and Physiotherapists. 17 projects have been submitted as presentations for the upcoming Irish Paediatric Association (IPA) Conference. In addition a further 10 projects are due for presentation at a variety of European Meetings in 2017, 1 project is now informing National UTI Guidelines and 1 project has been submitted for publication at a peer-reviewed Journal. In the year prior to the Research workshop initiative; 2 oral presentations and 9 (P) presentations were accepted at the IPA Conference. The feedback to date is overwhelmingly positive with Junior Doctors reporting greater support, interest and involvement in research.

Conclusions The workshops continue and have expanded to include the General Paediatric Departments of Dublin's 2 other Children's Hospitals. The opening of Ireland's new National Paediatric Hospital in 2022 will provide great opportunities for further development of the Academic Department of General Paediatrics.

The goal is that this initiative will contribute to a structured template for further Research workshops across all Paediatric centres in Ireland and provide a collaborative Network for General Paediatric Research in the future.

G187(P) SAFEGUARDING CHILDREN WHO DISPLAY SEXUALLY HARMFUL BEHAVIOUR- ARE WE UP TO SCRATCH? RESULTS FROM A MULTIAGENCY AUDIT

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10.1136/archdischild-2018-rcpch.182

Background Children and young people who develop sexually harmful behaviour (SHB) have usually experienced abuse and neglect themselves.¹ Multiagency procedures acknowledge that the perpetrators of SHB need active management to reduce the impact of on-going harm to themselves and others.

An LSCB audit in 2013 demonstrated that the needs of these children were not being recognised and procedures were not being followed.

Objectives Re-audit of management of alleged child perpetrators to establish whether guidance is being followed across 2 Local Authorities.

Methodology Children presenting as victims of sexual abuse during 2015 were identified where both victim and perpetrator were under 18. Cases analysed using the 2013 audit tool collecting data from health, children's services, police, Barnados, NSPCC and Youth Offending Services. Anonymised case histories were obtained from Children's Services to provide qualitative data.

Results Of 47 cases, there was an improvement in the number of strategy meetings/discussions with one LA increasing its numbers from 41% to 77%. There was also an increase from 75% to 86% in the other LA. However, there were 6 children across both LA's that did not have a strategy meeting or a discussion. One LA proactively involved YOS in strategy meetings to develop multiagency plans to protect children and enable them to return to school. However not all children benefitted from multiagency planning, some children reoffended and there was limited involvement by specialist services.

Conclusion Re-audit demonstrated improvement compared to 2013, however, services are still failing these children. Case studies demonstrated their complex lives and background of adverse childhood experiences. These children, despite having

the highest level of need can be the most challenging to help and engage. More should be done to meet the needs of this vulnerable group which may, in turn, help to transform the direction of their lives.

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G188(P) A SURVEY OF COMMUNITY PAEDIATRIC TRAINEES' CAMHS EXPERIENCE

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10.1136/archdischild-2018-rcpch.183

Aim It is difficult for Level 3/GRID CCH (Community Child Health) trainees to obtain mental health competencies in the curriculum. With Community Paediatrics facing increasing mental health challenges due to stretched CAMHS (Child and Adolescent Mental Health Service) services, the aim of our project was to survey the educational value of CAMHS posts for CCH trainees and ask: 'Are training posts in CAMHS of benefit?'

Method Two surveys were hosted on Survey Monkey; one for CCH trainees who had completed a training post in CAMHS and a second for those who had not. The surveys were distributed UK-wide via the BACCH Trainee Group and Regional Coordinators.

Results 18 CCH trainees who had not done CAMHS, and six who had, completed the survey. Four of the six CAMHS posts were split with community paediatrics. Feedback from these trainees suggested that this limited the educational value of the post. The two trainees who did a full-time CAMHS post rated their experience very highly and recommended the post. Trainees who had experienced CAMHS rated themselves as more confident at assessing for anxiety and depression and in risk-assessing for self-harm and suicide compared to trainees who had not. Average self-ratings for behaviour management, managing ADHD medication and recognising reactions to stress and bereavement were not clearly increased following the CAMHS posts.

Of the 18 CCH trainees with no experience in CAMHS, 50% reported that they planned to do a post in CAMHS. Of those who did not, 71% stated it was due to a lack of provision and 28% stated they had no interest in doing so.

Conclusion Most CCH trainees in the survey wished to have training in CAMHS and those who have, rated the experience highly. The educational value is limited by split posts. It is, therefore, recommended that deaneries develop full-time training posts for CCH trainees.

G189(P) CHILDREN WITH TRACHEOSTOMIES: THE IMPACT ON FAMILY LIFE

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10.1136/archdischild-2018-rcpch.184

Aim A tracheostomy is life-changing and brings many associated new challenges. This study offers an insight into the life of children with tracheostomies and the impact this has on them, their caregiver(s) and the family unit on a daily basis. We explore how they have coped with the transformation in their life and the issues important to them. Little is known to date about such families' experiences and quality of life once they have been discharged from hospital. Patient experience is being increasingly recognised as an important part of quality of care and as such we have a duty to allow our patients and their families express their views.

