

safe space, somewhere they could openly share feelings of isolation, sadness, difference and frustration. Young people emphasised the need to normalise the way they felt and some focused on enhancing peers' self-esteem, confidence and the development of their own identity particularly in the context of support received from health professionals.

Conclusions Young people used the discussion groups to find a supportive peer community where they could share personal emotional and social experiences and obtain advice relating to living life with CF. This type of peer support is not replicable through self-care support and management advice delivered by health professionals; therefore online support groups have an important role in supplementing existing professional support.

G23 YOUNG PEOPLE WITH DIABETES AND THEIR PEERS

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Aims Peer influences can impact across a range of adolescent behaviours. Type 1 diabetes (T1D) is amongst the most common forms of chronic illness to affect young people in the UK. Self-management is crucial, but managing their T1D is often very difficult for adolescents. It has been suggested that interventions to support adolescents with T1D could usefully include friends and peers, but little is known about how peers think about and respond to T1D. This research explored T1D from the perspective of adolescent patients, friends and peers.

Methods We conducted dyadic interviews with adolescent T1D patients aged 13–15 years and a nominated close friend (N = 20). We then carried out three focus group sessions with participants without any necessary prior T1D knowledge in a secondary school setting.

Data were thematically coded and final data interpretations were subject to independent scrutiny from young people the same age as our research participants, who assessed the findings in terms of relevance and usefulness from their own perspective.

Results Limited awareness of T1D amongst their peer group generally and school teaching staff was reported by interview participants. Close friends play a valuable role in recognising the importance of T1D management whilst also accepting and normalising the condition. Considerable variations in experiences of support provided in relation to T1D in the school environment were reported by all participants, including the extent to which peers were encouraged or even permitted to support patients.

Educational materials designed in response to issues raised in the interviews were piloted in classroom settings. Realistic vignettes developed from the interviews were used to facilitate group discussion. The simple materials were well-received and positively evaluated.

Conclusions This research highlights the need for greater awareness of T1D in schools amongst teachers and peers, but encouragingly suggests that simple educational sessions can be easily implemented and are well-received. The Children and Families Act (2014) means that safe and effective care for young people with T1D must now by law be embedded in the school system. Diabetes specialist nurses should be aware of potential peer influences and may be able to usefully assist schools looking to

sensitively and appropriately raise T1D awareness and facilitate optimal peer support.

G24 PATIENT EXPERIENCE: CAPTURING THE CHILD'S PERSPECTIVE

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Aims The aim of this work was to capture the experiences of children and families during their admission to a district general hospital.

Methods This was a mixed methods study. Three different surveys were developed for use by parents and carers, children aged 11–16 years and children aged 6–10 years. To add depth and richness to the data children's stories, pictures and poems were collected to generate data that reflected the children's creativity and imagination. Data were collected between January 2013 and December 2013.

Results A total of 560 parent surveys were returned from the day care ward (n = 362) and the clinic (n = 198). A range of different factors were identified that could improve services. These can broadly be divided into two categories. Category 1: Child and family centred factors included the following: some children aged 11–16 wanted the opportunity to speak to clinical staff without their parents present; there were not enough play facilities for children aged 11–16; not all staff were introducing themselves to the children or families; the environment could benefit from improvement. Category 2: concerns were raised about parents' expectations about waiting times in clinic were not always being managed; on the day care ward some family's were not kept informed of the delays for theatre or given realistic expectations for how the day will run.; and telephone follow up was not offered to all families.

The pictures and poems from children highlighted that food and play were the most important factors to them.

Conclusion Eliciting children's feedback on service provision is vital to make improvements to the services we provide. They are the ones experiencing our service and as clinicians we need to be engaging with them using different methods to ask them what we can do to improve the care we provide.

This work highlighted many areas for small changes that have led the staff to reflect on the services and adapt to meet the needs of the children.

G25 COMMUNICATING WITH PARENTS FOLLOWING A SUSPECTED ADVERSE DRUG REACTION IN A CHILD: WHO SAYS WHAT AND WHEN?

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Aim To pilot a prompt guide to support discussions between clinicians and parents following a suspected adverse drug reaction in a child.

Method We designed the prompt guide in response to the findings from the Adverse Drug Reactions in Children: Qualitative study (ADRIC: QUAL) that identified parents unmet information and communication needs following a suspected ADR in their child. The prompt guide was developed by the ADRIC: QUAL and wider ADRIC study team; reviewed by parent expert advisory groups and expert advisory groups at the Medicines and Health care products Regulatory Agency (MHRA) and the Royal College of Paediatrics and Child Health (RCPCH) medicines committee before being finalised. The prompt guide was piloted at a regional children's hospital and it is the findings of the pilot study that are reported here.

