selection was then widened to cover patients with recent HDU admission.

Results The service improvement project was implemented successfully, with the first ANP-led asthma clinic taking place in May 2021. 11 clinic sessions with 37 patient slots have been completed. 19% of patients were not brought (WNB), which is similar to Consultant clinic WNB rates. Nearly a quarter of patients were discharged, now equipped with the education to manage their children’s on-going symptoms. More than 50% continue to have on-going follow up to ensure on-going closer monitoring & meeting annual review requirements.

See figure 2
Abstracts

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Clinic outcomes

Conclusion
As a core group, we have established a well-functioning general paediatric asthma clinic. The operation of the asthma clinic enabled us to deliver high-quality care to our patients by adhering to national standards. The benefits of having ANPs (in permanent posts) to lead the clinics, has ensured its sustainability and efficacy as it is managed by highly experienced and senior clinicians. The clinic was specifically designed with longer clinic time slots, to focus on education and assessment which in turn led to achieving the national targets of Childhood Asthma management. We will continue to assess the asthma clinic, utilising the PDSA cycles, to make improvements and adaptations, thus striving for excellence in delivering paediatric asthma care.

REFERENCES
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REACH – SETTING UP A NEW TRAINEE-LED RESEARCH NETWORK

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Aims
Background
The involvement of trainees in research in paediatrics is dependent on individual enthusiasm and access to appropriate opportunities and support. These are affected by the frequency of rotations, the demands of busy paediatric training jobs and a lack of guidance on how to get involved. The relatively new RCPCH academic tool-kit goes some way to providing support and guidance and the college’s Trainee Research Network initiative aims to support existing trainee research networks and facilitate collaborative working regionally and nationally. Trainee ownership and leadership of collaborative multi-centre governance and research projects provides trainees with research skills mandated by the RCPCH Progress curriculum and as well as opportunities for peer networking and steering of research priorities.

Abstract 964 Figure 2  Clinic outcomes

Whilst over the past 5 years several trainee-led research networks have been set up, there are gaps across the country. Arguably, the most successful are those focussing on sub-specialty projects with General Paediatrics falling behind.

Objectives
We set out to establish a pan-London, trainee-led network that exists to support the conception and coordination of multi-centre research, audit and service evaluation projects to answer relevant general paediatric clinical questions. Additionally, this initiative provides opportunities for trainees to develop research competencies.

Methods
Founding trainees sought experiences of existing trainee network organisations active in research and clinical governance. Subsequently, a working group was assembled by promotion on social media and through the regional trainee network. A group of 16 interested trainees from ST1 through to ST8 was formed and initial meetings were held monthly in May-Dec 2021.

The working group divided into 3 key smaller subgroups; 1. Guidance documents & first project development 2. IT & communications 3. Trust network set-up

The group was overseen by a set of co-chairs ranging from ST4-ST8 and senior consultant support.

Results
The working group set to work on the 3 main workstreams and developed an initial set of resources which included;

1. Guidance documents & first project development:
   - Constitution
   - Project proposal form
   - Standard operating procedure guidance for projects
2. IT & communications:
   - Branding including network name and logo
   - Social media presence
   - Website and dedicated email address
   - Newsletter outline and mailing list template
3. Trust network set-up:
   - Review of regions and hospitals with collation of potential local stakeholders and consultants leads
   - Plan for recruitment of interested trust leads

In parallel the working group conducted successive brainstorming exercises of potential first projects, taking into account the outputs of other trainee networks, feasibility and current views on research priorities. Additionally, in recognition of the need to hear parent and patient as well as pan-region trainee voices, links to patient and public involvement (PPI) organisations are being established and a priority setting exercise is planned for 2023. A central committee was formed in December 2022.

Conclusion
The London REACH – Research, Evaluation and Audit for Child Health – network collaborative established its central committee, core guidance documents and communication infrastructure. A first regional trainee-led multi-site project will be conducted in 2022.

REFERENCE
1. www.reachnetworkldn.com

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PLAY NICELY: CIVILITY ON THE CHILDREN’S WARD

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Aims
Background
Physical illnesses occur in the context of emotional and psychological journeys of children and families. Inadequate support in hospital settings can hinder these journeys, contributing to poor experiences and outcomes for children and families. The problem is not unique to paediatrics or to the Royal United Hospital (RUH) and is, in part, a function of the human condition. Conflict may arise when differences in belief, identity, values, and culture are not facilitated to support positive relationships and the delivery of quality care. Civility is associated with resilience, adaptation, and healthy outcomes. Civility is dependent on education and training. The Kirkpatrick model for training has been adapted to assess the impact of civility training on children’s ward staff.

Methods
The RUH Children’s Ward has been nationally recognised for its holistic approach to the care of children and their families. The ward experiences high pressure with multiple priorities and high pressure working conditions. Prior to the implementation of the civility training, there was an absence of a formalised civility strategy and support system to create a safe and respectful environment for all. This initiative is the first in a series of initiatives to facilitate a culture of civility.

Civility training was delivered using the Kirkpatrick model which is an outcome-focused education and training model. The model is based on educational interventions and the impact they have on the learners and the organisation, enabling the organisation to achieve its goals. This quality improvement model, based on the original model by Kirkpatrick in 1959, has been adapted specifically to assess the impact of civility training on children’s ward staff.

Results
The Kirkpatrick level 1 evaluation included an electronic survey which was disseminated to nearly 300 children’s ward staff members. The survey was designed to assess the immediate impact of the civility training, exploring changes in knowledge and attitude levels. The survey was anonymous and voluntary, and the respondents were assured of confidentiality. The survey results were analysed using descriptive statistics, including frequency distributions and summary statistics.

Conclusions
The Kirkpatrick model was effective in evaluating the impact of civility training on children’s ward staff. The findings indicated an increase in employees’ level of knowledge and awareness of civility, which is a positive outcome for both the employees and the organisation. The results also suggest that the training had a positive impact on the attitudes of the employees, with a reduction in negative attitudes and an increase in positive attitudes towards civility. The implementation of the training was well-received by the employees, with high levels of satisfaction and willingness to recommend the training to others. The results of the Kirkpatrick evaluation also highlight the need for ongoing support and development to sustain the positive changes in the future.