Quality Improvement and Patient Safety

**679 BEYOND THE DRUGS – WHAT DO WE NEED? USING MULTIDISCIPLINARY SIMULATION TO LEARN HOW TO SAFELY FACILITATE RADIOLOGICAL IMAGING FOR VENTILATED NEONATES**

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**Background** Prior to 2019, magnetic resonance imaging (MRI) for ventilated neonates was not undertaken at our trust. Instead, a dedicated neonatal transport team would transfer the patient to the tertiary centre for imaging and then repatriate the patient. Due to the intensity of resources required for this 40 minute procedure, it was proposed that the teams and facilities at our trust should facilitate this instead. Training on using the transport incubator is provided at induction and team members are designated on the day to assist. Previously, the procedure has taken over 4 hours to complete.

**Methods** A multi-professional, inter-specialty in-situ simulation was delivered whereby a ventilated neonate was transported from the neonatal unit to MRI. The neonatal and radiology team were briefed and were asked to stay in their normal roles. Once the scenario was completed, the team were debriefed using a diamond debrief model and written feedback was requested to obtain qualitative and quantitative responses.

**Results** There were 6 candidates from the neonatal and radiology department. Reflective comments were overwhelmingly positive, with candidates explaining how the simulation helped to understand each other’s roles or ‘the strengths and failings in our common knowledge’. Candidates commented how this simulation had improved their confidence, with the average confidence score in managing this scenario increasing from 3.33 (where 1 is very low confidence to 5 as very high confidence) to 4.5. Two candidates suggested that equipment stocks needed to be re-evaluated e.g. MRI compatible ventilators and two others suggested formalising the process into a checklist or protocol and then running the scenario again.

**Conclusions** This simulation demonstrated why simulation based education is key to identifying latent threats and knowledge gaps due to systemic flaws. Since conducting this simulation, several changes have been made to the process in line with the candidates feedback. From a neonatal perspective, a checklist is being ratified as well as a laminated instruction card on how to set up the transport incubator. The MRI team collated key action points and have circulated them to those working with paediatric patients. Overall, the simulation has established a better communication channel for both teams to liaise with each other to improve the patient experience and safety. We aim to run this scenario again when all these interventions have been approved for use.

**Association of Paediatric Palliative Medicine**

681 **BEYOND THE DRUGS – PARENTAL PERSPECTIVES ON MANAGING MULTIFACTORIAL PAIN IN PAEDIATRIC PALLIATIVE CARE**

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**Background** Management of pain in Paediatric Palliative Care can be complex and challenging, and for some children, a single pharmacological agent is not enough. This may be due to the coexistence of several types of pain; difficulty tolerating medications; difficulty describing the pain; and emotional or behavioural overlay. Managing these symptoms is challenging for the child, their carers, and healthcare professionals alike.

**Objectives**
- To explore the parental experience of multifactorial pain in children with palliative care needs.
- To identify effective communication techniques with children with multifactorial pain, and their parents.
- To review the management of multifactorial pain, both pharmacological and non-pharmacological.

**Methods** A case-series of children (3 girls, age-range 2–8 years) known to the children’s hospice, with complex multifactorial pain were identified. Through an 8 item qualitative questionnaire allowing free-text entry, patient and family experience of pain, coping strategies, and communication techniques were explored. For each case, pharmacological and non-pharmacological methods of pain control were explored. A general inductive approach was used for thematic analysis.

**Results** Themes identified were:

- **Honesty** between children, parents and healthcare professionals. One child was very anxious about leaving her mother when she died. Her mother said ‘she keeps telling me that she doesn’t want to leave me, but we are not religious and I’m not sure what to say’. Age-appropriate communication about the end of life helped to reduce her agitation.

- **Listen** to parents about signs of pain. **Believe** parents if they say their child is in pain: ‘Even if you don’t see the pain, don’t discount it.’ Being made to feel like they are ‘making up’ pain, is frustrating and demoralising. One parent was told – ‘this type of tumour isn’t painful’.

- Being able to respond to breakthrough pain is empowering for parents. So is **advocating** for their child: ‘Whilst I have no control over the fact that she will die from this in the near future, I can advocate for her to be as comfortable as possible, with as little pain and as little emotional distress as possible.’

The value of **distraction**, but also the awareness that this may be challenging to provide at home. Limiting sensory