We identified suspected ADRs in children through daily ward visits. Treating clinicians used the prompt guide during routine conversations with parents about that suspected ADR. Clinicians then took part in a short structured interview.

Results The prompt guide was used 17 times by nurses ($n = 9$), specialist nurses ($n = 4$), and doctors ($n = 4$).

Clinicians who used the prompt guide felt it was easy to use; was helpful in structuring and pacing the discussion; ensured all relevant topics were covered; and empowered parents.

An unexpected finding was confusion about whether a child had experienced a suspected ADR and this influenced whether discussions with families took place. Where discussions did take place, there was confusion about who communicated with parents. While doctors felt nurses were often the first to recognise, and therefore communicate with parents about suspected ADRs, few nurses recognised their role in this process and their accounts suggest that they are poorly supported in this role.

Conclusion Optimal communication with parents about suspected ADRs in children depends on clinicians recognising a suspected ADR. Nurses potentially play an important role in communicating with families in such situations but they do not always recognise their role and there maybe unmet training needs.

G26

PARENTS' EXPERIENCES OF ADMINISTERING AND MANIPULATING MEDICINES FOR CHILDREN WITH LONG TERM CHRONIC CONDITIONS

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Aims

1. To explore the experiences and methods used by parents to administer long term medicines to their children.

Methods Semi structured qualitative interviews with parents of children who are prescribed long term medication for a chronic condition. Interviews were audio recorded and transcribed. Analysis was inductive and informed by the principles of grounded theory and constant comparison method.

Results Semi structured interviews with the parents of 13 ($N = 12$) children between 5 to 11 years; female ($n = 5$) and male ($n = 8$). The sample is currently being extending to include the parents of up to 20 children.

Parent's accounts were variable. Some parents reported no problems administering medicines to their child but other parents described prolonged 'battles'. Taste was cited as the main

reason for a child refusing a medicine. Some methods used by parents to encourage children to comply with medication, such as rewards and reasoning are commonly used by parents giving short term medicines but these methods needed to be regularly adapted over time as their effect wore off. Parents also described ordering medicines, giving two medicines together or missing medicine doses in order to reduce 'battles' and increase compliance.

Parents were confident in manipulating medicines (cutting, crushing or splitting tablets etc.), but had concerns about controlling the dose their child received e.g. tablets crumbling. Similarly, parents did not favour disguising medicines in food or drink as they felt this method did not work, risked losing the trust of their child, and their child potentially refusing that particular food or drink in the future. Furthermore, parents had concerns about controlling the dose of a medicine using this method.

Conclusion Some parents described 'battles' over administering medicine to their children that had a significant and negative impact on daily family life. Taste was the major barrier to compliance. Methods perceived as favourable by clinicians, such as disguising medicines in food and drink, were not favoured by parents who employed a range of alternative strategies, some of which involved altering medicine regimens and was not supported by evidence.

G27

SOCIAL INFLUENCES ON PARENTS' HEALTH SERVICE USE WHEN THEIR CHILD IS SICK: BARRIERS TO TIMELY TREATMENT?

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Acute childhood illness is surrounded by uncertainty and anxiety about the nature of the illness and when to seek professional help (Neill 2010). Social influences on health service use are complex but need to be understood if services are to address barriers to timely treatment.

Aim To explore the impact of social influences on parents' health service use during acute childhood illness.

Methods This paper draws findings from 3 projects which explored parents' decision making during acute childhood illness at home. These studies include: a grounded theory study with 15 families (Neill 2008), a social marketing project involving 23 parents in focus groups (Spencer and Neill 2013) and a modified grounded theory study with 27 parents using focus groups and interviews (Jones *et al.* 2013, Neill *et al.* 2014).

Results Three themes emerged in the data from all 3 projects: Social expectations; Family and social support; and Service design and its impact on access to services. Social expectations shape how parents perceive they are expected to act as mly 'good parents', including an expectation that they will use services appropriately, creating anxiety about attending too soon or too late. Family and social support provides emotional and practical support, not usually advice on how to manage the illness, contrary to professionals' assumptions about the role of extended families. Services are not designed with the child and family in mind: systems create delay, increasing parents' anxiety; difficulties in accessing services; limited continuity; and confusion about which service to use.

Conclusion A wide range of social factors influence parents' help seeking in childhood illness. When parents decide to