run charts have been produced and local centres are considering how to best achieve this improvement.

The next stages involve identifying and implementing further improvements both locally and regionally. We are hoping to utilise a nurse or allied healthcare professional via the regional paediatric network to facilitate this. For all interventions, the PDSA cycles with continuous monitoring of outcomes will be used to track effects. Where local changes lead to improvement in outcomes, we will use the regional nature of the project to enable other centres to learn and benefit from this learning.

G408(P) THE PRODUCTION OF A DIABETES INFORMATION FILM, BY YOUNG PEOPLE WHO HAVE DIABETES, AS A MEANS OF EDUCATING OTHERS

¹VE Dublin, ²S Green, ¹M Benitez-Castillo, ³T Edwards, ⁴A Leiva. ¹Child Health, Royal Free Hospital, London, UK; ²Hospital School, Royal Free Hospital, London, UK; ³Child Health, Royal Free Hospital, London, UK; ⁴E17 Puppet Project, London, UK

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Method After establishing a group of regular attendees to our Diabetes Education Days we wanted to make these more patient centred. We obtained a grant from the Diabetes Research and Wellness Foundation. Through the medium of puppet making and learning film skills the young people felt empowered producing their own educational film. Throughout the process, of four sessions spread over four weeks, the young people were supported by a multidisciplinary team consisting of consultant paediatrician, a specialist diabetes nurse, the deputy head of the Hospital school, a dietician, a team of professional puppet makers, and a film making expert. In addition to filming the actual process, the participants wrote and filmed their individual screenplays. There was opportunity to explore individual experiences and knowledge of diabetes in a fun, non-judgemental setting. Full consent was given by all attendees regarding the final distribution and use of the film.

Results The first of four sessions was a resounding success. Young people were desperate to attend the following sessions, altering schedules to ensure they could make them. During the process it became very clear they would like the film to be used as an educational tool. The response to the first viewing has given great verbal feedback and we are now in the process of collating formal qualitative data from the following groups: Children at the Royal Free Hospital School without diabetes, those with a new diagnosis and those who already have diabetes, which will be ready to be shared at the conference.

Conclusion Young people with diabetes embraced these sessions with huge enthusiasm. Having previously not known each other they quickly formed friendships and all actively took part, encouraging each other. They expressed and explored their knowledge in a relaxed environment, very different from clinic; given a rare and valuable opportunity to fully voice their opinions. At the same time, they loved the idea that the film productions they contributed to may go on to help other people.

For the professionals it was an incredibly inspiring experience and the film really does show diabetes through the eyes of the young people themselves.

G409(P) SAFETY CLIMATE & CULTURE A SURVEY OF PAEDIATRIC STAFF IN DISTRICT GENERAL HOSPITAL

S Kamath, A Khan. Paediatrics, Daisy Hill Hospital, Southern Health and Social Care Trust, Newry, UK

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Background Organisations working towards a culture of safety need a reliable measure to monitor the success of their initiatives. Using Safety survey tool, an organisation can gain information about the perceptions of front-line clinical staff.

Aim To gain information about safety in the clinical area and management's commitment to safety. The survey also provides information about how perceptions vary across Multi-disciplinary teams (MDT).

Method QI Working group carried out Literature search for safety climate and culture. RCPCCH –Safety survey was selected. Survey was pretested with a small group to ensure easy understanding and relevance. Survey was completed by MDT, medical, nursing, administrative and health care assistants in the Paediatric department.

Results 38 completed surveys received. Survey looked at Patient safety, Leadership, Staffing and communication. About 72% agreed that concerns were listened to by senior management. 76% agreeing that systems were in place to address concerns. 74% agreed that there was a medical and nursing leadership drive towards a safety centred organisation. Discussing errors at work was deemed easy. 72% felt that medical errors were handled appropriately. 65% received appropriate feedback about performance.

Conclusion This survey provided us in-depth information of safety culture within the department. It provided insight regarding various MDT's safety perception. We plan to address issues about error discussion. The Safety Awareness For Everyone i.e. SAFE initiative aims to reduce harm and improve safety.

REFERENCE

1. Safety Climate Survey. <http://primaris.org/sites/default/files/resources/Patient%20Safety/safety%20climate%20survey.pdf>

G410(P) SHOULD ACCIDENTAL ADMINISTRATION OF RESIDUAL ANAESTHETIC AGENTS IN INTRAVENOUS LINES IN CHILDREN BE CLASSED A 'NEVER EVENT'?

^{1,2}C Kanaris. ¹North West and North Wales Paediatric Transport Service, Warrington, UK; ²The Centre for Social Ethics and Policy, The University of Manchester, Manchester, UK

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General surgical and paediatric teams are increasingly required to share the responsibility of the postoperative care of children undergoing routine surgical procedures, they are therefore the first to be called should a child become unwell in the immediate postoperative period. With this in mind it is imperative to raise awareness of potentially catastrophic consequences following the administration of residual neuromuscular blocking agents that may linger in the intravenous line after the patients have returned from theatre.

