those with a neurological exam documented, no infant had all components of the standardised exam included in the documentation (level of consciousness, activity, tone, posture, primitive reflexes, and autonomic function), preventing retrospective assessment of grade of NE. There was no difference in the quality of documentation between those that did and did not receive TH.

By the time of discharge documentation had improved, and the grade of encephalopathy was detailed in twenty five patients (81%).

**Conclusion** The documentation of the neurological examination when determining eligibility for TH is inadequate. Though the documentation improves by discharge, initial documentation must be improved to ensure appropriate clinical practice and patient safety. To achieve this, educational sessions for staff and trainees has been initiated, after which repeated audit will be conducted as part of this quality improvement initiative.

**Aim and background** Incident reporting though poorly named is one of the pillars are of patient safety. Non-Consultant Hospital Doctors (NCHDs), while actively involved in patient care contribute minimally to incident reporting overall. This study evaluated NCHD knowledge of the incident reporting process and undertook an educational module.

**Methods** All NCHDS at Mayo University Hospital were invited to participate. Three scenarios were devised, reflective of actual cases, in conjunction with the authors and the quality improvement team. Pre and post-test questionnaires on the reporting process were devised that had a direct relevance and trainee perceptions on the training module were weighed and considered by the NCHD committee to ascertain clinical relevance for the trainees. A formal small group 30-minute instructional lecture with case discussion and actual case inputting was developed lead by the quality improvement team. Pre and post-test questionnaires on the reporting process were devised that had a direct relevance and trainee perceptions on the training process and barriers to reporting were elicited through thematic evaluation of the post training discussions which were recorded.

**Results** Forty (48%) trainees volunteered 23 SHO and 17 Registrars. The mean knowledge scores were 52 pre-test and 67 post-test. Trainees uniformly enjoyed being ‘walked through’ the reporting process and actually having a test opportunity to complete made it more real. Thematic evaluation suggest that trainees are not clear as to what constitutes an incident, have misconceptions of the incident reporting process and operate in an environment that is not conducive to reporting. Patient safety and incident reporting are not viewed as being interconnected.

**Conclusions** This educational module enhanced trainee knowledge, corrected misperceptions on its role and suggests that they are more likely to report on clinical incidents. The reporting tool, however, is not geared to the end user which is a hindrance in reporting and the language used facilitates a negative connotation.