

plays a significant role in reducing the DNA rate in the Paediatric outpatient setting. Telephone reminders and text messaging are extremely cost effective interventions, and hence routine reminders with confirmation of appointment should become standard NHS practice.

### G288 A REGIONAL REVIEW OF HUMIDIFIED HIGH FLOW NASAL CANNULA OXYGEN USE IN CHILDREN

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#### The aims of this review were four fold

1. To document the non-intensive care paediatric experience at a regional level of oxygen delivered via high flow humidified nasal cannulae (HHFNC).
2. To understand patient outcomes and safety data with respect to HHFNC oxygen.
3. To determine whether clinical data might help identify those children most likely to deteriorate on HHFNC oxygen.
4. To create a region wide guideline based on the findings.

Data was collected between October 2013 and April 2014. A pro forma was completed by local paediatric teams at all 10 hospitals within the regional critical care network on all episodes of the use of HHFNC oxygen. To inform guideline needs of the region, questionnaires about the use of HHFNC oxygen were completed by nursing and medical staff.

210 episodes of HHFNC oxygen use were captured. Experience with HHFNC oxygen varied widely within the region. It was used most frequently in children under a year of age diagnosed with bronchiolitis. Children with bronchiolitis who deteriorated whilst receiving HHFNC oxygen had a lower pH and higher work of breathing score two hours after commencing this form of respiratory support (Table 1). The proportion of infants with bronchiolitis receiving HHFNC oxygen who required intubation and ventilation was lower than found in a previous regional review in 2008 when continuous positive airways pressure (CPAP) was the standard means of providing respiratory support. Bronchiolitic infants receiving HHFNC oxygen

**Abstract G288 Table 1** Trends in children with bronchiolitis on HHFNC oxygen who deteriorated (escalated to CPAP, or intubation and ventilation), compared to those who did not deteriorate

	Deteriorated	Did not deteriorate	P value
pH pre HHFNC oxygen Mean, (Standard Deviation)	7.27, (0.076) n = 17	7.31, (0.072) n = 69	0.018
pH at 2 hours of HHFNC oxygen Mean, (Standard Deviation)	7.31 (0.104) n = 16	7.37 (0.049) n = 47	0.004
Work of breathing score at 2 hours of HHFNC oxygen Mean, (Inter-quartile range)	8, (7–9) n = 21	7, (5–7) n = 86	0.005

remained less likely to require intubation, even when adjusted for initial pH <7.25 as an indicator of severity (16% v 46%) (Table 1).

The use of HHFNC oxygen has become widespread in our general paediatric population. Our review demonstrates that HHFNC oxygen is safe in children for a variety of conditions, ages and weights. The use of blood gases and assessment of work of breathing pre and two hours after starting HHFNC oxygen could help identify those at risk of deteriorating. There is a suggestion that HHFNC oxygen may reduce the intubation and ventilation rate of children with bronchiolitis. A regional guideline has been designed based on these findings.

### G289 INCREASING PARENT RESILIENCE IN CHRONIC PAEDIATRIC CONDITIONS: THE CASE OF CHRONIC PAIN

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**Aims** Parenting a child with a chronic health condition can be difficult. Parent wellbeing is important in its own right, and also for the sake of the child. Parents who become, albeit understandably, anxious, over-protective or detached from their ill children may not provide them with ideal support. Where a child's illness improves, parental stress is likely to decrease. However, there are a range of conditions where a child's underlying health remains problematic. We aimed to establish whether parent resilience could be improved in the face of ongoing symptoms, in this case, in a population of adolescents undergoing treatment for chronic pain.

**Methods** 92 parents accompanied their child (adolescent, ages 11–18) for a course of residential treatment for non-malignant chronic pain. The adolescents had disabling idiopathic pain requiring treatment at a tertiary national specialist service. Parents accompanied their children through most of the three week programme, participating in exercise and psychology sessions, as well as having three hours of dedicated parent intervention. We examined (1) parental catastrophising about pain, (2) parenting behaviour and (3) parent stress up to a three month follow up.

**Results** Adolescents going through the programme showed no change in their underlying pain intensity, which remained high (7.7/10). They did make functional improvements. Despite ongoing adolescent pain, parents at the three month follow up period (n = 72, 76% data completion) showed significantly decreased catastrophising about their child's pain, less protective parenting behaviour, and reduced parenting stress. Parents showed a decrease in defensive responding around their child, and did not show any increase in their tendency to 'minimise' their child's ongoing pain.

**Conclusions** Parents can increase their resilience and show increasingly adaptive parenting, even in cases where their child's underlying condition does not improve. Here, parents were exposed to a programme of intensive psychological and physical rehabilitation with some dedicated sessions targeted at parent resilience. Their children's pain did not change, but their approach to it did. However, the intervention studied was targeted both at child and parent; research is needed to establish whether parent-only interventions can improve resilience.

