Doctors used procedure stickers significantly less often than ANNPs (2/7 vs 9/9, 29% vs 100%, P value < 0.01) with paralleled fall in full data documentation

Conclusions The marked improvement in documentation quality when the procedure stickers were used, leading to better compliance with BAPM framework standards, demonstrated how simple interventions can contribute to patient safety.

Certain areas however continued to be poorly documented. In several patients this included not detailing whether both lumens aspirated, which had been specifically highlighted as a risk in the previous safety alert. Other less well-completed areas included those which could not be completed at the time of the initial procedure, such as any line adjustments made after radiological studies, highlighting the importance of returning to the notes to complete documentation even at the later stage.

ANNPs demonstrated much better compliance with sticker use and completion. This may reflect that they were directly involved in the sticker conception and design or that they are permanent staff, whereas the doctors regularly rotated to different areas and units.

Despite improvements, continued education (especially of doctors) is needed to ensure that the sticker is used in full by all relevant team members.

British Association of Perinatal Medicine and Neonatal Society

1631

A NATIONAL SURVEY OF VOLUME GUARANTEE VENTILATION IN LEVEL 2 AND 3 NEONATAL UNITS IN THE UK

¹Rebecca Evans, ²Ashlea Norton, ¹Arindem Mukherjee, ¹Anupam Gupta. ¹St. Mary's Hospital, Manchester; ²Royal Manchester Children's Hospital, Manchester

10.1136/archdischild-2021-rcpch.758

Background NICE guidance (NG124, 2019) recommends volume targeted ventilation as the first line of invasive ventilation in preterm infants. Volume Guarantee[®] (VG) Ventilation is one of the hybrid modes which incorporates sophisticated algorithms of traditional time cycled pressure limited technology to minimise volutrauma. While it has facilitated volume targeting by helping to deliver a desired tidal volume, its unfamiliarity has created a new set of problems.

As a 'microprocessor technology rich' mode, VG[®] is often prone to 'failure' requiring a switchover to conventional mechanical ventilation. There is limited understanding of these events.

Objectives To survey usage of VG[®] in the UK neonatal units to improve our understanding of this mode of ventilation.

Methods An online national survey of Level 2 and 3 units was conducted to evaluate senior neonatal and paediatric clinicians' experience and confidence with using VG[®]. We also carried out a local departmental survey to gain perspective of senior nursing, ANNPs and junior doctors.

Results We sent questionnaires to consultants and senior registrars in 63 tier 3 units and 82 tier 2 units in the UK and

received 179 responses. Locally, we received 24 responses from our nursing and medical team.

Nationally, while 100% were aware of the VG[®], only 29% of the respondents correctly identified volume targeted ventilation is in keeping with recommendations from NICE guidance NG 124. 83% and 74% of clinicians from level 3 and level 2 units respectively advised the default mode of ventilation in their unit is VG[®]. Of the units who use VG[®], 69% use it in conjunction with AC/SIPPV as opposed to 31% with SIMV. 20% of clinicians rated their confidence levels below 8 (10 being very confident and 1 being not confident at all) with its use.

39% reported experiencing 'failures' >10% of the time. The common reported reasons for 'failure' were a large ETT leak and flow sensor errors. Commonly cited reasons for not using VG[®] were: lack of experience, lack of suitable ventilators, not enough educational resources, and desirability to keep the type of ventilation used consistent in the unit.

Our local survey indicated that 30% of our staff rated their confidence in using VG[®] at less than 8 out of 10. An intra-unit variability in practice was also observed, with 61% of clinicians reporting they use VG[®] with PC-SIMV and 39% use VG[®] with PC-AC/SIPPV. 61% of the local respondents reported experiencing VG[®] 'failure' >10% of the time.

Conclusions The majority of senior clinicians continue to consider VG[®] as synonymous to volume-controlled ventilation. In spite of the majority of the units using it as a default mode, the concerns about the unpredictability due to frequent 'failures' remain. These unpredictable failures need to be addressed by well-designed studies to help clinicians not only prevent but also manage these failures.

Young People's Health Special Interest Group

1633

EXPLORING THE EXPERIENCE OF ADOLESCENTS IN A PAEDIATRIC EMERGENCY DEPARTMENT – TOO OLD OR TOO YOUNG?

Kathryn Mullan, Elizabeth Dalzell, Rosaleen Manning, Stephen Mullen. RBHSC

10.1136/archdischild-2021-rcpch.759

Background In paediatric emergency medicine (PEM), the age of transition from paediatric to adult emergency care is variable across countries. The UK has no agreed national standard on ED age limits and this arbitrary upper age limit is often set locally by commissioning groups reflecting service capacity and the population in which it serves. In Northern Ireland, adolescents often fall into the adult domain, with the regional paediatric emergency department (PED) catering for children up to fourteen years of age.

However, in response to Covid-19 surge planning, the PED age limit increased to age sixteen. This decision marked significant progress in the regional strategy to shift paediatric services to 'a target transition stage of sixteen' as well as coinciding with the NHS Long Term Plan to move towards 0–25 service models. Our retrospective survey aims to explore