

We successfully condensed ETAT/ETAT+ training to two courses of shorter duration. 'Essential ETAT' was well received by participants, and a significant improvement in post-course test scores was achieved. Further evaluation at 6 months post course is required to indicate whether knowledge is retained and changes clinical practise.

**G119** **RECALL (RAPID EVALUATION OF CARDIO-RESPIRATORY ARRESTS WITH LESSONS FOR LEARNING): DEVELOPING A TOOL TO LEARN FROM PAEDIATRIC ARRESTS**

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**Aim** Our Trust, a tertiary centre, aims to eliminate predictable cardio-respiratory arrests (CRA) outside of intensive care by the end of 2013. Although CRA in hospitalised children is rare, the majority are preventable (Tibballs et al 2005). Local incident reports highlighted areas of concern such as poor documentation and incomplete monitoring. Review processes are lengthy and focus on errors rather than areas for improvement. The aim was to develop a new approach to rapidly review all CRA's and share lessons with the relevant teams.

**Method** Experienced clinicians, safety experts and risk managers used a Plan-Do-Study-Act (PDSA) approach to develop RECALL:

**PDSA cycles:**

detailed study of recent CRA's by team to identify key areas to structure review tool

tested key areas for completeness, ease of use and relevance key areas refined and tested again

categories identified for review: Assessment, Escalation, Clinical reviews, Interventions

tested proforma of questions to guide quick but systematic analysis of medical/nursing notes

Using care-bundle approach, five 'must do's' identified for each category

A traffic-light approach was applied to each category to communicate findings: Green (no areas for improvement), Amber (areas for improvement identified but unlikely to have prevented CRA) or Red (areas for improvement identified which may have prevented CRA). The RECALL tool was then tested prospectively over 8 weeks.

**Results** RECALL is now used to review all CRA at weekly meetings, each case taking 30minutes. Lessons for learning are disseminated weekly to the medical director, safety team and local safety leads (discussed at monthly board meetings). Changes are implemented locally with trustwide learning incorporated into improvement goals. The project has moved towards local team review with dissemination trustwide. Early results are promising with a reduced number of CRA (fig 1) and increased staff engagement.

**Conclusion** RECALL has facilitated a culture of learning so clinical teams understand how to improve recognition/escalation of seriously ill children. Common themes include completeness of observations and timeliness of interventions. A simple rapid assessment tool can provide timely and useful data that can be used to drive improvement.

**G120** **KNOWLEDGE AND ATTITUDES; ESSENTIAL INGREDIENTS FOR DEVELOPING CO PRODUCED TAILORED INTERVENTIONS FOR ASTHMA MANAGEMENT (MIA) IN SOUTH ASIAN AND WHITE BRITISH CHILDREN**

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Childhood asthma is a chronic illness affecting quality of life and leading to higher mortality in the UK than other countries. In the UK, prescription rates for relievers and preventers are lower for South Asian (SA) children. SA children are more likely to suffer uncontrolled symptoms and to be admitted to hospital with acute exacerbations compared to White British (WB) children. The MIA study aimed to

	1	2	3	4	5
1. Approach	Confrontational, judgmental approach	Attempts to establish rapport with the learner(s) but is either over-critical or too informal in manner	Establishes and maintains rapport throughout; uses a non-threatening but honest approach to create a psychologically safe environment		
2. Establishes learning environment	Unclear expectations of the learner(s); inadequate learning environment	Explains purpose of the debriefing or learning session but does not clarify learner(s) expectations	Explains purpose of debrief; clarifies objectives and learner expectations from the beginning		
3. Engagement of Learners	Purely didactic; facilitator doing all of the talking with no learner engagement; does not involve passive learner(s)	Learner(s) participates in the discussion but through closed questions; facilitator does not actively invite input from more passive learner(s)	Encourages participation of learner(s) through open-ended questions; invites learner(s) to actively contribute to discussion		
4. Reaction	No acknowledgment of learner(s)' reactions, or emotional impact of the experience	Asks the learner(s) about their feelings but does not fully explore their reaction to the experience	Fully explores learner(s)' reaction to the experience, appropriately managing any learner(s) who is confused or unhappy		
5. Descriptive Reflection	No opportunity for self-reflection; learner(s) not asked to describe what actually happened in the scenario	Some description of events by facilitator, but with little self-reflection by learner(s)	Encourages learner(s) to self-reflect upon experience using a step by step approach		
6. Analysis	Reasons and consequences of actions are not explored with the learner(s)	Some exploration of reasons and consequences of actions by facilitator but not learner(s)	Helps learner(s) to explore reasons and consequences of actions, identifying specific examples; relates it back to previous experience to offer explanations		
7. Diagnosis	No feedback on clinical or teamwork skills; does not identify performance gaps or provide positive reinforcement	Feedback provided only on clinical (technical) skills; focuses on errors only; does not target behaviours that can be changed.	Provides feedback on clinical (technical) and teamwork skills; identifies positive behaviours in addition to performance gaps, targets changeable behaviours		
8. Application	No opportunity for learner(s) to identify strategies for future improvement or to consolidate key learning points	Some discussion of learning points and strategies for improvement but lack of application of this knowledge to future practice	Reinforces key learning points identified by learner(s) and highlights how strategies for improvement could be applied to future clinical practice		

**Abstract G119 Figure 1** Objective Structured Assessment of Debriefing (OSAD) in Paediatrics

co-produce a tailored intervention framework for childhood asthma management by exploring the knowledge and attitudes towards asthma amongst WB and SA parents, carers and children.

