

safety increased from 1/5(20%) to 5/5(100%). Satisfaction increased from 2/5(40%) parents to 4/5(80%).

Staff actively exploring a child's needs with parents was particularly effective. The proportion of surveyed staff reporting exploring a child's needs with parents increased from 2/7 (28%) to 6/9(66.6%). Post-intervention, 4/5(80%) parents felt listened to about their child's needs, and that adaptations were made.

Graph 2 shows PED staff survey results. Staff reporting 'no confidence' to assess and manage autistic children dropped from 3/18(16%) to 0/16(0%). Most staff reported

'neutral' confidence post-intervention.

Conclusion Our data suggests a multi-disciplinary and co-produced QI can improve the experience and safety of autistic children in PED. Staff exploring sensory/behavioural needs with parents was the most effective intervention. We are continuing measurement monthly to ensure sustainability and are disseminating our findings.

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A SIX-YEAR REVIEW OF DEATHS, A DISTRICT GENERAL HOSPITAL'S EXPERIENCE: REFLECTION AND LEARNING

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Objectives Neonatal and paediatric mortality has remained a challenge worldwide, despite significant improvements in antenatal, neonatal and paediatric care. Case reviews and acting on lessons learned remain a powerful training tool in paediatrics.

This is a single centre, retrospective review of all neonatal and paediatric mortality cases in order to identify common risks, modifiable factors and learning points that contribute to these cases. Examples of good practice were also identified and promoted.

Methods All neonatal and paediatric mortality case reviews over 6.5 years from January 2017 to June 2023 were identified. In each case the patients age, cause of death and reported learning points were identified. The learning points were reviewed for each case to identify common themes.

Results The cohort included 34 cases, including 19 neonates, 8 infants (1 month to 2 years of age) and 7 paediatric patients (2 years to 18 years of age). Therefore, 56% of the mortality cases were neonatal and 44% were paediatric. The trend in paediatric deaths was between 1–4 deaths per year, with no clear change over time. Neonatal deaths were static apart from one surge. This related to an increased incidence of extreme premature deliveries in that year.

The common modifiable factors identified in neonatal mortalities included delay in securing an effective airway (42%), hypothermia (26%) and delay in antibiotic administration (21%). The main factor implicated in paediatric mortality was the delay in recognition and acting upon shock or sepsis. Other learning points included inaccurate or incomplete documentation, difficulty in contacting the Coroner, delay in contacting Toxbase and not considering muscle relaxants in cases of ecstasy overdose.

Conclusion This study demonstrates that the neonatal period is the most vulnerable time for a child's survival. Technical and practical difficulties were not uncommon in neonatal deaths, including difficulty establishing a secure airway as well as establishing intravenous access to administer antibiotics in an appropriate timeframe. Clinical acumen and knowledge is needed for early diagnosis of shock and sepsis. Following policy, such as contacting Toxbase, or a Coroner, appropriately were identified learning points. The department has introduced a training program using simulation methods and introduced new equipment such as a video laryngoscope to help reduce these identified risks and modifiable factors. Effective communication with maternity for early transfer of extreme preterms to a level 3 unit remains important.

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HOW DO FAMILIES MITIGATE PAEDIATRIC SAFETY INCIDENTS IN EMERGENCY DEPARTMENTS? A MULTI-METHOD NATIONAL ANALYSIS OF INCIDENT REPORTS

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Objectives Healthcare-associated harm is an international public health issue.¹ Children are a particularly vulnerable group, with 15%–35% of hospitalised children experiencing harm whilst receiving medical care.² Whilst many factors increase the risk of adverse events, such as a child's dependency on others to recognise and respond to illness, children have a unique protective factor in the form of their parents (guardians and families), who are well placed to detect and prevent unsafe care. Martha's Rule highlights the need to more effectively enable parents to function as safety advocates.³

We aimed to characterise the role of parents in mitigating patient safety incidents involving children within Emergency Departments.⁴

Methods Free text of patient safety incident reports submitted from Emergency Departments in England and Wales between 2014–2020 to the National Reporting Learning System (now the Learning from Patient Safety Events Service) were searched for terms like *parent*, *dad*, and *mother*. We were provided with 12,300 reported and created a weighted sample of 4000 reports.⁴ Two trained paediatricians and a general practitioner reviewed reports which were included for analysis if there was clear evidence in the narrative of parental involvement directly related to the reported incident. Reports were systematically coded using the Patient Safety (PISA) classification system.⁵ An inductive thematic analysis in NVivo informed the development of a mitigatory factor framework. An exploratory descriptive analysis identified the most frequent semantic relationships between type of incident, mitigating factors, and harm outcomes.

