

**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

consult they have exhausted their ability to cope with their child's illness independently. Parents need to know where, and when, to seek help and to be able to do so easily, without being judged for doing so. Services face the challenge of reducing barriers to timely treatment within financial constraints, if we are to reduce avoidable morbidity and mortality and improve UK child health outcomes.

G28

#### EFFECTIVE SAFETY NETTING: AN IMPORTANT CONTRIBUTION TO AVOIDING PREVENTABLE DEATHS

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Safety netting has conventionally been used during consultations when clinicians are uncertain about the trajectory of an illness to provide patients with guidance about when and where to re-consult (Roland *et al* 2013). Recent high profile events involving failure to recognise and appropriately safety net children with sepsis highlights this is a significant issue in healthcare.

**Aim** The aim of the paper is to raise awareness of the importance of quality safety netting information for parents of young children drawing on findings from the ASK SNIFF research programme.

#### Methods

1. Systematic integrative review of interventions designed to support families with an acutely sick child.
2. Qualitative study with 27 parents and 16 first contact health professionals using a grounded theory approach.

**Results** A review of over 7000 articles identified only 22 which examined an intervention educating and advising parents on when to seek medical care. Analysis of these papers showed that interventions which provide information on assessment and management and are endorsed by health care professionals (HCPs) have shown greatest effect. Irrelevant information appears to reduce parent's trust in the intervention. These findings validated the emerging themes from the qualitative work. Parents of sick children, in the latter, want information pre, during and post consultation with a HCP to inform their own safety netting decisions. Information is not routinely offered during consultations, is inconsistent in content and delivery method and often reported to be verbal only. The extent of safety netting was reported by HCPs to be influenced by parental status, an assumption of individual parent's knowledge and practical factors such as working printers. Both groups want safety netting tools to improve consistency and quality of information available for parents with a sick child.

**Conclusion** Safety netting information is essential for parents to know when to consult with a sick child. Absent or incomplete safety netting leaves parents to search elsewhere and with responsibility for assessing the reliability of information. Incomplete, inconsistent information may mislead and at best lead to increased consultations and at worst to delay and avoidable morbidity and mortality.

G29

#### AN EDUCATION PROGRAMME TO ENHANCE UNDERGRADUATE PRE-REGISTRATION NURSING STUDENTS' SKILLS IN RECOGNISING AND RESPONDING TO ACUTELY ILL/INJURED CHILDREN AND YOUNG PEOPLE: AN EVALUATION

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**Aim** The aim of this paper is to report on the evaluation of an educational innovation designed to enhance pre-registration nursing students' knowledge and skills in recognising and responding to acutely ill/injured children and young people.

**Background** It is recognised that nurses are frequently one of the first to note and observe the deterioration of a sick child and also may be the first to encounter a cardiac arrest (Nyman and Sihvonen 2000, Madden 2006). Literature indicates that student nurses require further education in the use and application of life support skills using supportive teaching strategies (Niemi-Murola *et al.* 2007, Gordon and Buckley 2009); students in this cohort endorsed this in that they specifically identified these areas as vital for their future role as qualified nurses. A combination of simulation and problem based approaches has been found to be more effective than lecture based teaching alone (Wayne *et al.* 2005, Bruce *et al.* 2009, Szogedi *et al.* 2010).

**Methods** Final year pre-registration children's nursing students (n = 40) on a BSc (Hons) Nursing programme completed an educational package delivered over four sessions. The training package consisted of a key note lecture, critical appraisal of clinical guidelines, seminar discussions of real life clinical scenarios, small group skills demonstrations and simulated teaching/testing using manikins. A five point Likert scale questionnaire, measuring students' self-perceived level of confidence, was used to evaluate the impact of the learning experience. Students completed a qualitative evaluation questionnaire as part of an end of unit evaluation.

**Results** Evaluation data revealed improvements in students' confidence, knowledge and skills. Comparisons of students' pre and post questionnaire scores revealed a statistically significant positive change in their self-perceived levels of confidence. The programme was positively evaluated as an educational package.

**Conclusion** This evaluation supports the role of a combination of teaching strategies to enhance knowledge and skills in undergraduate pre-registration nursing students in recognising and responding to acutely ill/injured children and young people.

G30(P)

#### ENHANCING THE PREPAREDNESS OF PARAMEDIC STUDENTS FOR MANAGING CHILDREN PRESENTING WITH CONGENITAL CARDIAC CONDITIONS IN THE PRE-HOSPITAL SETTING THROUGH AN ONLINE MULTIMEDIA EDUCATIONAL PACKAGE

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Paramedics are the front line clinicians in the delivery of pre-hospital emergency and urgent care in the UK and they face multiple challenges due to the unpredictability of their workload and the diversity of calls. Recently, proposed changes to children's cardiac services have prompted concerns that paramedics may attend an increasing number of children with congenital heart