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FATHERS MATTER TOO: INVOLVING BOTH FATHERS AND MOTHERS IN CHILD HEALTH RESEARCH

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Background: Current research within the field of children's palliative care primarily focuses on the perspectives of mothers, to the relative detriment of fathers. The reason for the absence of the male perspective has often been attributed to the difficulty of recruiting fathers and their unwillingness to talk, particularly about sensitive subjects. Given the expansion of children's palliative care over recent years, the needs to understand how fathers experience caring for their dying child and their perspective on how this care can be facilitated professionally is ever more acute. Such understanding will support health and social care professionals to ensure that the care they provide for children is family centred and addresses the needs of both parents.

Conclusions: This poster examines the pertinent issue of involving bereaved fathers in qualitative research interviews and considers the practical issues of such involvement. Little guidance exists regarding whether it is best to interview parents together or separately. The PATCH study used semi-structured interviews to examine bereaved parents' experiences of caring for their child at the end-of-life. Some parent couples were interviewed jointly, others separately. Advantages and disadvantages of both approaches will be outlined and excerpts from parent interviews will be used to substantiate points made.

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THE OYGEN TISSUE SATURATION (SPO2) AUDIT

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Background and aims: Pulse oximetry (SpO₂) is a fundamental aspect of PIC (Paediatric Intensive Care) (Hanning and Alexander-Williams, 1995). Due to widespread use of pulse oximetry, competence

and thus understanding of the basic principles related to this monitoring is vital. Clinical audit was performed to ascertain nursing knowledge related to the use of pulse oximetry.

Method: A questionnaire was given out to nurses (n=40) at a PIC unit. The questionnaire contained four questions regarding the use of pulse oximetry. The results were counted using nominal data and content analysis was used to ascertain themes.

Results: Less than half of those who participated felt that pulse oximetry was indicated in children who had respiratory distress (45%), respiratory failure (10%) or those who were requiring supplemental oxygen therapy (40%).

80% of participants could explain how pulse oximetry works. Common themes from content analysis were infrared light versus light meeting a sensor through the periphery and detecting the amount of oxygen bound to haemoglobin. 20% could not explain how pulse oximetry worked.

Disadvantages highlighted were burns related to use (35%) and inaccuracy on movement (55%).

Rotation of probe sites (82%) was listed as the most common nursing consideration when using pulse oximetry. Pressure sore and burn prevention, was also found to be paramount.

Conclusion: Results suggest that further education regarding the use of pulse oximetry is needed. Education regarding the indications for the use of this monitoring is required. Further, more indepth investigation is required.

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MAKING A DIFFERENCE: INTRODUCING PAEDIATRIC CRITICAL CARE OUTREACH SUPPORTS EFFECTIVENESS OF AN EARLY WARNING SCORING SYSTEM IMPROVING PATIENT SAFETY

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Nottingham Children's Hospital has recently developed and introduced an integrated Paediatric Early Warning Scoring tool and Observation Chart. To support this development and to enable the structured escalation plan to be instigated, a PCCOT team was also introduced and trialled for one month.

The aim of the trial was to find out what added benefit the PCCOT Nurse contributed to the PEWS system in the recognition and management of evolving critical illness thus enhancing patient safety. Other aims included improvement to the patient treatment pathway, to assess the types/range of skills the PCCOT Nurse needs and the level of activity of the PCCOT Nurse.

Utilising a service redesign model the project has moved through the following stages: **Problem Identification** Identifying issues surrounding 'failure to rescue' **Proposed initiative** PEWS and PCOTT . **Development of Tool** - PEWS, observation chart and escalation plan.

Pilot Stage The trial of PCOTT and new charts took place over 1 month.

Results: Total Number of patients 137. Average Number of PCCOT episodes per day 20 Time spent per episode 15 min - 6 hours Average PCCOT episodes per patient 5

Patients admitted to PICU/PHDU had higher PEWS score. Of 15 patients admitted to a higher level of care the transfers were controlled and timely. During the trial there were no cardiac arrests on the wards and only one 'collapse' needing ITU admission from a ward where PCOTT had not been involved.

Conclusion: Paediatric Critical Care Outreach supports the effectiveness of a PEWS System improving patient safety.

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PATIENT SAFETY: A CULTURAL MUST!

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Background and aims: Although patient safety has been a major topic in healthcare for more than a decade, the challenge remains to find effective and sustainable safety improvement programmes. A culture of safety is a key factor in the success of such programmes. We investigated the differences in patient safety culture on wards before the start of a safety program with wards where a safety program was implemented for several years.

Methods: A survey was undertaken amongst paediatricians and specialized nurses by means of the Hospital Survey on Patient Safety Culture

(HSOPSC) on wards without a safety program (group A) and on wards with a safety program (group B). The study took place at the Emma Children's Hospital, Amsterdam.

Results: In group A 252 surveys were provided with a response rate of 67% (64% nurses). In group B 153 surveys were provided with a response rate of 53% (80% nurses).

The HSOPSC consists of 40 questions, covering 11 dimensions. Results are presented in positive, neutral or negative ratings.

We found the following significant differences between groups (A vs. B) in positive ratings:

1. 'Feedback about and learning from error': 51% vs. 83%
2. 'Overall perceptions of safety': 48% vs. 59%
3. 'Frequency of event reporting': 38% vs. 59%
4. 'Hospital management support': 24% vs. 46%

Ratings in the other dimensions were unchanged.

Conclusion: Implementation of a patient safety programme improves some aspects in the culture on a ward, while other aspects demand more focused intervening.

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PATIENT SAFETY IN THE NICU

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Background: Patient safety is a spearhead of the University Medical Centre of Utrecht (UMCU), the Netherlands. It recognizes that human error is inevitable. Wherever possible, the system should be (re)designed in such a way that human error is discovered or intercepted before it leads to patient harm. Reporting incidents is part of the patient safety program running in our hospital. The Neonatal Intensive Care Unit (NICU) of the UMCU wanted to have more insight in the incident reports on their unit. By analysing the reports with NICU professionals, the chance of effective improvement on the department would be increased.

Aim: Increase of patient safety by incident analyses.