**UNDERSTANDING PARENTAL EXPECTATIONS: THE STRUGGLES OF YOUNG PEDIATRICIANS (A SINGLE-CENTER EXPERIENCE)**

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10.1136/archdischild-2019-epa.161

**Introduction** As pediatricians, we rely considerably on the collaboration with our patients’ parents, especially in outpatient care. Parental attitude towards medical advice is an important aspect in compliance with treatment. As young pediatricians in training, we sometimes encountered difficulties in understanding the particularities of parental mindset.

**Purpose** We aimed to explore several hypotheses that might lead to parental communication problems in our clinical practice. Also, we were interested in testing several factors we assumed influenced the attitude of caregivers toward their child’s pediatrician, such as online mass media and online discussion groups.

**Material and methods** We carried out a cross-sectional survey addressed to parents that sought medical care for their child at Cluj-Napoca Emergency Children’s Clinical Hospital. The parents were asked to fill in a printed or an online questionnaire with topics regarding their satisfaction after the medical consultation. Through the questions, we tried to ascertain if they felt sufficiently informed and reassured about their child’s condition and its course, if they needed more medical information about the treatment, if they had any reservations or mistrusted the prescribed treatment and how much of this influenced their compliance to the treatment. Through this, we aimed to understand the factors that make parents seek additional advice and where they go to find it.

**Results** Parental attitudes towards healthcare professionals seem to be influenced by internet-facilitated access to unprocessed medical information. Additionally, social media platforms likely represent the preferred framework to express opinions.

**Conclusion** We believe that understanding the expectations of our patients’ caregivers is of utmost importance in order to gain their trust and to build a relationship based on mutual understanding. It is our opinion that complementary to medical education, young pediatricians could benefit from counseling and training in communication skills, ultimately becoming better professionals.

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**OUT WITH THE OLD, IN WITH NEW: ARE WE STILL HESITANT IN IMPLEMENTING THE NEW NRP 7TH EDITION GUIDELINES TO DETERMINE INITIAL ENDOTRACHEAL TUBE INSERTION DEPTH FOR OROTRACHEAL INTUBATION**

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10.1136/archdischild-2019-epa.162

**Introduction** It is quite challenging to insert & accurately position Endotracheal tube (ETT) in preterms. Mal-positioned ETIs are associated with complications like hypoxaemia, pneumothorax and right upper lobe collapse. In addition, adjustment of incorrectly placed ETIs requires additional handling of the infant, exposure to radiation and potentially increased risk of infection.

**Aim** To determine the chance of error of the ‘6cm+birth-weight’ guide for calculating orotracheal-ETT position and further review the compliance with new ‘tip-to-lip’ guidelines on a national scale.

**Method** Three years retrospective data of pre-terms (<32 weeks), requiring intubations, was collected from various hospitals. These hospitals used ‘weight+6 cm’ as a guide for orotracheal intubations. Using the Radiology database, chest X-ray PA view of the first intubation, was considered as our standard to check optimal (T1-T3) and sub-optimal (above T1&below T3) ‘tip-to-lip’ ETT position. Data was then analysed based on birth-weight and categorised as follows: 500–1000 g and 1000–2000 g.

The results then prompted us to conduct a telephonic survey of 18 hospitals across Ireland, providing level 1–3 neonatal services. Paediatrics/neonatal registrars were contacted by phone to answer a five question survey regarding the current practice of calculating ‘Tip-to-Lip’ insertion depth of ETT in pre-terms at their hospital.

**Results** We found that as birth-weight decreases, the percentage of error (when using ‘birth-weight+6 cm’ as a guide), increases. For birth-weight between 500–1000 g, our results showed a 58% (22/38) error in tube insertion depth, this decreased to 50% (11/22) for neonates between 1000–2000 g.

The results from the telephonic survey were as follows:

<table>
<thead>
<tr>
<th>Method of insertion</th>
<th>No. of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight + 6 cm (8th ed. NRP)</td>
<td>8</td>
</tr>
<tr>
<td>NTL + 1 cm (7th ed. NRP)</td>
<td>2</td>
</tr>
<tr>
<td>7th ed. NRP (Consultant preference)</td>
<td>6</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
</tr>
</tbody>
</table>

**Conclusion** It is concluded using ‘weight+6 cm’ guide is less reliable and gives a higher chance of error in pre-terms <1000 g. Our survey showed that 55% of hospitals across Ireland still haven’t adopted the NRP 7th edition guidelines. The remaining hospitals though using NRP 7th edition, only 2/8 have specified the method implemented.

**Recommendation** All hospitals should follow the new NRP ‘Tip-to-Lip’ insertion depth guidelines for oro-tracheal intubation to reduce the likelihood of error. There should be intra-departmental unanimity on implementation and documentation of specified methods to make it easier for future studies on accuracy of different methods. Practical simulation based sessions should be conducted in every hospital to propagate more awareness & to enhance intubation skills of health care professionals.

**IL1-β LEVELS AT PRESENTATION WITH PAEDIATRIC MILD TRAUMATIC BRAIN INJURY ARE HIGHER IN CHILDREN WITH PREVIOUS MILD TRAUMATIC HEAD INJURIES**

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10.1136/archdischild-2019-epa.163

**Aims** To evaluate end components of the innate immune system, the inflammasome, in mild Traumatic Brain Injury (TBI),
Improve paediatric team handover: a quality improvement project

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10.1136/archdischild-2019-epa.164

Introduction The importance of good communication during transition of care is well recognized. Poor handover has been linked to serious patient harm. Paediatric team handover at shift change was identified as an area in need of improvement. Therefore, a project was designed to look at the current paediatric team morning handover practices and to improve the overall quality of clinical handover.

Aims The objective of this quality improvement project is three-fold: 1) To assess the quality of current handover practices, 2) To improve handover using ISBAR communication tool, and 3) To re-audit clinical handover implementing changes.

Methods An assessment was performed to establish current handover practices. Paediatric team handovers at shift change from 01/08/2018 to 31/08/2018 were assessed. Daily handover sheets and attendance log-books were reviewed to determine the number of admissions, number of handover sheets and handover duration in minutes. The primary intervention involved education on the ‘ISBAR’ communication tool. Formal training was provided for consultants and non-consultant hospital doctors (NCHDs) explaining the ‘ISBAR’ handover communication tool. An ‘ISBAR’ handover form was implemented. Handover was re-audited from 01/09/2018 to 30/09/2018 to assess changes in practice. A prospective daily log of the number of hospital admissions, number of handover sheets and handover duration was recorded.

Results A baseline assessment of the paediatric team handover pre-intervention in August 2018 showed that the median number of admissions overnight was 5, the median duration of verbal handover was 23 minutes and written handover involved a median of 3 A4 landscape pages. Following implementation of changes to current handover practices, the median number of admissions overnight in September 2018 was 5, the median duration of verbal handover was 14 minutes and written handover involved a median of 2 A4 landscape pages.

Discussion The initial assessment revealed the paediatric team handover failed to comply with national clinical guidelines. There was no use of a standardized template, handover content was variable, important information was often omitted and irrelevant information was included. In summary, this study improved the quality of clinical handover by incorporating a standardized template and by providing NCHDs formal training in handover communication skills.

Conclusion Introducing the ‘ISBAR’ communication tool improved the quality of paediatric morning handover and overall efficiency of communication. Identified areas for ongoing improvement include reducing interruptions, ongoing training/education, incorporating a multidisciplinary approach and regular re-auditing.