

Design/Methods: On 3/09, 3 experts in the field (Drs. P Thureen, CL Berseth and J Higuera) and 100 neonatologists from 25 countries were invited to participate.

Guidelines for consensus process, literature search and future preparation of educational material and authorship were developed, reviewed and agreed by all. Participants from different countries were distributed in 12 groups, which interacted and worked together for 5 months to answer 3-5 questions of clinical/physiological relevance, reviewing all global literature and local factors. Answers were received, collated and reviewed by 2 coordinators and the 3 experts. On 9/09 participants and experts met in Cusco, Peru for 6 hours (with lectures by experts, presentations by groups, discussion, and all literature available)

Results: 49 neonatologists participated. Presentations by each group and general discussion in a collaborative forum were used to develop a consensus regarding nutritional management of the newborn and to recommend strategies. The final consensus summary will be published, posted on the web and circulated through thousands of units in Iberoamerica.

Conclusions: This 3rd SIBEN Consensus Group of Iberoamerican neonatologists led to an innovative interaction of physicians from 18 countries of the region, improved education of all participants and ended with a consensus on clinical approaches to nutritional management of the newborn. Furthermore, it could become valuable as a model to decrease disparity in care and to improve outcomes in this and other regions.

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**PARENT SATISFACTION SURVEY IN
PAEDIATRIC INTENSIVE CARE UNIT:
CURRENT PERSPECTIVE OF PARENTAL
EXPECTATIONS**

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Background: In PICU, most children are unable to express their needs and to reflect on care received. The parental satisfaction is essential to assess quality of services and is an important outcome issue. The satisfaction surveys need to have a clear

link to action and be tested for their reliability and validity.

This survey was aimed to develop and implement an easy to use parent satisfaction survey specifically for PICU that could be administered before discharge.

Methods:

- A parental satisfaction survey was designed including 53 items that were identified from literature review and discussion with consultants.—
- The **Likert scale** was used to record responses.—
- This was an anonymous postal survey sent after the discharge to the parents of children admitted in PICU (Newcastle General Hospital, Newcastle UK) from Jan-Jun 09.

Results:

- 110 surveys were sent out in total and 40 (37%) were received back.
- More than 75% of parents either strongly agreed/agreed that they were satisfied with the quality of the service they received except in the areas related to accommodation and siblings where the satisfaction was about 40-50%.
- Pain assessment by medical staff, stricter infection control policies, better discharge planning and communication regarding the planned procedures were the major areas of concerns from the parents.

Conclusion: The audits should be performed to assess the pain management (assessment, analgesia) and consenting issues in PICU. A survey should be designed with the involvement of parents that could be completed just after discharge.

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**LANGUAGE BARRIERS TO PAEDIATRICIANS:
A PROSPECTIVE NATIONAL SURVEY**

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Introduction: World wide migration has led paediatricians to come in increasing contact with

a number of patients with limited language skills. We examined the extent of the problem and the provision of interpreter services to paediatricians across the UK.

Methods: Consultant paediatricians in the UK were invited by email to complete an anonymous web based survey. Information was collected on the languages spoken by the paediatricians, the languages needing interpretation, methods of interpretation used and the difficulties faced.

Results: Of the 647 responding paediatricians, 462 (76.1%) spoke English as their first language. About 202 (33.9%) can speak only English. French (32.1%), Hindi (15.1%) and German (9.1%) are the languages most commonly spoken by consultant paediatricians across the UK. Polish was the language most commonly needing interpretation (58.1%), followed by Urdu (50.4%), Bengali (44.3%) and Somali (37%). A majority (54.5%) of the paediatricians have 1-5% of their patients with limited language skills. Most (89.4%) paediatricians needed interpreter's upto 4 times a week. The availability of a bilingual family member (78.6%) and bilingual staff (61.3%) and difficulty accessing a professional interpreter (30.4%) were the most common reasons given by the paediatricians for not requesting a professional interpreter.

Conclusions: In the UK, Polish, Urdu and Bengali are the languages most commonly needing interpretation. The ready availability of adhoc interpreters and the difficulty in accessing professional interpreters seems to prevent paediatricians from using professional interpreters. Urgent measures are needed to address this growing need.

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INITIAL RISK SCORE PREDICTS SURVIVAL WITHOUT SEVERE INTRAVENTRICULAR-HEMORRHAGE (IVH) AND/OR PERIVENTRICULAR-LEUKOMALACIA (PVL) IN VERY-LOW-BIRTHWEIGHT (VLBW) OR VERY-LOW-GESTATIONAL-AGE (VLGA) INFANTS

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Background: We showed that a predictive model with eight perinatal risk factors correctly predicts

pre-discharge mortality (ESPR 2009). We aim to predict neonatal survival without severe IVH and/or PVL.

Methods: In 2006-07, EuroNeoNet collected data from 5,270 VLBW/ VLGA infants (< 32 weeks), admitted before day 28 to 65 NICUs from 14 European countries. A combined outcome for post-discharge survival without grades_{3,4} IVH and cystic PVL was used. Regression models to predict survival and combined outcome were developed adjusted for perinatal factors by step-wise selection. Calibration by Hosmer-Lemeshow and discrimination by area under ROC curve was used, latter validated on a different sample. Models to predict combined outcome adjusted by birthweight and/or gestation were also performed. Comparisons between models were based on non-parametric tests over ROC curves.

Results: Mean(\pm SD) gestation was 28.6(2.7) weeks and birthweight 1,178(382) g. Adding the need for resuscitation at birth (more than just O₂ therapy) to previously developed model for survival (gestation, birthweight, gender, prenatal-steroid-use, delivery-mode, 1 and 5-min Apgar scores and major congenital anomalies) correctly predicted survival without severe IVH and PVL (AUC: 0.825; 95%CI 0.81-0.84; H&L: 0.489; validation sample: H&L:0.061, AUC 0.829;95%CI:0.807-0.85). This model performed better than those based on birthweight and/or gestation.

Conclusion: Score based on nine initial risk factors adjusted for neonatal survival without severe IVH and PVL can be used as a short-term surrogate for risk of adverse developmental outcome at follow-up. The score could be used to measure quality improvement initiatives.

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