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POSTER WALK – NURSING 2

ID 953. Nordic survey shows wide variation in discharge practices for very preterm infants

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Background

Routines for discharge of preterm infants have gradually changed toward transfer to home at lower postmenstrual age and weight. Neonatal home care may improve health by reducing parent–infant separation, facilitating parent–infant bonding, and



increasing parental empowerment. Earlier discharge to home-based care could therefore be beneficial but requires an understanding of which criteria and preparations are important for safe discharge and how to assess infant and parent readiness. This survey aimed to explore discharge routines and criteria, related assessment tools, and post-discharge support for very preterm infants in Nordic countries.

Methods

Medical directors of all (n=89) level 2 and 3 neonatal units in Denmark, Finland, Iceland, Norway, and Sweden were invited by e-mail to complete a web-based multiple-choice survey with an option for additional free text commentaries. Questions addressed discharge criteria and process, education and information given to families, support after discharge, and physician's opinion on early discharge and home-based care.

Results

We received a response from 83/89 neonatal units (93%). In all responding units, infant discharge readiness was clinically evaluated by the staff. Discharge criteria varied between units with PMA 33+0 and infant weight 1500g reported as a minimum, in addition to normal temperature without external heating and cardiorespiratory stability. Formal tests for cardiorespiratory stability were used by 30/83 units (36%). Discharge criteria related to infant weight or growth were used by 49/83 units (59%). For discharge with a feeding tube, parental ability to speak the national language or English was mandatory in 38/83 units (45%) with large variation between countries. Post-discharge home visits and video-based home care were provided by 49/83 (59%) and 42/83 units (51%), respectively. In 45/83 units (54%), discharge planning and parental preparation were not initiated until the two last weeks of the hospital stay.



Conclusions

Discharge readiness was mainly based on clinical assessment with criteria varying between units despite similar population characteristics and care structure. This variation indicates a lack of evidence base and a need for further studies. Removal of barriers to neonatal homecare, such as language criteria and late parental preparation could facilitate going home.

None declared

ID 839. PARENTAL EXPERIENCES SURROUNDING PROCEDURAL PAIN IN INFANTS: EXPLORATORY RESULTS FROM THE PETAL TRIAL

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Introduction

Neonatal pain is an important source of distress for both infants and parents [1]. Parents' active involvement in care may improve parental wellbeing [2]. Yet, presence during painful procedures can elicit a range of positive and negative emotions in parents [3], which have not been fully explored. Here we report parents' experiences and anxiety scores while participating in PETAL, a multicentre randomised controlled trial, which aimed to establish whether parental touch provides effective pain relief for procedural pain in neonates [4].

Methods

112 baby–parent dyads (65% mothers, 35% fathers) were enrolled in PETAL. Parents gently stroked their baby's leg either before or after a clinically–required heel lance and answered an anonymous questionnaire about their involvement. Parental anxiety

before and after the heel lance was measured using State Trait Anxiety (STAI-S) questionnaires. The Premature Infant Pain Profile Revised (PIPP-R) and EEG activity were used to quantify infants' pain-related responses. Linear regression was used to quantify the association between STAI-S scores post-procedure and parental (gender, STAI-S scores pre-procedure), infant (PIPP-R score, EEG response, postmenstrual and postnatal age, sex) and contextual factors (site, reason for blood sampling).

Results

Of 106 surveyed parents, 98% were happy their child took part in PETAL. Most parents assigned positive descriptors to their feelings while being involved in their child's care at the time of the blood test, such as 'useful' (64%) and 'reassured' (53%) (Fig. 1a). Parental anxiety significantly decreased following the blood test during which parents were actively involved (Fig. 1b). Parental anxiety following the blood test was strongly related to pre-procedural anxiety scores (beta=0.71, $p < 0.0001$) but not to the other factors explored ($p > 0.05$).

