Abstract 1549 Table 1 Views on whether respondent would refer to coroner/PF

Case	Brief summary of case	Referral	No referral	Unsure
1	22+1/40. HFOV in 100% oxygen. Cranial ultrasound reveals bilateral parenchymal infarcts. Decision made with parents to re-orientate care.	5 (8.1%)	55 (88.7%)	2 (3.2%)
2	38+1/40 Oesophageal atresia. Baby dies 72 hours post-operatively with clinical signs and microbiology confirmation of E. Coli sepsis.	49 (79%)	9 (14.5%)	4 (6.5%)
3	Term. Admitted for therapeutic hypothermia. Abnormal cerebral function monitor trace, abnormal clinical neurology and MRI brain shows profound abnormalities in the thalami and white matter. Decision to re-orientate care. No parental concerns or obstetric care issues.	31 (50%)	24 (38.7%)	7 (11.3%)
4	35/40 Confirmed trisomy 18 with aortic atresia and PDA. Palliative care pathway initiated. Given paracetamol for pain related to bruising. 1 hour later, collapsed and resuscitation unsuccessful.	24 (38.7%)	29 (46.8%)	9 (14.5%)

significant impacts upon the practitioner, the family and from a legal perspective.

Objectives To describe contemporaneous neonatal and paediatric consultant practises with respect to referral of hypothetical neonatal deaths to HM Coroner/PF.

Methods Online survey conducted between July-October 2020 of neonatal and paediatric consultants in the UK.

Results 62 responses were received with the majority being from level 3 neonatal unit consultants (87%). 22/62 (36%) of respondents did not have a policy or guideline for referral to the Coroner/PF (87.1% from level 3 neonatal consultants). 23/62 (37%) believed referral criteria were uncertain or unclear and only 4/62 (6.5%) respondents believed referral criteria to be unambiguous. Views on whether the respondent would refer patients from 4 clinical cases were sought (table 1).

Conclusions Our data suggest clinical uncertainty and therefore, variation when deciding if a neonatal death should be referred to the Coroner/PF except in the context of extreme prematurity and significant postnatal level of critical illness and brain injury (Case 1). This is particularly so for babies who die in the context of therapeutic hypothermia and HIE (Case 3). We propose stronger senior neonatal-Coroner/PF dialogue alongside the already established medical examiner role to reduce variation in clinical practise, protect clinicians and to ensure the right decisions are made for the bereaved family within the confines of existing legislature.

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NEONATAL NURSE SHADOWING PROGRAMME: EXPLORING NEW WAYS OF LEARNING IN PAEDIATRICS & INTENSIVE CARE (A PILOT STUDY)

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Background Holistic and multi-disciplinary care within paediatrics & child health is widely valued, and neonatal medicine is no exception. During a baby's journey in neonatal intensive care, the role of the neonatal nurse is vast and crucial to their wellbeing, offering a blend of skill, knowledge, and compassion to a vulnerable population of patients. As junior paediatricians, the focus of learning mostly revolves around medical diagnoses, resuscitation, and procedural skills. However, rarely do trainees get exposed to the untapped reservoir of knowledge that exists amongst our allied healthcare professionals, notably the neonatal nurses; even rarer is a formal, structured way to access this.

Objectives The benefits of shadowing experienced NICU nurses could be invaluable for paediatric trainees at the start of their career. The primary aim of this pilot study was to launch a new programme involving all senior house officers (SHO) in one 6-month rotation in secondary (Level 2) & tertiary (Level 3) neonatal intensive care. The goals were to add a new dimension to their neonatal education, improve their confidence in troubleshooting bedside problems, improve team cohesion and eventually improve patient care overall.

Methods During the 6-month rotation, every neonatal SHO had at least one day pre-allocated on the rota for 'Nurse Shadowing'. A specific timetable, devised in combination with Neonatal Nurse Educators, allowed supervised experience in caring for premature and term infants on NICU, assisting in drug/trolley checks, and attending nursing meetings. SHOs were given an optional list of skills to observe (e.g. nasogastric feeding). Every trainee was also allocated a nurse mentor on the day. The impact of the pilot programme was analysed using anonymised questionnaires with Likert scale questions (1 = not confident, 5 = very confident), assessing their confidence in the 22 suggested skills before and after the shadowing days – a mean improvement in score for each skill was then calculated. The nursing team members also completed a tailored questionnaire to evaluate their experience of the days.

