

48 DEVELOPING DUMMY PATIENT DATA SPECIFIC TO GREAT ORMOND STREET HOSPITAL

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There are an increasing numbers of secondary use cases for patient data. However, access is tightly controlled and it is not possible for researchers to develop applications on patient data. These issues can potentially be addressed through anonymisation of data. However, it can be a laborious process to remove all identifiable data and for many purposes, e.g. testing new systems, alternative datasets would be equally effective. There are anonymised datasets e.g. MIMIC-III, that could be used but they are disproportionately based on United States hospital data and unlikely to reflect the GOSH patient population or data structures. Also, there are no up-to-date anonymised datasets, e.g. MIMIC-III data was collected between 2001 and 2012. We developed an in-house tool to generate dummy patient data that mimicked the GOSH DRE database.

Real data was analysed to provide a dataset level summary of each column, e.g. patient ages, and saved as a configuration file. A separate system was then used to generate data based on this configuration for an arbitrary number of fake patients. This resulted in dummy records that reflected GOSH data structures but were devoid of any clinically meaningful or real patient data.

By generating dummy data that accurately reflects the structure of GOSH data it is possible to quickly make analytical tools without any information governance concerns or risk to patient data. Within the team it has been used to add new functionality to existing applications and has the potential of allowing collaborators to make tools for GOSH without the need to access patient data.

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51 CLINICAL HOLDING: PROVIDING; SAFE, EFFECTIVE, ACCEPTABLE, AND TRANSFERABLE (SEAT) SKILLS, WE CAN START MINIMISING THE IMPACT OF TRAUMA THAT LIFE-SAVING TREATMENTS CAN HAVE ON BOTH STAFF AND PATIENTS

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Background At Great Ormond Street Hospital (GOSH), we have a mission of putting the 'child first and always', this includes giving them a voice in decisions about their care. This can only be done by acknowledging their rights and ability to consent. For some children and young people (CYP) holding still for a clinical procedure can be anxiety provoking especially if they lack the mental capacity to understand the importance of life saving treatment; staff utilise clinical holding (CH) skills to ensure everyone's safety.

Methods A pan trust teaching programme was introduced with the support of a specialist training company and completing a training needs analysis, skills were adapted to support staff to make decisions that consider the rights of our CYP, reduce the impact of trauma (RTIOT), and promote a collaborative approach by planning safe holding techniques and empowering the voices of patients. The hope for the future is to strengthen the trusting relationships between parents and their children, RTIOT on patients and staff and promote GOSH as a safe environment to receive on-gong care.

Results More than 200 staff have been trained in CH skills. Feedback from staff who have attended the training has been extremely positive and they highly recommend the course. This has raised the awareness throughout GOSH and increased the demand for this training. Gosh currently has twelve trainers who are supporting the future education of staff to safely hold a patient for clinical interventions. This positive impact has inspired interest from senior managers to invest in the future of staff to become trainers.

Conclusion This is very exciting for the future care that GOSH provides; we will be able to effectively plan safe care, that would have otherwise been a struggle for patients to engage with and might have had a traumatic experience.

Acknowledgements for funding or support We received funding from the GOSH Learning Academy (GLA) to fund trainers to support the education of this skill.

54 SUCCESSFUL MANAGEMENT OF POST-OPERATIVE MALIGNANT JUNCTIONAL ECTOPIC TACHYCARDIA WITH COMBINATION THERAPY OF AMIODARONE AND IVABRADINE

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Background Post-operative Junctional Ectopic Tachycardia (JET) is the most common haemodynamically significant tachycardia leading to significant mortality and morbidity even in the current era of improved surgical and post-operative management strategies. Novel treatment options with minimal adverse effect profiles are desirable to play a pivotal role in managing this cohort of critically ill children.

Case Presentation We describe an infant who underwent atrial septal defect (ASD), large inlet subaortic ventricular septal defect (VSD) closure, pulmonary valvotomy, and mitral valve repair complicated with malignant JET soon after coming off from cardiopulmonary bypass (CPB) leading to severe biventricular dysfunction and worsening mitral regurgitation. The patient was successfully managed with the combination therapy of Amiodarone and Ivabradine in addition to