methods if initial intubation is unsuccessful. Video laryngoscopy (VL) may allow faster time to best view and better views compared to direct laryngoscopy (DL) during intubation of the anatomically normal neonate.² Furthermore, VL can be effective for training purposes allowing real time feedback from senior colleagues and quicker acquisition of intubation skills.³

Objectives The primary objective is to educate paediatricians to use VL. The secondary objective is to assess change in opinions and confidence in VL following simulation training.

Methods Within a district general hospital, 17 participants including 12 paediatric trainees and 5 non-trainee participants (consultants, physicians associates and medical students). Each participant completed a pre and post simulation questionnaire, which included assessment of prior VL education and experience, understanding of planning for failure and confidence in VL technique. Low fidelity simulation training of VL (MacGrath) and airway adjuncts was undertaken by paediatric and anaesthetic colleagues.

Results Of the participants, 8/17 (47%), including only 3/12 (25%) of the trainee group, had received previous training in VL, and 5/17 (29.4%) had previously used VL during real time intubation. In the pre-education group, 4/17 (23.5%) preferred initial intubation attempts using VL, which increased in post education group to 8/17 (47%). In the pre-education group, 6/17 (35.2%) stated they would choose VL for second intubation attempt, which increased in the post-education group to 15/17 (88.2%). In the pre-education group 4/18 (23.5%) stated they would be confident in using VL for second intubation attempt, which increased to 13/17 (76.4%) in the post-education group.

Conclusions VL is a beneficial tool for neonatal intubation and non-invasive surfactant administration, and is a useful for allowing real-time feedback on the procedural skills from a supervising senior. In our study, we demonstrated that VL training and experience wasn't extensive, and following a short education programme, confidence and enthusiasm for VL increased.

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ADVERSE CHILDHOOD EXPERIENCES (ACEs) AWARENESS: A TRUST-LEVEL EVALUATION

Vivien Wong-Spracklen, Susan Ozer, Inyang Takon, Vinod Tyagi, Sarah Corrigan. *East and North Hertfordshire NHS Trust*

10.1136/archdischild-2021-rcpch.345

Background Adverse Childhood Experiences (ACEs) are events that can potentially cause lasting adverse impact in later life. By identifying ACEs early in the course of a child's clinical encounter, healthcare members are in positions to help direct appropriate support to the child and family.

Objectives To measure ACEs-awareness levels among healthcare staff dealing with children. To identify barriers preventing healthcare staff from identifying and proactively implementing interventions when encountering ACEs in clinical practice.

Methods A questionnaire survey, held over 7 weeks, was sent to medical staff in acute paediatrics, neonatology, community paediatrics, emergency medicine, and acute maternity services. Email invitations to a GDPR-compliant survey platform was distributed, upon approval from various departmental safeguarding leads. Results were consolidated and analysed using Excel software. Respondents from CAMHS were excluded due to CAMHS operating under a different trust.

Participants were asked about their current awareness of ACEs and their confidence levels using ACEs in their daily clinical practice; where they had received their ACEs-training; and whether they were keen to attend ACEs-training. They were also asked to select from a list, what would be classified as ACEs.

Results 87 responders out of 283 invites (31% response rate) were received. 38 responders (44%) were Nursing staff, 7 (8.0%) were Midwifery staff, 16 (18.5%) Consultants, 2 (2.3%) associate specialists, 15 (17%) specialty registrars, 5 (5.7%) senior house officers, 1 (1.1%) foundation doctor, and 3 (3.4%) allied health professionals (dietician, health play specialist, and advanced nurse practitioner).

Most respondents, 34 (39%) had never heard of ACEs. Only 12 (14%) respondents were confident in applying ACEs in clinical practice.

When shown a list of social circumstances and asked to identify which were ACEs, 75 (86%) correctly identified all ACEs in the list. ACEs that were least recognised by responders were 'Migration' (78, 90% had correctly identified this ACE), 'Parental mental ill-health' and 'Bereavement' (82, 94%).

75 (86%) respondents were unaware of ACEs-training in the Trust. 71 (82%) had never attended ACEs-training before. Of those who did (16; 18%), cited ACEs-training were from Online modules, safeguarding training run by the Local Authority, Royal College of Paediatrics and Child Health Level 4 training, or regional paediatric study days, and trust induction.

79 (91%) respondents expressed eagerness to attend ACEs-training. Of the respondents who expressed 'No,' (8, 9%), reasons were: 'Different priorities,' 'Unsure of benefits,' 'Covered in safeguarding,' and 'A trauma-informed approach rather than the ACEs model, is better.'

Conclusions ACEs-awareness among healthcare staff working with children is suboptimal, but staff showed eagerness to learn about ACEs. This positive attitude should be further developed by incorporating effective, relatable training sessions either through in-house training, leaflets and posters to raise awareness of intervening and preventing ACEs, or via online Trust or external continuing professional development (CPD) providers' Learning Modules. As a result of our study, ACEs-training was introduced in Safeguarding induction and training. With more frontline awareness, it is hoped that protective, resilient factors that will help counteract the impact of ACEs can be implemented promptly, into the lives of affected children attending health services.