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

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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?

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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

the experience of young people in the PED during this time and their preferred setting to receive care.

Objectives To determine the satisfaction reported by adolescents when visiting a PED and elicit the acceptability of both paediatric and adult services in this age group.

Methods A prospective 10-point survey was developed to assess adolescents' overall satisfaction with their PED experience as well as their views on the waiting room setting, clinical treatment areas and staff. Data was collected over an eight-week period from adolescents aged fourteen and fifteen attending PED. The survey was administered at point of discharge or admission to hospital and completed anonymously. A 5-point likert scale was used to gauge the experience of adolescents with the addition of a free text response to allow for further comments on patient experience.

Results Fifty-three patients completed the survey with 99% rating their overall experience as good or better. The majority of participants were not known to paediatric services (85%). 43% of respondents had attended an ED in the previous twelve months of which eleven had previously attended an adult ED. Over half of these patients (55%) preferred the paediatric setting. Conversely, 70% of those who previously attended a PED wished to continue to be seen in this setting. Common themes included reduced fear and anxiety in PED, as well as the perception that paediatric staff have a better understanding of needs. Additionally, adolescents with specific needs expressed a lack of readiness to attend adult services with concerns surrounding lack of familiarity and challenging sensory environments.

Conclusions The majority of adolescents surveyed showed preference for the PED with environment and communication approaches identified as influencing factors. Our study highlights the importance of considering the needs of the adolescent as distinct from those of young children and adults. Wherever emergency care services are delivered to young people, providers should strive to provide an 'adolescent friendly' environment to meet physical, emotional and psychological needs. Clinical need, service capacity and individual choice should be considered in future decision-making tools to determine the setting in which emergency care is delivered.

1634

BRIDGING THE GAP: AN INNOVATIVE APPROACH TO HEARING THE VOICES OF OUR LOCAL YOUNG PEOPLE

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Background Adolescents have specific and defined healthcare needs yet often fall between the current provision of paediatric and adult healthcare services. Adolescents account for 36% of Emergency Department (ED) attendances and 20% of inpatient care,¹ yet compared with older adults, adolescents report being less satisfied with their care, feeling less involved with their care, and less likely to feel they are treated with dignity and respect.²

In 2018 a needs analysis was conducted by Young Harrow Foundation (YHF) in collaboration with the ED with the aim of improving the experiences of young people (YP) attending

hospital.³ Building on this, based on a concept piloted between YP in Hackney and the Metropolitan Police looking at Stop and Search processes, the Bridging the Gap Youth Committee has been established. This 12-month project brings together local YP with ED and Paediatric staff, facilitated by the Young Brent Foundation (YBF), to discuss the challenges faced by both groups within the hospital environment.

Objectives

- To provide YP and staff with a forum to discuss care for adolescents and young adults within the ED.
- To foster understanding between the two groups.
- To use the forum to develop solutions to challenges faced by YP, with a view to improving care.

Methods Local YP were invited to participate through links with YBF, Young Harrow Foundation (YHF) and the St. Giles Trust with which the ED work closely. Monthly two-hour virtual roundtable sessions are planned to operate from February 2021. The structured sessions are recorded and include an ice-breaker, communication exercises and breakout rooms in order to encourage honest dialogue and interaction with a focus on challenges both groups face within the hospital environment. Parties are encouraged to create an innovative model of working with YP leading to positive engagement and sustainable relational opportunities.

Results Our first roundtable event was attended by 15 staff and YP. The following themes were identified:

Work pressures:

Adolescent participants recognised the pressures faced by staff working in the ED environment and how this can create potential barriers to good patient care and, in particular, effective communication.

Trust:

A number of reasons for a lack of trust in professionals were raised, including occasions where confidentiality may have to be breached for safeguarding purposes.

Communication:

Differences in language used by YP and healthcare professionals were identified an obstacle to good communication.

Conclusions Adolescents' experiences of healthcare are affected by unexplained waits, difficulties with understanding and a lack of trust in healthcare professionals.

To broaden the scope of discussions and reduce the risk of engaging 'professional patients' with prior experience of health improvement work, YP will be recruited via the hospital-embedded youth worker service.

Means to improve the relationship will be fed back to hospital staff during departmental teaching, awareness events and via adolescent working group meetings. Adolescent-specific information and resources will be promoted, and a Young People's Charter setting out the rights of YP using the service will be created. Listening to the voices of young people is fundamental to the success of future policy design and practices.

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