Conclusion

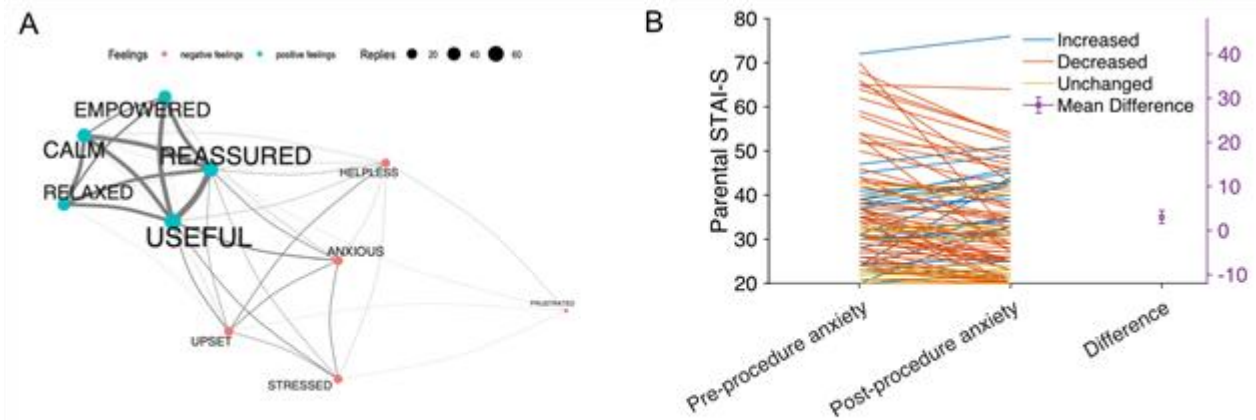
Parents experienced positive feelings when being actively involved in their child's procedural comfort care as part of PETAL. Involvement in comfort care interventions in neonatal clinical trials is acceptable to parents, and providing parents with this opportunity may be considered for future research.

1 Kyololo, Journal of Pediatric Nursing (2019)

2 Bekar, Journal of Pediatric Nursing (2022)

3 Franck, The Clinical Journal of Pain (2005)

4 Cobo, BMJ Open (2022)



(A) Graphical representations of parents' answers to the multiple-choice question "Being actively involved in my child's care at the time of the blood test made me feel". Lines show how often different adjectives were chosen in conjunction. (B) Parental anxiety was significantly decreased after the clinical procedure (paired t-test with p-value derived using 10000 permutations; n = 106, mean difference = 3.1, t = 4.1, p = 0.0001).

Figure 1.

Figure 1.

LB is funded by a BLISS (a neonatal charity promoting parental involvement) research grant. RS, EA, FM and CH are named applicants on this grant, but not funded by it.



ID 569. Parent Co-Designed Drug Information Resources for Parents and Guardians taking Neonates Home - PADDINGToN Study

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Background

Most medication administration on NICU remains nurse-led. There is an acute lack of suitable information for parents whose babies require medication on discharge, which exacerbates parental stress. The aim of this multi-centre PADDINGToN study was to co-design clear information resources with parents, to meet neonatal parent's needs.



Methods

Information needs were identified from e-surveys of parents and Health Care Professionals (HCPs) and focus groups with parents. Examples of good practices were gathered from other hospitals, study sites, parent recommendations and online searches of available resources.

Parents were invited to take part in online co-design focus groups. Resource packs for review were sent electronically and via post to each participant in advance and reviewed in the focus group. The resources were refined and discussed in follow up meetings. Parents agreed a final version of the parent/neonatal unit packs for evaluation, which involved review by a new group of parents/HCPs, not involved in the design process. The new resources and a short questionnaire on their utility were distributed via online stakeholder groups, parents and HCPs recruited from the study sites (n=5).

Results

The parent resource pack contains general advice about giving medicines to babies, commonly used medicines, Frequently Asked Questions, a Medicines Administration Record and useful contacts. The neonatal resource pack contains templates for a teaching session about medicines, individual baby's medicines schedule, medicines education checklist and a Medicines for Children poster.

58% of parent respondents (n=26) were giving 1–3 medicines and 35% were giving 4–6 medicines on discharge. 96% had received some information about medicines prior to discharge.

HCP feedback (n=22) Responses included: 8 nurses, 4 Advanced Neonatal Nurse Practitioners, 8 doctors and 2 Pharmacists from the 5 study sites. 100% of HCPs would use the presentation template, thought the individual patients medicine schedule would be useful and would recommend the introduction of the resources in their unit. Table 1 shows the parent and HCP feedback.

Conclusion

The feedback from both parents and HCPs was extremely positive and comments made during the evaluation process have been incorporated in the final resources. The co-design process has proven to be invaluable.

	Mean score (1 not at all useful – 5 very useful)	Range of scores
Parent evaluation (n=26)		
Helpful to prepare for giving medicines at home	4.65	3-5
Clear information	4.69	3-5
Useful links to information about specific medicines	4.73	3-5
Medicines Administration record useful	4.54	1-5
HCP evaluation (n=22)		
Usefulness of the Medicines Education Checklist template	4.68	4-5
Usefulness of the Medicines for Children poster	4.64	3-5

Table 1: Parent and HCP feedback on PADDINGToN co-designed resources

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None declared

ID 437. REPATRIATION OF NEONATES AFTER INTENSIVE CARE; OPPORTUNITY FOR IMPROVEMENT

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Background

Neonatal care in United Kingdom is provided in a network model where infants requiring complex care are transferred to Neonatal Intensive Care Units (NICU) either in-utero or ex-utero are transferred back i.e., repatriated to the local neonatal units. Facilitating the repatriation of these infants within an appropriate timeframe is likely to enhance the family experience, promote family-integrated care, and alleviate capacity pressures in the NICU. The study aimed to identify the number of additional days those babies stayed in hospitals outside their local hospital and to implement a quality improvement strategy based on the audit findings.

