this population directly attributing their awareness to our interventions.

Abstract 1015 Figure 1

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 be 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.

Abstract 1005 'WHY AM I STILL HERE?’ A QUALITY IMPROVEMENT PROJECT LOOKING AT REDUCING WAITING TIME FOR ADMINISTRATIVE DISCHARGE PAPERWORK

Emily Sivers, Qasim Malik, Ian Wacogne, Nicola Davey. Birmingham Women’s and Children’s NHS Foundation Trust; Faculty Lead, QIClearn Programme

Aims To aim for general paediatric patients being discharged from an acute assessment unit at a tertiary children’s hospital, to receive a discharge letter in less than 20 minutes from decision for home being made.

Methods Both high level process maps and fishbone diagrams were used in identification of possible areas of improvement. A prospective, observational data collection focused on recording the time intervals between the different stages in the completion of a discharge letter for each patient.

Timing commenced from decision to discharge and included finding a computer, completion of typing a discharge letter and then printing the letter for a hard copy to be given to the patient on their exit from the department.

Several PDSA (Plan, Do, Study, Act) cycles were then completed, and the data was continuously re-assessed throughout. See figure 1

Results 30 discharge letters were analysed over the course of 4 months. Initial data collection (discharge letters 1-20) showed a difference in our day and night timings to completion of writing a discharge letter. Median time at night was only 11 minutes, compared to a median time of 27 minutes during the day.

Following the implementation of 2 new computers, the median time for the completion of a discharge letter reduced to 13.5 minutes in day time hours. This is a 50% reduction in time taken.

See figure 2 for run chart over study period.

Abstract 1005 Figure 1

Abstract 1005 Figure 2 Run chart
Conclusion Discharge letters are an essential form of communication that professionals in the secondary care sector use to communicate with our primary care counterparts. However, the execution of generating these letters is often seen as laborious and time consuming. Our project identified that there were often delays, which prolonged patient stays, delayed medical practitioners from clerking new patients and contributed to a sense of frustration for both medical and patient groups.

Initial data collection showed a clear distinction between day and night shift timings. Demand for computer use is less competitive in an out of hours shift, supporting our theory behind increasing access to computers as a main change idea for this quality improvement project.

Figure 2 shows a clear reduction in total time taken to produce a discharge letter following the access to more computers in the clinical area. The project has further established that access to effective equipment and resources can reduce the time burden associated with generating administrative paperwork.

Throughout this process there has been added value from the early introduction of senior clinicians in the design of this quality improvement project. There has been benefit from both their expertise and their authority to make changes within the workplace. The use of PDSA cycles has given the project a structured and step-wise approach that has helped to engage others in the workplace by making the aim feel more achievable.

Supporting the sustainability of this improvement should focus on changes that make the administrative process more streamlined. Both time and ease of task are important in engaging clinical staff in producing accurate and timely discharge paperwork for our patients going home.

Aims The project aims to determine the level awareness of NICE guidance for the identification and treatment of paediatric sepsis within the emergency department and paediatric department in a district general hospital in Wales. A standard was set at 100% for all paediatric patients with suspected sepsis to be treated within 1 hour of assessment, according to the Sepsis Six guidelines. Additionally, the level of source detection through secondary investigations would be assessed. Implementation of a recognition and management tool, alongside consideration of a Sepsis Six toolkit would enable a quality improvement aspect to be integrated into the project with the goal of improving the accuracy of diagnosis and management of paediatric sepsis.

Methods Patients with a suspected diagnosis of sepsis admitted to the paediatric ward were identified retrospectively. The project identified the number of cases with a primary diagnosis of sepsis, with or without a source of infection and assessed the efficiency of managing paediatric sepsis. The primary outcome measured was the proportion of cases of suspected paediatric sepsis identified and treated within 1 hour of admission to the paediatric ward. Secondary outcomes included relevant investigations for source detection of sepsis and the use of the NICE ‘Traffic Light System’ to guide appropriate triaging for senior involvement.

Staff from the Paediatric department and Emergency department were educated on the implementation of a Sepsis Six Protocol the possibility of introducing a ‘Sepsis Six Toolkit’ and encouraged to trial this for a few months with the goal of bringing practice closer to the 100% standard. A second audit cycle would then be repeated and data reassessed to determine a change from the baseline in achieving the target standard.

Results From the first cycle, out of a total of 83 cases, 28 (33.7%) cases were officially diagnosed as sepsis. 23% of suspected sepsis and 27% of diagnosed sepsis cases completed the Sepsis Six within 1 hour, however, many did not initiate all the components. Additionally, few cases performed secondary investigations for source detection and many did not document on the significance of further investigations. 12 (43%) of cases had source detection, with urosepsis being the most common. Although some components of the protocol were not completed, the majority of suspected cases involved early senior contact and patients being reviewed within 1 hour of triaging.

Note This section is to be updated with further findings once project has been completed.

Abstract 478 Figure 2 Proportion of sepsis cases pie chart FN

Abstract 478 Figure 1 Efficiency of Sepsis Treatment

Conclusion Early recognition of paediatric sepsis is crucial for appropriate management and escalation of care. This project

478 IMPROVING THE IDENTIFICATION AND TREATMENT OF PAEDIATRIC SEPSIS WITHIN A DISTRICT GENERAL HOSPITAL: AN AUDIT AND QUALITY IMPROVEMENT PROJECT

Fumani Nubi, Humphrey Okuonghae. Prince Charles Hospital

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