

TORCH screen, 15 infants had a1 antitrypsin level, 13 infants had Gal-1-p level, 25 infants had abdominal ultrasound scan and 26 infants had urine metabolic screen). Regarding diagnosis: 18 babies had TPN related cholestasis, 3/40 had biliary atresia, one had choledochal cyst. 3/40 had liver failure. All babies received ursodeoxycholic acid and 80–90% had vitamin supplements (vitamin K, E, and/or dalavit). 27 babies were referred to the liver team.

Conclusion Conjugated hyperbilirubinaemia is rare on neonatal units. Infants who are less than 33 weeks gestation and less than 1251g are most at risk. The majority were diagnosed with TPN-associated cholestasis. It is important to develop guidance for diagnosis and treatment for conjugated hyperbilirubinaemia in the neonate to ensure cost effectiveness of a more streamlined investigation plan, limiting discomfort and risk of anaemia for babies and also consistency in management.

G137(P) PATENT DUCTUS ARTERIOSUS OF PREMATURITY: TO TREAT OR NOT TO TREAT?

VM Shethalli, S Nittur, A Wong, O Uzun. *Department of Paediatric Cardiology, University Hospital of Wales, Cardiff, UK*

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Background Incidence of patent ductus arteriosus in neonates is 30–60% depending on the degree of prematurity. Although patent ductus arteriosus is associated with significant morbidity and mortality in preterm infants, there is a wide variation in management of patent ductus arteriosus in preterm infants.

Methods We reviewed of our 22 year experience from 1992 to 2013 in all neonates diagnosed with a haemodynamically significant patent ductus arteriosus at the University Hospital of Wales. Haemodynamically significant patent ductus arteriosus is described as: (1) left atrium/aortic ratio of >1.5 , (2) significant left heart volume overloading, (3) bounding femoral pulses, (4) hyperactive precordium and (5) persistent ventilator requirements.

Results A total of 200 cases were eligible. The results are summarised in the Table 1:

Abstract G137(P) Table 1

	Pharmacologically treated	Not treated
n	88 (44%)	112 (56%)
Males n (%)	42 (47%)	65 (57%)
Median gestation in weeks (Q3-Q1)	26 (25–28)	27 (26–31)
Median Birth weight in grams (Q3-Q1)	850 (700–1077)*	1020 (820–1387)*
Median NICU stay (Q3-Q1)	62 days (27–104.75)*	34 days (13.5–64)*
Median left atrium/aortic ratio (Q3-Q1)	1.72 (1.5–2)*	1.43 (0.9–2)*
Treatment Success rate	37(42%)	N/A
Surgery/catheter	36 (40.9%)*	21 (18.7%)*
Necrotising Enterocolitis (NEC)	14/88 (15.9%)	20/112 (17.8%)
Intraventricular Haemorrhage (IVH)	12/38 (13.6%)	13/48 (11.5%)
Chronic Lung Disease (CLD)	29/38 (76.13%)	29/48 (60.4%)
Death	12/88 (13.6%)	13/88(11.6%)

*P = < 0.05 .
(Q3-Q1) = Interquartile range.

Pharmacological treatment = Treatment with either Indomethacin or Ibuprofen

Conclusion There were no significant differences in NEC, IVH, CLD or death between treatment and no-treatment group despite the former cases being at lower gestations with lower birth weights. Our result may lend further support towards non-surgical management of patent ductus arteriosus with medication if treatment is not considered to be contraindicated.

G138(P) THE RAPID DEBRIEF: A TOOL THAT TRANSFORMS LEARNING AND SYSTEM CHANGE

¹R Puttha, ¹S Yuen, ²R Thalava, ¹H Abdalla, ¹N Moghal. ¹Paediatrics, George Eliot Hospital, Nuneaton, UK; ²Orthopaedics, Tameside General Hospital, Manchester, UK

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Aim To test the rapid debrief tool as a way of extracting immediate learning to implement system changes following the care of the critically child; overcoming the dispersion of people and memories in the traditional incident reporting cycles.

Method A rapid debrief was tested immediately after the care of a critically ill child was completed by the team. A template was used to collect what improvements were needed technically (resources, skills) as well human factors such as communication and leadership. Action plans were generated by the team. The debrief and action plan was then circulated to all staff and discussed at the weekly service meetings. Outcomes were monitored by the Paediatric Resuscitation Group.

Results A total of 29 rapid debriefs were completed over 12 months, generating 81 action plans, of which 50 have been completed. Many of the actions were completed before the incident forms reached the clinical governance system. 20 related to equipment, 5 to medications, 7 to team issues (communication, leadership), 10 training issues and 11 planning and organisation wide issues. Compared to the year previous to the rapid debrief, clinical Incident reporting now shows a 1.7 times increase of low risk incidence reporting; incidents of moderate or high risk have been reduced by half. Staff feedback has been very positive. The learning outcomes include the development of safe hand-over tools, improving resuscitation resources and team needs, incorporating human factors into the resuscitation training to build team resilience and an open challenging culture.

Conclusion The rapid debrief has helped improve our care of the critically ill child through the immediate extraction of learning and implementation of improvements. The tool enables faster system change compared to traditional reporting governance systems.

G139(P) ADVANCED NEONATAL EMERGENCIES: CONFIDENCE AND EXPERIENCE LEVELS OF NEW REGISTRARS

JM Parasuraman. *Paediatrics, Severn Deanery, Taunton, Somerset, UK*

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Aims Paediatric trainees, who step up to the role of registrars at ST4/5 levels, are required to be competent in neonatal emergencies. Some of the competencies as highlighted by the RCPCH curriculum for level 2 are:

1. Ability to lead initial and advanced resuscitation when required
2. Ability to intubate pre-term babies without supervision
3. Understanding of the principles and ability to initiate mechanical ventilation