Methods

Study was done at a local neonatal unit (Level 2) in Greater London area. We analysed 10 months (Jan-Oct 2022) data related to neonates who were repatriated back to our facility. Repatriation criteria were based on the network's level 2 neonatal unit service specifications; gestational age >27 weeks, weight >800g, not on invasive ventilation, not currently undergoing therapeutic hypothermia, and receiving at least half feeds if <34 weeks gestation. We excluded surgical babies with a stoma and private hospital transfers from our analysis. We also examined demographic information, reasons for transfer, and the average duration of stay in another hospital beyond the specified criteria

Results

Over a 10-month period (Jan–Oct 2022) there were 43 babies repatriated. 6 babies were excluded and 37 were included in this study. The median gestation was 30 weeks, and the median birthweight was 1203g. All the babies were repatriated back from a level 3 unit. The reason for repatriation and average number of days these babies stayed beyond specified criteria in a level 3 is shown in figure 1.

Conclusion

The study revealed that, on average, neonates stayed 16 days longer than required in a level 3 neonatal unit. This information can be utilized to enhance the repatriation process, enabling better family–integrated care locally, optimise intensive care capacity in Level 3 units and reduce cost of care.

Reason for Repatriation & Days stayed in level 3

- Beyond 72 hrs of expected criteria: 33 babies (89%)
- Average number of days babies stayed beyond criteria in level 3 was 16

Reason for repatriation (n)	< 27 weeks (n=14)	HIE (n=2)	Surgical review (n=6)	Sick neonate (n=3)	ROP surgery (n=2)	Booked in another hospital (n=1)
Average Days stayed in level 3 beyond criteria	19.7	2.7	1.5	3.9	-0.1	8.6

Reason for Repatriation and days stayed in level 3 neonatal units beyond specified criteria



Reason for Repatriation and days stayed in level 3 neonatal units beyond specified criteria

Both authors involved in the British Association for Perinatal Medicine (BAPM) framework on safe and effective repatriation in neonates



ID 161. Improving positive feedback on the NICU via QR codes

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Within healthcare, it is important that we learn from our mistakes and share this learning to improve care delivered. However, it's also important to recognise positive performances and share learning points from these too. There is growing evidence from within healthcare settings about the power of positive feedback within teams to improve team morale, increase learning and improve patient experience. By learning from excellence and not just mistakes, we can maximise our learning opportunities and create a positive work environment in which people feel supported in and able to deal with adversity.

Methods

Whilst there were positive feedback mechanisms at The Hospital for Sick Children's Neonatal department (SickKids) such as 'shout outs' in handovers and sticking a name on board, there was no easy way to give written feedback. Based on examples in the UK including Leeds Teaching Hospitals Trust GR8X, positive feedback QR codes were introduced into the SickKids Neonatal department. These QR codes were made following engagement with the senior clinical nurse manager and subsequently IT. Once the QR code was established, emails were sent to all Neonatal team members to explain what these QR codes were for and how to use them. Posters were used in all staff areas, which included the codes.

Results

Since introduction there have been 56 nominations.

January 14. March 23. March 15. April 4. From a variety of staff including Charge nurses, bedside nurses, fellows, Staff, social worker, speech and language therapist.

Themes highlighted including team work, advocating for patients, supporting new nursing staff, celebrating success such as being signed off to use US to insert IVs, general positive attitude.

Conclusion

This QR code positive feedback method has been well received by the department, with a good uptake. It continues to be advertised across the unit. This data was presented at a Grand Round to promote it again and ask for ongoing feedback. Going forward, the plan is to identify common themes and with that learning to be shared amongst the team via clinical governance meetings. Improving the experience for both staff and hopefully families by building upon a positive working environment.

none declared



ID 911. Improving Thermoregulation Practices in local neonatal unit: A Quality Improvement Initiative

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BACKGROUND

Thermoregulation plays a critical role in providing optimal care for newborn infants. Conversely, both cold stress and hyperthermia can have severe metabolic consequences contributing to increased morbidity and mortality.

