Methods I identified babies of birthweight less than 1kg on BadgerNet. Their discharge summaries showed whether they received insulin. Their prescription charts were reviewed for whether GIR was documented on prescribing insulin. The total number of bloods taken in the first 24 hours of starting insulin and whether the baby had an arterial line were noted. Findings were presented on 24/02/21 to the neonatal team and we discussed and suggested possible changes to improve documentation of GIR.

Results The number of babies less than 1kg birthweight identified as having received insulin on the unit was 13. 54% of them had their GIR documented the first time insulin was started whilst 46% did not. 69% of them had an arterial line whilst 31% did not. 56% of babies with arterial line had their GIR documented whilst 44% did not. 75% of babies without arterial line had their GIR documented whilst 25% did not.

The average number of times blood was taken in all the babies in the audit was 6.5. The average number of times blood was taken in babies with an arterial line was 5 whereas it was 8.8 in those without arterial line.

The number of times blood was taken from babies whose GIR was not documented was 2% higher than those whose GIR had been documented.

Conclusions The majority of babies had their GIR documented but there is big room for improvement. Documentation of GIR may be associated with a reduction in the number of times blood is taken.

Recommendations 1. Place the formula for GIR on the second side of the insulin prescription chart where the GIR is written to make it easier to see.

2. Calculate GIR using our e-handover system which allows for IV fluids to be prescribed on it and also shows GIR of the total fluids prescribed.

3. Consider speaking to pharmacy if GIR is raised and ask for a bespoke TPN bag with less glucose.

4. Nursing staff could prompt medical staff to write the GIR on insulin charts before giving insulin.

5. Present findings to the new cohort of trainees starting in March 2021, highlighting the importance of calculating the GIR and acting on it before starting insulin.

British Association of Perinatal Medicine and Neonatal Society

1041

AUDIT ASSESSING ANTIBIOTIC ADMINISTRATION FOR SUSPECTED EARLY-ONSET NEONATAL SEPSIS ON THE POSTNATAL WARDS IN ADDENBROOKE'S HOSPITAL, UK

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Background Neonatal sepsis is a systemic infection in newborns and a significant cause of morbidity and mortality. Early signs of sepsis are often non-specific; hence it's essential to identify risk factors and commence treatment as soon as possible, to optimise outcomes.

Following the results of a previous audit in Addenbrooke's Hospital in 2018 and with the COVID-19 pandemic; from September 2020 there has been a change in the practice in

our neonatal unit. Instead of transferring babies to NICU for cannulation and antibiotics administration, midwives have been trained to administer antibiotics on the postnatal wards. This minimises COVID exposure and aimed to reduce the time taken to administer antibiotics.

Objectives Following the recent change in practice, the aim of our audit was to assess the time taken for antibiotics to be administered after the decision has been made to treat and explore the reasons behind any delay in antibiotic administration on postnatal wards. Our set standard was that 100% of babies with early onset neonatal sepsis should have antibiotics administered within one hour of decision made to treat, as per the NICE guidelines.

Methods Retrospectively we identified neonates on the postnatal ward that were >35 weeks gestation, >1.8 Kg, born in September 2020 and November 2020 that underwent a partial septic screen. We obtained the following data: gender, mode of delivery, decision time to screen, time taken for antibiotics to be prescribed, duration for antibiotics to be administered and reasons for a delay in performing the septic screen or administering the antibiotics.

We also sent an online questionnaire to doctors working at the hospital to help determine potential reasons behind antibiotic administration delay.

Results Out of 100 babies analysed, 15% of the babies requiring treatment received antibiotics within the hour from decision time.

	Median (Minutes)	Range (Minutes)
Time taken for antibiotics to be administered after decision to treat	106	17–553
Time taken for antibiotics to be prescribed after decision to treat	59.5	0–249
Time taken for antibiotics to be administered after prescription	41	0–425

There was no significant difference between results from September and November 2020.

The questionnaire revealed that reasons for delay included; delay in communication of risk factors between midwifery to neonatal team, neonatal team being busy with emergencies/clinical duties, poor stocking of cannulation trolleys and assumption that medical team had administered the antibiotics. **Conclusions** We did not meet the NICE guideline standard in administering antibiotics for suspected neonatal sepsis. However, implementing this change helped to minimise separating babies from mothers and reduced the risk of COVID 19 exposure.

We identified issues resulting in delay of antibiotic administration and presented this to the neonatal and midwifery team. We introduced a sepsis cannulation box and also a template on the electronic patient record system (EPIC smart phrase) which highlights babies requiring treatment to midwives, along with the subsequent steps to follow. We also recommended that doctors prescribe antibiotics prior to cannulation and most importantly we raised awareness of the NICE guidelines to the multidisciplinary team.