### G290 THE DEVELOPMENT OF A PAEDIATRIC HEALTHCARE AT HOME SERVICE

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**Aims** The 2012 NHS mandate recommended reduction in the length of stay for inpatients, to improve the care of patients with both long term conditions and those with acute problems. Reference was also made to improving patients' experience of care.

In paediatrics, these visions are most easily realised within ambulatory paediatrics. In April 2014 a pioneering ambulatory care service was established at our hospital, with 'Healthcare at Home' (HAH). The first children's service of its kind, it is a consultant led, nurse delivered model of acute paediatric care. The nurses visit children up to four times a day, to administer medication, perform observations and provide clinical review. The observations and notes are recorded electronically. A daily consultant-led virtual ward round is conducted with the HAH nurses, facilitated by review of the patient's electronic health records. The initial goal was to enable early discharge from hospital, with future aspirations to facilitate admission avoidance with direct admission to HAH from the paediatric emergency department.

**Methods** Activity data for the first 9 months has been analysed and patient experience feedback has been evaluated.

**Results** 78 patients have been accepted onto the HAH service to date, giving 815 visits, and saving 389 bed days. 796/815 (97.7%) were for administration of IV medication, with 48% for medications needing to be administered more than once a day. Referrals are increasing, with the majority from the general paediatrics service (90.5%). Orthopaedics, gastroenterology and neurosurgery contribute the remainder. There have been 28 episodes of patients re-attending following transfer to HAH; 22/28 (78.6%) have been due to problems with intravenous access, and 6/28 (21.4%) for clinical review. No patients have required readmission to the hospital. Patient feedback has been excellent with 100% of questionnaire responders saying they would recommend HAH to their friends and relatives.

**Conclusion** HAH is in its infancy but, thus far, has delivered exemplary clinical care. As stated in the NHS mandate, improving the experience of patients' and their families is essential. The development of a flexible and robust community nursing service, which provides excellent acute clinical care is a proven means of facilitating this.

### G291 THE FRIENDS AND FAMILY TEST FOR CHILDREN AND YOUNG PEOPLE: KEY RECOMMENDATIONS

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**Aims** The Friends and Family Test (FFT) is currently used nationally in adult acute care settings, and from April 2015 it will be compulsory for all children and young people (or their parents) to be offered the question. Although the guidance suggests wording for younger patients, there is no evidence that it has been rigorously tested with them. Our research therefore

explored children's views of the FFT question including wording, response options and overall design, to propose the most suitable version for children and young people.

**Methods** A focus group with young patients explored views on patient feedback and different versions of the FFT. This informed the development of several child-friendly versions of the question, differing in wording and style. Eight interviews were conducted with patients at a large acute hospital trust, and their preferred wording and presentation options were incorporated into a final survey form. This was cognitively tested with twelve young patients ranging from four to fifteen years old, to ensure that questions were appropriately worded and interpreted as intended.

**Results** The adult question phrasing was unpopular: the word "recommend" and the response options "likely" and "unlikely" were problematic and not always understood. The phrase "if they needed similar care or treatment to me" was essential for understanding of the question. A five-scale response scale was recommended over a three-scale option as it ensured that a range of responses were used. Children preferred to feedback using an "agree/disagree" scale, and favoured images of a monkey character over cartoons and easy-read style photos.

**Conclusion** This research highlights the importance of involving children and young people in the design and wording of questions to ensure that they are appealing and appropriate to them. The question form is currently being piloted with two large acute NHS Trusts using a hand-out methodology with an online option. We encourage healthcare organisations to adopt our format when implementing the FFT for their paediatric patients, since it has been thoroughly tested to ensure that it is suitable for younger populations.

### G292 ARE WE DOING IT RIGHT? COUNSELLING FOR RADIOLOGICAL IMAGING IN NON-ACCIDENTAL INJURY

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**Aims** Children undergoing radiological investigations for child protection are exposed to radiation. Good communication is vital if the child is to be properly and safely investigated. A requirement of obtaining informed consent for these investigations is to understand and be able to explain the risk / benefit of the procedures. We aim to identify how this is carried out nationwide and discuss attitudes and practice around full informed consent in child protection imaging.

**Methods** We carried out an online survey of all paediatric doctors in the UK. The survey was advertised in the RCPCH Wales e-bulletin and the RCPCH Health Policy bulletin.

**Results** From Wales and England, 61 paediatric doctors completed the survey. Of which, 44% of responders were consultants. Consent is taken for radiological imaging by 67%. Verbal consent only is taken by 58%. Only 36% provide information on the radiation exposure caused by the radiological imaging. Despite this, 80% of responders thought it was important to explain the radiation risk of doing such investigations.

**Conclusion** Although paediatricians consider it important to explain the risk/benefit of radiological procedures for child protection imaging, less than half undertake full written informed consent with fewer consenting for specific radiation exposure risks. Is this reluctance to take full informed consent due to a