The National Neonatal Audit Programme (NNAP) standard emphasises the timely achievement of normothermia. This local quality improvement (QI) initiative was launched to improve thermoregulation practices in newborn care, with a particular focus on preterm infants.

This QI aimed to evaluate current management practices of hypothermia during resuscitation and upon admission to Neonatal Intensive Care Unit (NICU) for all preterm babies less than 34 weeks gestation.

METHODS

A retrospective audit was initially conducted to evaluate existing standards of practice. As a result, all babies born less than 34 weeks at this hospital were included with no exclusions. The initial audit spanned over six months, from 1st January 2022 to 31st July 2022, whereby 76 eligible babies were identified and included.

Based on the analysis of baseline data, respective recommendations were developed and implemented. This included a structured "Thermocare Bundle", which consists of a robust education programme followed by standardised local guidelines and flowchart guidance for all staff.



Subsequently, a prospective continuous re-audit was conducted over two months, from 1st March 2023 to 30th April 2023, and 25 eligible babies were identified. Data were collected from electronic healthcare records (BadgerNet) and medical notes, followed by necessary analysis.

RESULTS

Figure 1a shows a comparison of percentages for the temperature on admission to NICU, whilst Figure 1b shows a comparison percentage of the temperature during resuscitation, for both pre and post audit period.

The majority of the babies had no recorded temperature during resuscitation, which improved post-audit. Lack of documentation was a key limitation identified and addressed before re-audit.

CONCLUSION

The implementation of "Thermocare Bundle" resulted in significant improvement. The primary focus of this bundle was implementing a sustained education program for the wider multidisciplinary team: midwifery, obstetric and neonatal staff. In addition, structured flowchart for managing hypothermia has been introduced, encompassing delivery room cuddles to enhance the family-centred experience as part of the project followed by regular audits to demonstrate sustained improvements.

FIGURE 1a: TEMPERATURE RECORDED ON ADMISSION

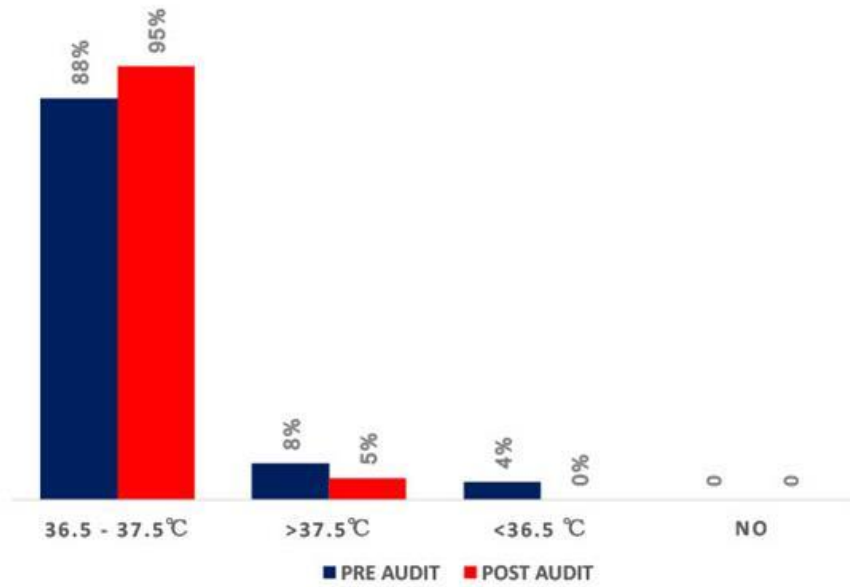
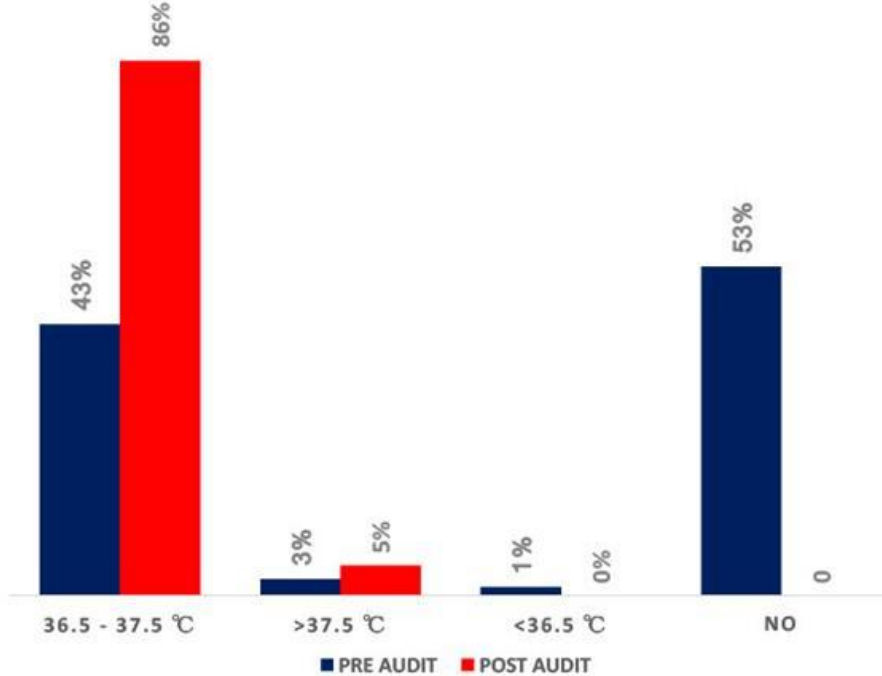