Results A total of 1065 (27%) reports were included for analysis. Parents were involved in mitigating incidents in over two thirds of reports (714, 67%). The most common mitigatory factors included: 'family advocates for child', 'parent expresses concern about care given', and 'family chases healthcare

appointment'. The most frequent incidents with parental mitigatory factors related to diagnosis and assessment (157, 22%), e.g., a missed diagnosis, medication (150, 21%), e.g., wrong medication prescribed, and treatment (89, 13%), e.g., insufficient treatment given. In 229 (32%) of these reports, parents prevented harm or further harm.

Conclusion Parents play a key role in preventing safety incidents and harms when their children receive healthcare in Emergency Departments. Identification of mitigation factors within incident report narratives will support health systems to identify where they should investigate further or intervene to improve safety. Our analysis has identified priority areas to enable the co-development of recommendations and strategies to deliver safer paediatric care and support parents as child safety advocates.

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TERTIARY PATIENT COMMUNICATION: MORE THAN JUST A TWO-WAY STREET

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Objectives Digital transformation of the health service is a priority for the Department of Health and Social Care and NHS England.¹ Parents and young people want to access advice and services quickly and easily.² Technology should be used by providers to reach out to other providers and by patients to enable them to obtain quick access to advice.³ The use of apps and digital tools to empower patients, parents and carers in sharing decision-making and taking a more active role in their health and care has been encouraged.^{2 4 5}

Aims A service evaluation of the messaging functionality of the online patient portal (integrated with the electronic patient record) for communication between staff and patients/parents/carers with their specialist clinical team. Aims were to identify message themes; understand message pathways and response/resolution times; consider how to optimise the service, clinical care and patient experience.

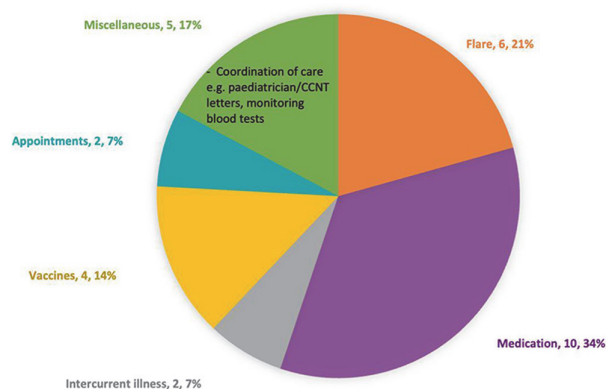
Methods Analysis of messages received into separate pooled inboxes for rheumatology registrar, clinical nurse specialist (CNS) and administration groups during a typical working week (13–17th March 2023).

Results Registrar messages (29) –

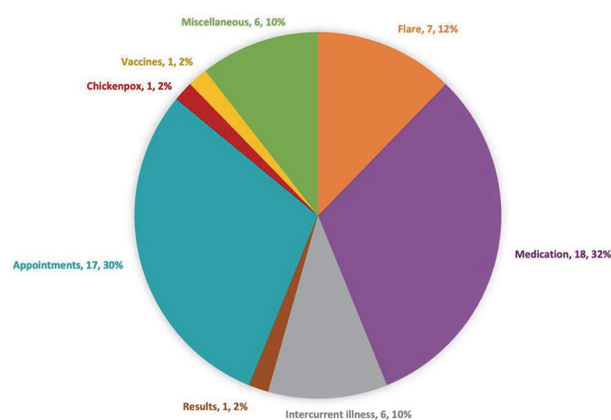
- Predominantly from patients with juvenile idiopathic arthritis (62%)
- Reasons: medication issues (45%), disease flare (29%), tests (13%), results (7%), appointments (6%)
- 28% led to further contact with patient/parent (7% telephone advice) or care team (7% review with specialist team, 14% liaison/review with local team)
- 21% re-directed to MDT colleagues (e.g. CNS, physiotherapist, pharmacist, consultant)

- 79% actioned in <2 days
- CNS messages (29) –
- Majority (34%) about medication issues (graph 1)
- 41% resolved by CNS
- Remainder re-directed to MDT (e.g. all medication requests/queries to consultant/SpR/pharmacist as appropriate)
- 83% actioned in < 2 days
- Admin messages (57) –
- Cumulatively large volume
- Various reasons (graph 2) including 48 (84%) clinical queries requiring redirection to MDT (often to two/more clinical groups), resulting in 63 onward messages (1.3x amplification)
- 93% actioned in < 2 days

Conclusion This preliminary work demonstrates utility of the patient portal for rheumatology service users to communicate health and disease management issues with the team. Overall, messages were handled promptly. However, there is scope to improve efficiency – avoiding duplication of message processing and delays from unnecessary re-routing. Work is underway to refine a proposed flowsheet for message triage and action within the team, as well as revision of the Rheumatology FAQs leaflet and information online. Satisfaction of involved stakeholders will be surveyed before and after implementing changes; and impact on patient/parent/carer engagement and healthcare experience will be further evaluated.



Abstract 6676 Graph 1 Reason for CNS Message



Abstract 6676 Graph 2 Reason for admin message