Incident reports of patients accidentally receiving residual neuromuscular blocking drug in the intravenous line following an operation may be rare but it is a clinical problem with potentially grave sequelae and one not currently classed as a 'never event'

We review the literature on the incidence of such events and conclude that these are likely to be under-recognised and under-reported. We subsequently make a case of why these cases should be reclassified as 'never events'. Finally we make recommendations on, what procedures can be followed to minimise the incidence of such events.

G411(P) CAPTURING CHILDREN AND YOUNG PEOPLE'S VOICES: IMPROVING PATIENT-CENTRED PAEDIATRIC CARE

H L'Estrange-Snowden, S Gancarczyk, B Hopwood, J Pentelow. *Patient Feedback Team, Picker Institute Europe, Oxford, UK*

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Aims The intention of the survey was to provide actionable insight into the experiences of children, young people and their families when receiving care as an inpatient or day case admission at NHS trusts.

Methods The Children and Young People's Inpatient Survey was developed and piloted by Picker Institute Europe alongside specialist children's hospitals in 2010. Focusing on aspects of care that children reported as important, this survey has been extended to cover day case admission and licensed to the Care Quality Commission since 2014. Running for the second time in 2017, the Children and Young People's Inpatient and Day Case Survey is now a biannual part of the National Patient Survey Programme.

This survey was specifically designed to be engaging and child-friendly, containing three versions of the questionnaire: one for parents of children aged 0–7 years; one for children aged 8–11; and the other for 12–15 year olds. Whilst targeted at children/young people, the last two versions contained sections for parents/guardians to also provide feedback.

Results presented are from 71 acute NHS trusts in England. Each provided a systematic stratified sample (three age brackets, date of birth and gender), totalling 73 344 patients who received care between October and December 2016. Feedback was invited via postal questionnaire sent to patients' home addresses, followed by two reminders to non-responders.

Results An overall response rate of 26% (n=18,687) for eligible patients was achieved, of which 92% of children reported that overall they were (very) well looked after. Similarly 84% of parents felt that members of staff definitely provided information about their care and treatment that they could understand. However, 55% of children did not feel fully involved in decisions about their care and treatment, with 30% reporting that they did not always understand what hospital staff said and 22% not being able to fully discuss their worries.

Conclusions The survey provided a high level of actionable feedback, highlighting some areas of good performance, for example most children felt able to ask staff questions, as well as areas for improvement such as greater provision of emotional support.

G412(P) SHARING 'BEST PRACTICE' AMONGST TRAINEES AND TRAINERS TO OPTIMISE THE QUALITY OF PAEDIATRIC TRAINING

M Van de Vijver, P Prentice, O Wilkey, R Kainth. *London School of Paediatrics, RCPCH, London, UK*

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Aims The Paediatric Trainee Survey is performed annually in a continuing effort to improve paediatric training across the deanery by anonymously obtaining feedback from all Paediatric trainees about their experiences in training. Every year, this survey highlights a wide variation in quality and practice in training across the deanery. Therefore, this project aims to identify the local practice which makes certain trusts excel in their training feedback and distribute this information across the deanery with the goal of ensuring equal standards and experiences.

Method Using the 2016 Paediatric Trainee Survey, we analysed the quantitative results and identified the top three performing trusts for each of the selected five survey indicators. These indicators covered the following aspects of training; Induction, Internal and external teaching opportunities, management experience and training, clinical leadership training opportunities and teamwork and morale in the department. The College Tutors and Trainee Representatives for the identified trusts were contacted with specific questions related to their indicator to obtain information about their local practice. This information was collated and distributed on the Deanery bulletin and website and at Deanery training days with feedback obtained through discussions with trainees and trainers.

Results Feedback was obtained and analysed from the top performing trusts and common themes in local practices were identified for each of the five survey indicators. These themes were named 'Best Practice' and shared amongst the trainees and trainers in the deanery.

Conclusion This project has highlighted main themes in practices in five key aspects of Paediatric training which have been shared across the deanery to improve the overall standard and experience of Paediatric Training. Subsequent work is required to obtain the same information amongst the remaining survey indicators highlighted in the annual Paediatric Trainee Survey and in distributing these practices to other deaneries in the United Kingdom.

G413(P) NICU QUALITY IMPROVEMENT: MESSAGE OF THE WEEK!

SSK Dhulipala, TJ Bibby, P Heap, S Nedungadi, K Tanney, M Parr. *Neonatal Intensive Care Unit, Manchester University Hospitals NHS, Manchester, UK*

10.1136/archdischild-2018-rcpch.402

Aims Critical or High Level Incidents are unfortunately a part and parcel of clinical care, which we all strive to eliminate or at very least minimise. In most units, when they occur, an incident form is submitted online by the clinical staff involved. An investigation may be carried out, and the individuals involved receive feedback. Often, incidents recur due to poor awareness of past events, as disseminating information to different clinical teams is challenging.

To enhance awareness of NICU High Level Incidents, this large neonatal intensive care unit has sought out novel ways to disseminate feedback on incidents occurring, to improve clinical practice and maximise learning from adverse events or near misses. As part of improving knowledge of HLIs and the investigation outcomes, a middle-grade Risk Management role was created in May of this year, alongside the corresponding senior nursing roles.

Methods Since commencement of this QI initiative, the named Risk registrar acts as a liaison doctor, disseminating feedback