FIGURE 1b: TEMPERATURE RECORDED AT RESUSCITATION



none declared



ID 153. Use and complications of invasive lines in a tertiary care neonatal unit

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Background: Insertion of intravascular catheters is the most common invasive procedure in neonatal units with growing recognition of potential risk for complications. Our research objective was to assess utilization, positioning and complication rates associated with use of different invasive lines.

Methods: The retrospective study analyzed invasive lines inserted between 1st January 2018 – 31st December 2020 in the tertiary NICU, University of Szeged. Data – on patient characteristics, catheter position, dwell-time, elective removal, complication, line-related infection – was collected from the electronic patient monitoring system.

Results: Total of 417 indwelling catheters were inserted in 218 neonates, Majority of lines were PICCs (n=182) and UVCs (n=154), with smaller number of CVCs (n=32), peripheral arterial catheters (n=29) and UACs (n=20). Increasing gestational age was associated with decreased use of invasive lines (1.86 lines/baby vs. 0.72, 0.23 and 0.29 in <28th GW, 28–32nd GW, 33–37th GW, >37th GW respectively). Most of the PICC lines (94.1%) were correctly positioned, as opposed to only 28.6% of UVCs. Average dwell-time differed widely based on the type of catheters (UVC 3.9 days – CVCs 17.2 days). One-third of PICCs had complications, most frequently sepsis and extravasation (8.8–8.8%). Almost all UVC's adverse event were mechanical: dislodgement (6.5%), occlusion and leak (3.2–3.2%), extravasation (2.6%). Overall CLABSI rate was 6.3:1000 catheter days with highest rate in CVCs and lowest in UVCs (11.2:1000 vs 1.7:1000 catheter days).

Discussion: Placement and maintenance of 'life lines' is crucial with increased survival of extremely premature infants. Correspondingly, extreme premature infants had an eight-fold chance of having an indwelling catheter compared with the lowest catheter frequency in the late preterm group. A low success rate of UVC positioning was observed with only a quarter sited in the required location. Leading cause of UVC complications were dislodgement questioning the securing technique for umbilical catheters. More than third of the CLABSI bacteria were not susceptible to aminoglycosides and flucloxacillin.

Conclusion: Overall complication rate of invasive lines on our unit is comparable with international data. The question of securing umbilical lines and the adherence to the antibiotic protocol for neonates with indwelling lines needs to be revisited.

	n	%
PICC	182	
complication	65	34.6%
paravasation	16	8.8%
sepsis	16	8.8%
occlusion	10	5.5%
phlebitis	9	4.9%
suspected sepsis	8	4.4%
damaged	4	2.2%
no complication	116	64.8%
UVC	154	
complication	28	18.2%
dislodgement	10	6.5%
occlusion	5	3.2%
leak	5	3.2%
paravasation	4	2.6%
liver lesion	3	1.9%
sepsis	1	0.6%
no complication	126	81.8%
CVC	32	
complication	9	28.1%
sepsis	6	18.8%
occlusion	1	3.1%
PTX	1	3.1%
damaged	1	3.1%
no complication	23	71.9%
peripheral arterial line	27	
complication	9	33.3%
occlusion	7	25.9%
dislodgement	2	7.4%
no complication	20	74.1%
UAC	20	
complication	2	10.0%
occlusion	1	5.0%
dislodgement	1	5.0%
no complication	18	90.0%

No conflict of interest.

ID 752. Complaints and litigation relating to the care of babies admitted to a maternity department and level 3 neonatal unit in the UK.

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Introduction

There were 624,828 live births in England and Wales in 2021 [ONS data], of which 559,728 deliveries took place in NHS hospitals [NHS digital]. It is an anxious time for parents, and vital we offer family-centred care whilst learning from shortcomings. Publishing/sharing parental complaints data promotes transparency and accountability, and highlights parents' priorities. This may illuminate areas for improvement, through quality improvement initiatives or staff education[1].