**Methods** Semi-structured interviews with a purposive sample of 44 children aged 5–12yrs (33 SA, 14 WB) and 65 parents/carers (49 SA, 16 WB) were used to explore barriers and facilitators to asthma management. A comparative thematic analysis was conducted.

**Results** WB families were more likely to have pre-existing knowledge of asthma than SA families; previous knowledge of asthma strongly influenced how families managed childhood asthma in both communities. In a minority of SA families, 'fear of the unknown' prevented families from investigating asthma further. Beliefs regarding the causes and nature of asthma were similar in both groups, however whilst 33% of SA families attributed asthma to either God's will or Karma, no WB families did so.

All communities reported that advice was often given by extended family members but this was more prominent in SA families, especially in relation to complementary asthma management strategies.

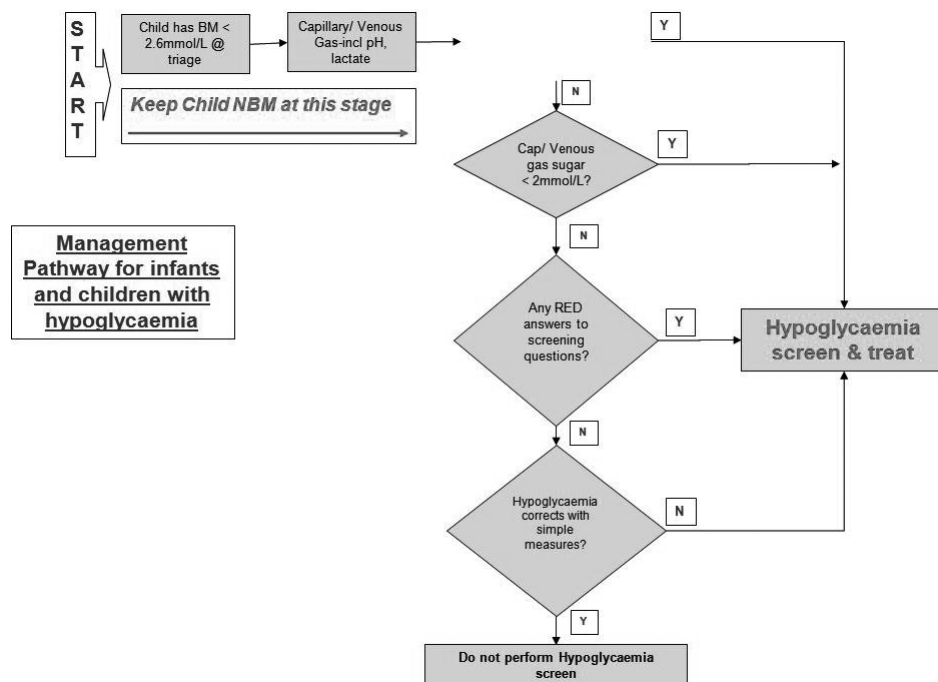
SA and WB families both reported a lack of information-giving by health care professionals in relation to asthma.

**Conclusions** Pre-existing knowledge and attitudes surrounding asthma differ between SA and WB parents and directly impact on management. Intervention Co-production is increasing in use and popularity. The MIA project supports the co-production model by highlighting the importance of identifying attitudes and beliefs towards asthma from different ethnic groups so that interventions can be tailored to address their fears and concerns more effectively.

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## G121 ARE WE OVERINVESTIGATING HYPOGLYCAEMIA IN CHILDREN PRESENTING WITH GASTROENTERITIS IN A DISTRICT GENERAL HOSPITAL SETTING?

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Abstract G121 Table 1

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**Aims** To develop a safe but less invasive approach to the investigation and management of hypoglycaemia in infants and children.

**Methods 2010** We performed an audit of all hypoglycaemia screens undertaken between 1st February–12th May in a large district general hospital using retrospective case-note analysis.

Using these results we conducted a consultation exercise involving local consultants, biochemists and a tertiary metabolic specialist to develop a simple screening pathway that was also in line with the National Metabolic Biochemistry Network (NMBN) guidelines for investigation and management of hypoglycaemia. The pathway emphasises that symptomatic hypoglycaemia is a clinical emergency and permanent brain damage is a risk if treatment is delayed.

Table 1: 1st February 2011: The screening pathway was introduced into clinical practise

Table 2: 2011 & 2012: Re-audit of clinical practise in both years for the same time period (1st February– 12th May)

**Results** In 2010, 22 hypoglycaemia screens were performed, all of which were normal, except for a recurrent finding of mildly elevated 3 hydroxy-butrylcarnitine (as would be expected during fasting). 19 sets of case-notes were obtained. These showed 18/19 children had gastroenteritis, 17/19 had no significant past medical history and 16/19 were admitted.

In 2011 and 2012 there was a substantial reduction in the number of screens performed in infants and children (10 in 2011; 7 in 2012). No significant abnormalities have been identified. The admission and follow up data for 2011 & 2012 is currently being analysed.

Total numbers of infants and children referred to hospital, and the proportion of children diagnosed with gastroenteritis were similar in all three years.

**Conclusions** Analysis of practise in 2010 highlighted a population of previously well children who presented with symptoms of gastroenteritis and were incidentally found to have hypoglycaemia and were therefore investigated accordingly.