with maternity & community HCPs in highlighting the importance of prompt diagnosis and subsequent referral and management.

Conclusion On-going audit is important to identify trends/improvements. Continued education sessions for HCPs can assist with increasing awareness of cleft conditions, and the idea of 'link nurses' or 'cleft champions' could be considered. With a changing Model for Children's Healthcare in Ireland further work is required with Neonatology, General Paediatrics, General Practitioners and Genetic teams to formulate more robust pathways for equal access to care and to assist potential syndrome diagnosis. In the interim the Cleft Team propose that each child has access to a named paediatrician locally for <5 years of age and that there is enhanced communication between HCPs involved in a child's care.

P180 QUALITY IMPROVEMENT PROJECT OF DISCHARGE SUMMARIES IN OUR LADY OF LOURDES IN DROGHEDA

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Aims Quality improvement (QI) as a concept for clinical research has become more prevalent in recent years. Quality improvement is a focus on changing the way in which patient care is delivered. Central to this is developing a more rounded, patient-focused approach to the design and delivery of care.¹ Discharge summaries are an important aspect of patient care and having the correct content is essential to communicate treatment plans with general practitioners.

Methods An regular review of discharge summaries on the paediatric ward was conducted in Our Lady of Lourdes Drogheda over a 4 week period. An initial 2 week review of charts was conducted and then an education session was carried out with NCHDs and results were explained. Five areas were considered for analysis, time to discharge summary completion (T2DSC), use of abbreviations (UOA), correct diagnosis documented (CD), correct follow up and referral (FU&R) and overall impression of discharge summary(OI). A sample of 20 random charts was used. The review was carried out again at two further points after a further education session to assess if there was an improvement.

Results The average for T2DC was 2.7/5 for week 1&2. It was 3.35/5 for week 4. UOA was 3.5/5 initially and 3.65/5 after week 4. CD was 3.12/4 and 3.9/4 after week 4. FU&R was 2.07/4 and 3.8/4 for week 4. OA was 3/5 and 3.9/5 for week 4.

P value was 0.64 comparing totals of week 1 & 3. Comparing week 1 & 4 p value was <0.05 for all parameters and 0.000003 for total.

Conclusion QI in discharge summaries demonstrated a significant improvement in quality of discharge summaries in OLOL in Drogheda over the time period identified. It demonstrates how QI is a useful tool to improve aspects of clinical practice.

P181 AN AUDIT OF PAEDIATRIC STAFF ATTENDANCE AT PREMATURE DELIVERIES ≤ 32 WEEKS GESTATION IN CAVAN GENERAL HOSPITAL A LOCAL UNIT

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Background and aims Based on the model of care for neonatal services in Ireland 2015, Cavan General Hospital is classified as a level 1 local unit. Therefore it offers routine and special care to infants ≥32 weeks gestation. Infants ≤32 weeks should usually be transferred to a regional/tertiary unit, preferably in-utero, however this is not always possible. Currently there is no national/local guideline in place to indicate which paediatric staff should be called routinely to attend premature deliveries. The aim of this audit was to establish who currently attends premature deliveries. Also to explore what would be best-practice in a level 1 unit like Cavan and make appropriate recommendations.

Methods A retrospective chart review was carried out of all premature deliveries ≤32 weeks gestation over a 3 year period from 2012 to 2014. Data such as mode of delivery, indication for delivery, members of the resuscitation team in attendance and use of steroids were recorded and analysed.

Results In total, 27 deliveries were reviewed, 12 vaginal deliveries and 15 Emergency Cesarean Sections. Based on gestation; < 26/40: (n=3), 26–30/40: (n= 7), 30–32/40: (n=17).

Abstract P181 Table 1 Members of Neonatal Resuscitation Team present at ≤32/40 weeks gestation deliveries

All in Attendance (Consultant, Reg, SHO, SCBU Nurse)	3
Reg & SCBU Nurse	8
Consultant, Reg, SCBU Nurse	4
Reg Alone	4
Consultant, Reg, SHO	3
Reg, SHO, SCBU Nurse	2
Consultant & Reg	1
Reg & SHO	1
Consultant Alone	1

The Paediatric Registrar was present at 26/27 (96%) of deliveries, a SCBU Nurse at 18/27 (66.6%), the Paediatric Consultant at 12/27 (44%) and the Paediatric SHO only documented at 9/27 (33.3%). Of note a paediatric consultant attended all 3 deliveries <26/40 and 6/7 deliveries between 26–30/40.

Conclusion In our small cohort, there was wide variation with inconsistent practice. Resuscitation documentation needs improving. A SCBU Nurse and Paediatric Registrar were the commonest resuscitation team. Deciding on a gestational cut off and defining high-risk deliveries would be helpful in establishing a standardised protocol for when a consultant paediatrician should be in attendance at a delivery.