Objective

To review parents' complaint and litigation data regarding care of their baby/ies admitted to neonatal intensive care unit (NICU), Special Care Baby Unit (SCBU) and maternity department over 10 years.

Methodology

We retrospectively reviewed complaints received on the care of newborn babies admitted to Labour Ward, Postnatal Ward, SCBU and NICU of Homerton University Hospital. Anonymised data was collected from the legal and complaints departments from 2010 to 2020. Themes were drawn by the first author and checked



independently by the second. Complaints have been coded to all the relevant themes, i.e., various complaints have been coded to multiple themes.

Formal research ethics approval of the study was not required as per the NHS Research Ethics Committee tool.

Results summary

There were 117 complaints relating to the care of 119 babies (2 complaints referred to both babies in twin deliveries) between 2010 and 2020. These were both written formal complaints and legal complaints. 23 (19.6%) of these complaints were upheld following investigation. 42 (35.9%) of the complaints were partly upheld, most often because the complaint contained multiple aspects to it which were assessed separately. 48 (41.0%) complaints were not upheld following investigation. 4 complaints did not have a recorded outcome. The principal themes for complaint which came out of this study were injury at birth (26.5%, n=31), communication shortfalls relating to information-giving by a neonatal doctor (38.5%, n=45), midwife (33.3%, n=39) or other professional (15.4%, n=18).

Conclusion

A large proportion of complaints received on care provided to newborn babies relate to communication, specifically information provision to parents. This highlights the importance of communication and communication training, particularly breaking bad news.

Ref:

1. Aiyengar A et al. BMJ Paediatrics Open 2021

None declared

ID 842. Octyl-butyl-cyanoacrylate glue for securement of peripheral intravenous catheters: A retrospective, observational study in the neonatal population

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Background:

Evidence-based insertion and maintenance strategies for neonatal vascular access devices (VAD) exist to reduce the causes of VAD failure and complications in neonates. Peripheral intravenous catheter failure and complications including, infiltration, extravasation, phlebitis, dislodgement with/without removal, and infection are majorly influenced by catheter securement methods.

Methods:

A retrospective, observational study using routinely collected data on intravenous device use in a large neonatal intensive care unit in Qatar. A 6-month historical cohort was compared with a 6-month cohort after the introduction of an octyl-butyl-cyanoacrylate glue (CG). In the historical cohort, the catheter was secured using a semipermeable transparent membrane dressing while in the CG cohort, CG was applied at the insertion site on initial

insertion and after any dressing change. This was the only variable intervention between both groups.

Results:

A total of 8330 peripheral catheters were inserted. All catheters were inserted and monitored by members of the NeoVAT team. 4457 (53.5%) were secured with just a semi-permeable transparent dressing and 3873 (46.5%) secured a semi-permeable transparent dressing with the addition of CG. The odds ratio for premature failure after securement with CG was 0.59 (0.54–0.65) when compared to the catheters secured with a semi-permeable transparent dressing, which was statistically significant ($p < 0.001$). The correlation between the occurrence of a complication and the use of CG for device securement was significant ($p < 0.001$).

Conclusions:

The risk of developing device-related phlebitis and premature device removal, increased significantly if CG was not used for adjunct catheter securement. In parallel with the currently published literature, this study's findings support the use of CG for vascular device securement. When device securement and stabilization concerns are most pertinent CG is a safe and effective adjunct to reducing therapy failures in the neonatal patient population.

Table 2. Intravenous access data for cohort groups.

	Non-CG group n=4457 (%)	CG group n=3873 (%)	p-Value	
Catheter size (Ga.)				
24	50 (1)	4 (1)	<0.001	
26	4407 (99)	3869 (99)		
Indication				
Blood products	160 (4)	170 (4)	<0.001	
Continuous Infusion	3980 (89)	3203 (83)		
Intermittent Infusion	250 (6)	429 (11)		
Procedure*	67 (1)	71 (2)		
Side of cannulation				
Left	2417 (54)	2204 (57)	0.014	
Right	2040 (46)	1669 (43)		
Site of cannulation				
Elbow	3 (<1)	0 (0)	<0.001	
Foot	630 (14)	331 (8)		
Hand	3656 (82)	3430 (89)		
Lower arm	157 (3)	105 (3)		
Lower leg	5 (<1)	4 (<1)		
Upper arm	4 (<1)	1 (<1)		
Upper leg	2 (<1)	2 (<1)		
Attempts	Skin punctures	1.3 ± 0.5		1.4 ± 0.7
Reason of removal				
Elective	1655 (37)	1919 (49)	<0.001	
Accidental	130 (3)	105 (3)		
Leaking	445 (10)	386 (10)		
Occlusion	219 (5)	160 (4)		
Phlebitis	594 (13)	123 (3)		
Infiltration/extravasation	1365 (31)	1121 (29)		
Lost to follow-up	49 (1)	59 (2)		
Dwell time				
Hours	31.0 ± 24.3	37.1 ± 31.1	<0.001	

Ga.: gage; PIVIE: peripheral intravenous infiltration/extravasation.

