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

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

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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.

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CATCAM: A NEW SOLUTION FOR CONGENITAL CATARACT SCREENING?

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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).