on a weekly basis to the medical team, through (P) production, email and discussion at communication meetings. Information given highlights recurrent themes, near misses and the learning points from recent HLIs. In tandem, nursing teams receive similar feedback about incidents relevant to the care that they provide.

**Results** In this 60-cot unit, 40 to 60 critical incidents are reported each month, demonstrating our culture of openness and education. Since May 2017, Messages of the Week have focused around medication errors (prescribing and administration), inter-specialty communication, discharge planning, documentation and WBITs (wrong blood in tubes.) There is a significant improvement in reported awareness of HLIs at all grades.

**Conclusion** As we strive to improve the quality of care that we provide for our NICU babies and their families, we must continue to explore novel methods of enhancing education and communication within our teams. With challenges in shift working and high turnover of staff in large neonatal units, disseminating a clinical risk Message of the Week to front-line working and high turnover of staff in large neonatal units, parents and their families, the aim is to identify fundamental principles. Our next stage is to explore these themes through multi-professional and parental focus groups with the aim of co-designing and implementing Always Events.

**REFERENCE**


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**Always Events: Lessons in Paediatric Care**

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Aims ‘Always Events’ is a framework of practice that aims to improve patient experience through positive goal-setting in a person- and family-centred approach. Through partnering with patients and their families, the aim is to identify fundamental behaviours that should be performed by the healthcare system for every patient, every time.

The aim of this study was to explore families’ experience of their inpatient journey to inform the development of Always Events guidelines with the ultimate goal of enhancing families’ experience of care.

**Methods** We conducted one to one structured parent interviews exploring aspects the parents or their child had experienced while on either the general paediatric or neonatal ward. The interviews and questions were designed to encourage open discussion focusing on the patients’ journey in the department from admission to discharge, aimed at identifying practices that could be integrated as Always Events. Responses were transcribed, collated and coded.

**Results** 23 interviews were conducted: 9 from the general paediatric population and 14 from the neonatal unit. The responses were positive, with all parents reporting a high level of care and appreciating being asked what mattered to them. Themes considered to be key in improving their experience included honest and informed communication (both staff to staff and staff to parent), collaborative and practical understanding of care (parental education, familiarisation of the unit before and during admission, and comprehensive discharge decision making), and the creation of a safe and comfortable environment. Parents on the neonatal unit also cited peer support as highly valuable.

**Conclusion** This pilot study highlighted the value of engaging families in establishing potential Always Events within the paediatric department. Two benefits emerged: firstly, parents enjoyed providing feedback and found the process rewarding; secondly, it identified valuable experiences relating to everyday care which could be explored further and used to develop fundamental principles. Our next stage is to explore these themes through multi-professional and parental focus groups with the aim of co-designing and implementing Always Events.

**REFERENCE**