Data are represented as mean ± standard deviation, or as absolute numbers (percentages rounded to the nearest full number where appropriate).

Data is tested with χ^2 testing or with unpaired t-testing, as appropriate.

*VAD insertion related to a procedure if required in diagnostic imaging like MRI or CT-scan.

Table 2: Intravenous access data for cohort groups.

Table 2: Intravenous access data for cohort groups.

None declared



ID 897. Improving outcomes for preterm babies: Implementation of a Perinatal Care Bundle in a Tertiary Neonatal Unit

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BACKGROUND

Perinatal care bundles have been shown to reduce overall perinatal mortality. It allows optimising the key factors in management for those babies born preterm. Successful implementation of such bundles has been demonstrated in some networks across England, including the “PERIPrem bundle”, showing evidence of improving outcomes for preterm infants.

An adapted Perinatal Care Bundle was developed locally to improve outcomes of preterm infants in line with NHS Long Term plan. This bundle provides standardised care to ensure necessary interventions are in place to improve outcomes.

METHOD

Before the implementation of the “Perinatal care bundle”, a retrospective baseline audit was conducted for all babies born <34 weeks gestation without any exclusions during the audit period (1st January 2022–31st July 2022).

Following retrospective analysis, recommendations and interventions were proposed focusing on key areas for improvement and implemented by the relevant teams. To assess the effectiveness of these changes, a prospective re-audit was conducted over 2 months, 1st March 2023 – 30th April 2023. The study relied on data from BadgerNet and medical notes.



RESULTS

76 babies were identified in the initial retrospective audit, and data was analysed. After implementing recommended interventions, prospective re-audit identified 21 babies who met the criteria. Table 1 shows the nine key elements of the Perinatal Care bundle measured for pre and post-implementation.

CONCLUSION

Implementing the adapted perinatal care bundle in the neonatal unit has resulted in widespread improvements across seven elements of care. This success can be attributed to the education, increased awareness amongst all staff involved in the care, collaborative working with maternity colleagues and improved overall documentation of interventions completed. The main limitation of the re-audit was the small sample size as it was aimed to give a snapshot of the progress prospectively.

We aim to launch a 'Baby Passport' that includes all of the Perinatal care bundle elements. This can be used to empower parents by keeping them informed and involved throughout their journey. Additionally, we plan to strategise and focus on individual elements by completing mini-audits separately to engage a wider task force and continue to improve care.



TABLE 1: COMPARISON OF PERINATAL CARE BUNDLE ELEMENTS MEASURED

PERINATAL CARE BUNDLE ELEMENTS MEASURED	BASELINE	RE-AUDIT
All babies born less than 34 weeks should receive a COMPLETE course of steroids	57%	90%
All babies born less than 30 weeks should receive Magnesium sulphate prior to birth	91%	75%
All babies born less than 34 weeks, where possible should have delayed cord clamping for atleast a minute	58%	81%
All babies born less than 34 weeks, have opportunity for delivery room cuddles	8%	62%
All babies born less than 34 weeks have normothermia after birth (during resuscitation)	43%	86%
All babies born less than 34 weeks have normothermia on admission to neonatal unit	88%	95%
All babies born less than 30 weeks , received caffeine during their stay	100%	100%
All babies born less than 34 weeks, received buccal colostrum within 6 hours of life	14%	52%
All babies born less than 32 weeks or birthweight <1500g, received probiotics	100%	100%

None declared

ID 360. Delivery room cuddles for Extremely preterm infants – is it feasible? Is it safe?

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Background

Our neurodevelopmental care bundle for extreme preterm infants (born <26/40 gestation) includes a period of 72 hours of minimal handling after admission to the neonatal unit. Delivery room (DR) cuddles were introduced to facilitate early direct parental contact with their baby, promoting parents as key partners in care from the very first moments of their infant's life. Early contact between parents and their babies is recognised as a key step in optimising early maternal breastmilk, other benefits include transfer of parental microbiome, reduced parental anxiety and increased bonding.

