Aim To keep mothers and babies together and decrease term hypoglycaemia admissions through implementation of a new guideline for management of healthy term babies with asymptomatic hypoglycaemia in the first 48 hours; in line with the British Association of Perinatal Medicine neonatal hypoglycaemia framework for practice, by the 1st of October 2018.

Methods Hypoglycaemia threshold in healthy term babies <48 hours was redefined as ≤ 2.0 mmol/l (previously ≤ 2.6 mmol/l) and the use of buccal dextrose gel in its treatment.

A multidisciplinary group was set up in the level 3 NNU. The guideline was disseminated using a 'read and sign' approach. A buccal dextrose monograph was developed. The blood gas analyser on labour ward was upgraded to allow neonatal sampling. Champions supported implementation through educational 'buzz' sessions and training videos. Test PDSAs were carried out, resulting in further training and guideline revision.

Results Baseline data revealed that hypoglycaemia made up 4% of term admissions (2% full admissions, 2% short stay ≤ 4 hours {SS}). 37% of babies required IV fluids, 44% required nasogastric feeds and 19% were given oral formula top-up feeds. 41% of women intended to exclusively breastfeed, 7% were doing so at discharge. For quality assurance, a prospective audit of blood gas glucose and lab blood glucose was carried out. Our outcome measure is % of term admissions to NNU with hypoglycaemia. Since implementation there is a trend towards reduction in admissions - 2 SS admissions only. Our process measure is compliance with the hypoglycaemia bundle - currently 65%. Our balance measures are: any adverse events, incorrect protocol (term vs preterm) use and an increase in breastfeeding rates. 1 infant >48 hours with no hypoglycaemia risk factors was treated on this protocol. There has been no incorrect protocol use. 72% of women intended to breastfeed, 47% were exclusively breastfed at discharge.

Conclusion There is a trend towards reduction in separation of mothers and babies. Bundle compliance requires ongoing work. Understanding barriers has been key to maintaining interdisciplinary staff engagement. There are ongoing challenges around equipment, the use of two different thresholds in term and preterm infants and avoiding person dependency.

G82 CHANGING THE 'NO CHANGE' CULTURE: INCREASING USEFULNESS OF THE SCBU WARD ROUND

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Aim This Quality Improvement project aimed to increase the usefulness of ward rounds in a busy Special Care Baby Unit (SCBU; i.e. low dependency neonatal unit). Most babies' primary reasons for remaining inpatient in SCBU are to gain weight and establish oral feeds. Despite this taking weeks for some, they were seen daily on ward round. Baseline data showed that 86% ward round plans for these low risk babies made no changes to management. My aim was to halve this number in four months.

Method Babies that required daily medical review (table 1) were identified and excluded from the project, leaving only low risk infants. The medical team were instructed to actively seek out babies of concern by discussion with nurses before ward round.

Abstract G82 Table 1

Exclusions

- Any nursing concerns (ask explicitly)
- Any parental concerns
- On treatment dose antibiotics, intravenous fluids, morphine
- Being observed for drug withdrawal
- Known cardiac defect that could lead to heart failure
- 'Rooming In' prior to discharge

The first PDSA cycle introduced the project to colleagues. Subsequent cycles reduced the frequency of ward round to three times per week, trialling different days. Data was collected from clinical notes. Balancing measures were details of babies that became unwell in the data collection period.

Results The frequency of ward round plans making no changes to management of low risk babies dropped from 86% to 17%, which surpassed the aim. Doctors felt they had more time to help colleagues on the postnatal ward, complete discharge paperwork further in advance (thus facilitating morning discharges) and for projects. Medical and nursing teams were satisfied that well babies were not examined and disturbed daily.

Conclusion Medical and nursing teams are more satisfied with ward rounds occurring three times per week instead of daily for low risk babies in SCBU. More work is needed to look into ways to empower nursing staff to lead on care in low risk babies on their journey to discharge. This project would have had more impact if a reliable measure could be found for staff efficiency.

G83 REDUCING LENGTH OF STAY FOR CHILDREN WITH PROLONGED ADMISSIONS TO HOSPITAL

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Aims To reduce the length of stay for patients with prolonged admission to a tertiary paediatric hospital. To improve experience for patients by reducing the disruption to their personal and family life, development and education, reduce discomfort and risk of healthcare associated harm. To improve capacity for the institution to undertake additional activity, improving financial performance. This additional activity would also reduce waiting times and improve access to care for other children. To improve the experience for health care professionals by enabling better care and reducing conflict.

Methods We systematically collected data on length of stay for inpatients across our institution (excluding neonatology) retrospectively and prospectively. We reviewed this data and shared it with clinicians (and continue to do so), we engaged with families and staff to identify their priorities and learn from their experiences. We initiated a range of projects related to this theme, including new care standards, new electronic documentation, education and collaboration sessions, new working practices and new staff roles. We developed a governance structure to monitor and sustain these new approaches, and are continuing to work on continuous improvement across a range of metrics.