

### G211(P) TRANSFERRING THEM OUT WHILST THEY ARE STILL IN: THE EXPERIENCE OF THE EMERGENCY BED SERVICE WORKING WITH THE NEONATAL TRANSPORT TEAM

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**Introduction** The Acute Neonatal Transfer Service (ANTS) for the East of England is supported 24/7 by Emergency Bed Service (EBS), whose role in recent years has extended to providing a cot location service for in-utero referrals from the 17 delivery units across the region. The process of locating both an antenatal bed and potential NICU cot is time-consuming involving multiple phone calls to several centres. Short-term outcomes of the process were reviewed.

**Material and methods** All in-utero referrals to the EBS from 1/1/2017–30/6/2017 were reviewed using the ANTS database. Demographic details and reasons for referral were identified. The outcome of the process including whether an antenatal transfer occurred, reasons for non-transfer, distance travelled for transfer and whether or not delivery occurred within 7 days was also recorded.

**Results** 193 in-utero referrals were made to EBS in the 6 month period, 41, 131 and 21 from Level 1, 2 and 3 units respectively. The 2 most common reasons for referral were a predicted need for a higher level of neonatal care (n=99) and the regional NICU being closed (n=82). 151 of the women underwent antenatal transfer and of these, 51 delivered within 7 days. 112 were transferred to a centre within the East of England, 39 were sent out of region and this necessitated repatriation by ANTS back to the region. Of the 42 women who were not transferred, 8 declined, 29 too unstable to move to the identified receiving unit and in 5, no bed/cot could be found. Amongst those transferred, 75 travelled less than 50 miles while 61 and 15 had to travel more than 50 miles and 100 miles respectively.

**Conclusions** 33.7% of infants referred in-utero delivered at the receiving centre within 7 days. 96% of these infants were extremely preterm (<27 weeks). 50% were transferred more than 51 miles away from their primary location needing retrieval by ANTS back to their local units. The emotional and financial impact on these families is yet to be explored. The Operational Delivery network is working on capacity planning to address capacity issues that resulted in 42% of referrals.

### G212(P) PREMEDICATION USE IN NEONATAL INTUBATION: ARE WE DENYING BABIES ADEQUATE ANALGESIA FOR INTUBATION?

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**Aims** To assess the frequency of premedication use for neonatal unit intubations. To analyse medication use by condition of the baby and indication for intubation.

**Methods** Local guidelines for premedication use were reviewed. Data was collected contemporaneously in ten neonatal units (five ITU, four LNU, one SCBU) using a standardised proforma over an eight week period. Babies intubated on the unit were eligible for inclusion and were identified from

weekly checks of the BadgerNet system and by reviewing the notes of ventilated babies. Data were collected on; weight, gestation, indication for intubation, choice and timing of medication, condition of the baby and documented reasons for not using premedication.

**Results** There were 307 intubations in total, 96 (31%) occurred on labour ward and were excluded. 212 neonatal unit intubations were analysed. Sixty-six (31%) of babies had no premedication for intubation. Of these; 30 (45%) were classified as being spontaneously breathing, 21 (31%) were apnoeic but could be mask ventilated, 6 (9%) were difficult to mask ventilate and 4 (6%) were apnoeic and bradycardic despite attempts to mask ventilate. An additional 12 (5%) babies had unsuccessful intubation attempts without premedication followed by successful intubation with premedication. Forty percent of babies not receiving premedication had a documented reason for this decision in the notes. Reasons included; 'No IV access' (4), 'Unable to cannulate' (1) 'Difficult to mask ventilate' (3) and 'in/out surfactant' (6).

Units varied in their choice of medication. Morphine was used for analgesia in 55 intubations. Only three had a time gap of more than five minutes between morphine and muscle-relaxant. Given the delayed onset of action of morphine most these babies are unlikely to have received adequate analgesia during intubation.

**Conclusions** Previous research demonstrates that premedication blunts the adverse physiological responses to neonatal intubation and improves the chances of successful intubation. Providing analgesia and sedation for intubation should be considered humane care. Our data demonstrates that premedication is not used in all non-emergency intubations and could be used more widely. These results could be used to change current practice leading to quality improvement in patient care.

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### G213(P) FAMILY INTEGRATED CARE – IMPLEMENTATION IN A TERTIARY NEONATAL INTENSIVE CARE UNIT

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**Aims** In the Family-Integrated Care (FiCare) model in Neonatal Intensive Care Units (NICU), parents are primary care-givers, while nurses and doctors teach and coach them and experienced veteran parents provide peer support. FiCare was developed by the neonatal team at Mt Sinai Hospital, Toronto, who had been inspired by remarkably improved outcomes seen in Tallinn, Estonia. Inspired by this model, we undertook to develop and implement FiCare on our unit.

**Method** A proposal was prepared and discussed with the consultant and nursing leads. A multi-disciplinary team was quickly formed of enthusiastic nurses, parents, doctors, ANNPs and other members of staff. Planning meetings were regularly