Methods

A retrospective review of electronic notes for all inborn babies born 01/01/2021 – 31/12/2022 with a gestation of <26/40 was undertaken. Parental experiences were sought using an online questionnaire.

Results

24 inborn <26/40 infants were identified in 2021, 45.8% were cuddled in the delivery room, thermoregulation was maintained and no significant difference between pre and post cuddle temperature was found (37.1°C & 37.1°C p=1.0). The proportion of infants cuddled in 2022 increased to 71.4% (total n=35) with no significant difference in pre and post cuddle temperature (37.1°C & 37.2°C p=0.72). There were no adverse

events during or related to DR Cuddles. Of those not cuddled reasons documented included; mother clinically unstable (13.0%), baby clinically unstable (8.7%), parents declined (4.3%), baby born in a non-clinical area (4.3%), no documented reason (69.6%).

Parent feedback for this intervention was overwhelmingly positive and highlighted the positive impact this experience has on families, with comments including ‘The experience was fantastic and very much appreciated...creating an early bond with our baby. Getting to see him and talk to him as soon as he entered the world was incredible’.

Conclusions

Delivery room cuddles in our extreme preterm population were safe, did not adversely impact thermoregulation and had a positive impact on families who received them. Our focus on improving DR cuddles led to a significant increase in the proportion of infants cuddled by one of their parents. We will focus on understanding and addressing the reasons why some parents were not offered DR cuddles, and increasing the number of birth partners who are offered DR Cuddles.



Table 1		
	2021 (n=24)	2022 (n=35)
Gender	Male: 15 (62.5%) Female: 9 (37.5%)	Male: 25 (71.4%) Female: 10 (28.6%)
Gestation mean (Range)	24+5 (23+2 – 25+6)	24+1 (22+5 – 25+5)
Birth weight mean (Standard deviation)	737g (SD = 135)	699g (SD = 116)
Singletons	18	33
Twins	6	2
Proportion who had DR cuddles	45.8%	71.4%
Admission temperature if no DR Cuddles - Mean (Standard deviation)	37.0°C (SD = 0.49)	37.3°C (SD = 0.48)
Admission temperature for those who received DR Cuddles - Mean (Standard deviation)	37.2°C (SD = 0.63)	37.1°C (SD = 0.79)

None Declared



ID 326. PARENTS' EXPERIENCE IN PARTICIPATION IN DIFFERENT SETTINGS OF DUTCH NEONATAL CARE: A CROSS-SECTIONAL SURVEY STUDY

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BACKGROUND

The challenge of transitioning to parenthood in the NICU can be stressful for parents and potentially impact parent–infant bonding. In Family Integrated Care (FICare), parental participation in neonatal care is pursued by four pillars: staff and parent education, psychosocial support and environmental interventions. FICare reduces parental stress. However, misconception arises that FICare can only be implemented in single family rooms (SFR). To provide parents' perspectives for implementation and optimization of FICare, we describe parents' experiences in neonatal care participation in different architectural settings.

METHODS

Parents of newborns hospitalised to a Dutch neonatal ward in 2015–2020 were recruited via social media. The online survey, categorised by the FICare pillars, inquired parents' experience of the admission. Experiences were described using descriptive and comparative statistics, stratified by department architecture.



RESULTS

Of the 345 respondents (98% mothers), most (94%) were parents of preterm infants (69% gestational age <32 weeks). 224 parents had infants admitted to an open bay unit (OBU) and 121 to single family rooms (SFR). Median length of hospital stay was 50 days (SFR 46 days; OBU 56 days; $p=0.025$). Overall, parents were satisfied with the received care and felt involved in both settings. However, 54% felt bonding was impaired (SFR 44%; OBU 59%; $p=0.021$) and 55% experienced the admission as traumatic (SFR 44%; OBU 61%; $p=0.003$).

More parents in SFR were able to attend medical rounds (79% vs 58%, $p<0.001$). Of all parents attending medical rounds, 57% felt free to share their own observations and 30% felt welcome to participate in decision-making. 14% of all parents reported being invited to educational sessions and 19% received support of veteran parents. Parents in SFR spent more time with their child (median 12 hours, IQR 8–24) than in OBU (median 6 hours, IQR 5–9) ($p<0.001$). Feeling separated from their child was reported more often by parents in OBU than in SFR (87% vs 59%, $p<0.001$).

CONCLUSION

Although parents are generally satisfied with participation in Dutch neonatal care, steps need to be taken to diminish trauma, feelings of separation and impaired parent–infant bonding. Regardless of architecture, parent participation beyond merely presence requires specific attention.

None declared