Methods In July 2015 all children with tracheostomies or who had recently been decannulated, in our Trust were identified. A letter was sent out to the identified eligible nine families in January 2016 inviting them to participate in this project by completing age appropriate questionnaires- Paediatric Quality of Life questionnaire, Strength and Difficulties questionnaire and Hospital Anxiety and Depression score and advising them that a follow up phone call would take place to offer them an opportunity to participate in a semi-structured face to face interview should they opt in to the project and want to participate.

Results Of the nine families contacted five agreed to the face to face interviews and six families returned the questionnaires. Interview data were transcribed and evaluated for emerging themes. Interpretative analysis was performed by the lead researcher, and independently analysed by a Clinical Psychologist for quality assurance. Themes were developed from the analysis and agreed upon by both researchers.

The main themes identified included adjusting to new roles, inconsistent care, effect on family relationships, present and future worries and coping with difficult decision-making.

Conclusion The study helped us gain a deeper understanding of what matters to these families and identify the following opportunities for improving care.

1. Multidisciplinary tracheostomy teams with allocated slot at one stop clinic for psychologist and social work to destigmatise these roles and meet families to ensure they know how to access these professions when required.
2. Opportunity to meet other families as standard.

British Association of Perinatal Medicine

G190

PATIENT SAFETY INCIDENTS IN NEONATOLOGY: A 10-YEAR DESCRIPTIVE ANALYSIS OF REPORTS FROM NHS ENGLAND AND WALES

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10.1136/archdischild-2018-rcpch.185

Introduction One in eight babies receive neonatal care in the United Kingdom. Neonates are vulnerable to patient safety incidents due to their immature physiology and requirement for highly intensive care. Patient safety is predicated on the ability to learn from unsafe care. This study is the largest analysis of neonatal patient safety incidents reports from England and Wales to identify the most frequent and most harmful incidents on neonatal units.

Methods The National Reporting and Learning System (NRLS) database receives incident reports from all NHS organisations in England and Wales. All reports submitted from neonatal units between 1 April 2005 and 29 December 2015 were analysed. Exploratory descriptive analysis identified relationships between structured data variables in NRLS, including: type of incident, reported reason for medication error, drug name, and severity of harm outcome. The most frequent or harmful relationships were discussed by a multidisciplinary team with patient safety expertise and knowledge of national guidance.

Results A 2.2-fold increase in reporting exists from 2006 (n=5,172) to 2015 (n=16,466). Of 1 25 832 reports, over one fifth (n=28,796, 22.9%) described harmful outcomes. Errors during delivery of a treatment or procedure were most frequent (23.3%, n=6,703) with 24.4% (n=1,636/6,703) describing extravasation injury. Medication errors accounted for one fifth of reports (21.9%, n=27,522/125,832) of which 13% (n=3,570/27,520) resulted in harm. Most frequently an omission of a medication or ingredient (21.3%, n=784/3,678), wrong or unclear dose or strength (18.5%, n=679/3,678) and wrong frequency (14.5%, n=534/3,678) were reported. Gentamicin (17.4%, n=3,196/18,395), parenteral nutrition (7.07%, n=1,301/18,395) and morphine (6%, n=1,112/18,395) featured most often. Severe harm outcomes resulted from incidents involving morphine (n=5), parenteral nutrition (n=2) and calcium-related medication (n=2).

Conclusion One in five reported safety incidents resulted in iatrogenic harm to a neonate. A quarter of incidents occurred during the delivery of a treatment or procedure. We have identified the most frequent and most harmful reported patient safety incidents involving neonates over a 10 year period. Further in-depth characterisation of reports is required to inform the design of preventive interventions, particularly incidents that persist despite existing patient safety interventions used in the past decade.

G191

CATCAM: A NEW SOLUTION FOR CONGENITAL CATARACT SCREENING?

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10.1136/archdischild-2018-rcpch.186

Aims Congenital cataract is the leading cause of childhood blindness worldwide; surgery before 9–10 weeks of age is necessary to optimise visual outcome. We investigated the accuracy of the Newborn Infant Physical Examination (NIPE) red reflex test in the detection of cataracts and compared it to CatCam, a novel hand-held infrared digital imaging device.

Methods We first reviewed the notes of all children having cataract surgery under 3 years of age over a 2 year period to determine how and when referral had occurred. Subsequently, we undertook proof-of-concept testing for CatCam in two populations: one of normal neonates undergoing NIPE screening, and secondly in an enriched population of children attending a tertiary paediatric ophthalmology clinic. Evaluation of ease of use and statistical comparison of diagnostic accuracy was made between CatCam and red reflex testing by direct ophthalmoscope (DO).