Aims To identify current practice in sedation for painful procedures in children and young people (CYP) on the paediatric cardiology ward and to establish if in line with local and National Institute for Health and Care Excellence (NICE) guidance.

Methods This was a retrospective audit (January to April 2021) of all CYP discharged from the Paediatric Intensive Care Unit (PICU) to the paediatric cardiology ward with chest drains, mediastinal drains or pacing wires in situ following cardiac surgery. Electronic case notes and drug charts were reviewed for each patient to identify the date and type of cardiac surgery, when the drains/wires were removed (and therefore duration in situ), sedation used, observations performed, sedation score, nil by mouth times and post removal complications.

Results Twenty-two patients were initially identified, 3 were excluded because drains/pacing wires were removed in PICU and 3 were excluded as there was no mention of drains/pacing wires in the notes. Of the remaining 16 patients, 9 had chest drains, 6 had pacing wires and 1 had a mediastinal drain in situ. The median duration drains and pacing wires were left in situ was 4 days (range 2-13 days). Sedation used for removal included midazolam (10 patients, doses between 100-300mcg/kg), choral hydrate (4 patients, does between 50-75mcg/kg) and 1 patient received morphine at 0.1mg/kg. All doses were dependent on weight. Of the patients who had midazolam 2 required a second dose, 2 received a morphine bolus intravenously and 2 received a dose of oral morphine prior to removal. Sedation was not documented for 1 patient. Fasting time was documented for 13 patients. The median fasting time prior to removal was 4 hours (range 0-11 hours). Sedation score was not documented for any of the patients. 4 patients had documented complications following removal (this could be an underestimate as sedation score was not recorded); 1 patient developed opioid toxicity, 1 required surgical removal of ventricular pacing wires, 1 developed pleural effusion and one chylothorax. Parents/carers did not receive formal written/verbal information on sedation, but it was often explained on the ward round.

Conclusion The most common drug of choice was midazolam (although buccal rather than intranasal) which is in line with the NICE guidelines for painful procedures, however there was no specific local guidance for sedation for removing drains/wires and therefore the first line medication varied. A new guideline specific to these situations is now being written, which will include reminders to give specific advice and information to parents/carers about sedation as per NICE guidelines. The guideline will also cover formal documentation of sedation score to ensure side effects and complications are not missed as well as ensuring adequate documentation on the decision for removal which was not well documented. Repeat audit will then be performed after the implementation of the new guideline.
this population directly attributing their awareness to our interventions.

Conclusion Whilst the posters have shown promising initial impact on awareness, it would be prudent to further push our message via social media, especially involving Asthma UK. The main challenge was assessing the impact of interventions, due to the difficulty in objectively measuring behaviour changes versus stated intention. Preliminary results are positive, yet modest.

This information needs to become implemented into asthma care as standard to make a larger impact. This is something we are working towards, both locally and nationally.

REFERENCE
1. Greener NHS campaign to tackle climate ‘health emergency. NHS UK.