

**Results** A total of 30 infants were included in the survey; 22 of these infants were  $\geq 32$  weeks gestation at birth, and the other 8 infants were  $< 32$  weeks gestation. The results are shown in Table 1. A total of 372 days were saved with a cost saving around £167,400 ( $\approx$ £450/scbu day). No family used additional support. No infant was readmitted due to poor growth or skin infection.

**Conclusions**

- Early discharge to home on NG feeds was safe and the infants gained weight appropriately. This saved a median of 8 bed days. The families required routine support from their close relatives and community team.

**G127(P) IS THE NEONATAL LIFE SUPPORT COURSE REALLY THAT STRESSFUL? AN OBSERVATIONAL STUDY**

<sup>1</sup>N Holme, <sup>1</sup>C Harrison, <sup>2</sup>NJ Shaw. <sup>1</sup>Peter Congdon Neonatal Unit, Leeds Teaching Hospitals NHS Trust, Leeds, UK; <sup>2</sup>Neonatal Intensive Care Unit, Liverpool Women's Hospital, Liverpool, UK

10.1136/archdischild-2015-308599.126

**Objectives** To determine whether there is a significant stress response to the neonatal life support airway test (NLSAT) amongst nurses, midwives, doctors and other professionals; to compare level of experience with the stress response measured in each participant and identify whether high stress levels correlate with difficulty passing the NLSAT.

**Design** Quantitative observational study measuring stress levels of candidates on the NLS course using salivettes to measure salivary cortisol levels and a validated anxiety questionnaire (State Trait Anxiety Inventory).

**Setting** NLS course centres in the UK in 2013

**Participants:** 80 healthcare professionals (nurses, doctors and midwives) enrolled on the NLS course.

**Interventions:** Stress levels measured at baseline (10am), immediately before and then 20 min after the initiation of the NLSAT. Demographic data including professional experience and prior exposure to the NLS course was collected.

**Results** Cortisol measurements failed to detect any significant rise in stress levels. Significant stress levels were induced by the NLSAT when measuring anxiety scores with baseline mean scores of 39.63 (11.75), mean pre-NLSAT scores of 48.38 (SD 12.89, p-value  $< 0.001$ ) and mean post-NLSAT scores of 42.82 (SD 13.65, p-value 0.03). STAI scores significantly rose in all professionals from baseline to post-NLSAT ( $p < 0.001$ ) with greatest change detected for midwives (+11.82 (SD 7.64, p-value  $< 0.001$ ) compared to nurses (+8.86 (SD 12.1, p-value  $< 0.001$ ) and doctors (+7.96 (SD 2.9.69, p-value  $< 0.001$ ). There was no impact of experience on stress levels. It was not possible to determine if stress levels impacted on performance due to the low re-sit rate (7.5%).

**Conclusions** Stress levels induced by the NLSAT are significant and need to be considered when instructing and developing the NLS course with variation amongst different healthcare professionals.

**G128(P) ABSTRACT WITHDRAWN**

**G129(P) THE EFFECT OF INDIVIDUALISED CARE ON MATERNAL ANXIETY AND DEPRESSION**

P Shah, S Roth. Neonatal Unit, Barnet General Hospital, Barnet, UK

10.1136/archdischild-2015-308599.127

**Aims** The introduction of individualised care rooms (ICR) at Barnet Hospital has allowed family-centred neonatal care to take place in an environment where the mother is empowered as the main carer for her newborn with the support of trained staff. This study aims to quantify the effect this has on maternal mood in the postnatal period.

**Methods** Mothers of babies that had either been in the special care baby unit (SCBU) or ICR for 3 or more days were asked to complete the Edinburgh Postnatal Depression Questionnaire. The questionnaire is scored out of 30, with a higher score representing more severe concerns regarding maternal mood.

**Results** Questionnaires were handed out to 10 parents in each of the 2 groups. They were returned by 7 parents from ICR and 8 parents from SCBU. The average length of stay was 18 days in the ICR group and 24 days in the SCBU group. The mean score was 4.57 in the ICR group, compared to 10.37 in the SCBU group with a p value of 0.04.

**Conclusion** This study highlights how important maternal involvement and empowerment can be in neonatal care. Improvements in maternal mood will aid bonding and have a positive effect on the emotional and social development of the child and the family unit.

**G130(P) WHAT IS THE EFFICACY OF NITRIC OXIDE IN NEONATES WITH PRETERM PROLONGED RUPTURE OF MEMBRANES?**

S Pal, E Walker, M Ramphul, AE Curley. Rosie Neonatal Unit, Cambridge University NHS Foundation Trust, Cambridge, UK

10.1136/archdischild-2015-308599.128

**Background** Preterm prolonged rupture of membranes continues to be associated with significant morbidity and mortality, predominantly as a result of respiratory failure due to pulmonary hypoplasia and/or pulmonary hypertension. Although iNO is not routinely indicated for treatment of respiratory failure in the preterm infant successful treatment with inhaled nitric oxide (iNO) has been reported in small studies.

**Methods** Retrospective review of neonates with PPROM of latency 14 days or more at gestation less than 34 weeks at birth from June 2008–July 2014. Infants with respiratory failure who were treated with nitric oxide were compared to those who had not received iNO, and timing of treatment was correlated with outcome.

**Results** 41 patients with PPROM (range 23<sup>+2</sup>–33<sup>+5</sup> days) were included, of whom 61% (25/41) had respiratory failure with oxygenation index  $> 20$  (OI 53.5 (IQR 38–87). Respiratory failure was associated with ultrasound confirmed oligohydramnios ( $p = 0.01$ ) and male gender ( $p = 0.03$ ). 64% (16/25) of infants with respiratory failure were started on iNO. Within the iNO group all patients demonstrated significant reduction in OI following iNO; 81% responding within 1 h. The median OI prior to iNO 59 (IQR 47–88) vs after iNO administration 7.3 (IQR 4.7–10.8) ( $p < 0.01$ ). Neonates were more likely to respond quickly to iNO if it was started early ( $< 6$  h,  $p = 0.047$ ). This was a small cohort of infants and although infants receiving iNO had a higher OI this did not reach statistical significance. There was no difference in rate of bronchopulmonary dysplasia, intraventricular haemorrhage or mortality between patients who received iNO compared to those who did not.

**Conclusion** PPROM is associated with significant mortality (22%) and morbidity with 92% BPD and 29% IVH grade 3 or above. These babies show significant respiratory failure with