Results Fourteen SHOs were enrolled in the programme. 14/14 (100%) of doctors would recommend the programme to future trainees, and 13/14 (93%) felt it improved their team-working and relationship with the nursing team. The three most valuable skills for trainees were setting-up a transport incubator (+2.9), using infusion pumps (+2.5) and ventilator/CPAP set-up (+2.2). In every skill assessed, the SHOs felt on average more confident after their experience. Certain skills however, such as iNO use (+0.3) and PN administration (+1.5), were less frequently observed. Seventeen neonatal nurses were involved, and 17/17 (100%) agreed or strongly agreed that participation was enjoyable, improved their

rapport with paediatricians and that the programme would improve overall NICU patient care.

Conclusions The *Neonatal Nurse Shadowing* pilot programme has shown that nurse shadowing on an ICU can have promising impacts on paediatric education, as well as team cohesion and patient care, based on our staff's experiences. There has been interest from our local neonatal network to trial the programme elsewhere, with an ambition to expand it to paediatric/cardiac ICUs and Emergency Departments going forward.

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INTRODUCTION OF VIDEO MESSAGING TO A TERTIARY NEONATAL UNIT DURING COVID-19: THE STAFF AND PARENT EXPERIENCE

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Background Family integrated care (FiCare) advocates parents as primary caregivers. There is growing evidence demonstrating its associated improved outcomes for babies and it forms an integral part of the Bliss baby charter, BAPM national service quality indicators and Best Start in Scotland.

Covid-19 has presented new challenges in delivery of FiCare with restrictions on entry to the neonatal unit resulting in family separation being a more pertinent issue than ever. Benefits of asynchronous video messaging have been documented by Patel et al. and in April 2020, during the peak of the first wave of Covid-19 in the UK, a new, secure video messaging service – vCreate – was introduced to our unit. It has become an integral part of FiCare and we report here the staff and parent experience.

Objectives To evaluate the neonatal unit staff and parent experience of introduction of a secure, video messaging service (vCreate) to a tertiary neonatal unit during the Covid-19 pandemic.

Methods Neonatal unit nursing staff were asked to complete a free text response to the question 'What do you think about vCreate?'

Parents were asked to provide free text responses about their thoughts on vCreate, any negative experiences they have had and how they felt use of vCreate could be improved. In addition, parents were asked if they would recommend vCreate to other parents.

Anonymous free text responses underwent qualitative content analysis to identify common themes.

Results Survey responses were obtained from fifty staff members and thirty set of parents.

Among staff, common themes identified were how quick and easy the equipment and application are to use and how much family appreciate the videos. The few negative comments pertained to staff wishing for further education on vCreate account set up.

Themes throughout parent responses were reduced anxiety and worry, less feeling of separation, positive effects on breast milk expression, particularly overnight and a sense of inclusion, feeling that they were not missing out on any significant moments in their baby's journey. The small number of negative responses alluded to families wishing to receive more videos.

All parents who completed a questionnaire would recommend vCreate to other parents.

Conclusions Initial responses from staff and parents have been very positive and emphasise the important role vCreate plays in FiCare delivery. They provide an invaluable insight into the staff and parent vCreate experience to date and will help direct future use of the messaging service in our unit.

Planned next steps include aiming for every baby on our unit to have a vCreate account and video within 24 hours of admission and to expand use of the vCreate platform to provide parent education resources.

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WALKING IN THEIR SHOES: SUPPORTING THE UNIQUE JOURNEYS OF NICU PARENTS

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Background 'His tiny body wired to machines broke our hearts. We felt scared, helpless, exhausted and alone. Born 12 weeks early, weighing just 2.4lbs (1.1kg), the emotional turmoil of ventilators, surgery, feeding tubes and his daily fight to grow was unbearable. The psychotherapy we received was essential but when our boy was ready for home, we certainly were not' – former NICU parent.

Parents whose babies require hospitalisation due to prematurity, illness or congenital abnormalities experience an emotional journey which can increase the risk of anxiety, depression and post-traumatic stress. Mothers of premature babies are 40% more likely to suffer with postnatal depression than full-term babies.¹ Perinatal ill-health has a lasting impact on parental relationships, children's wellbeing, employment and social integration. Parents on neonatal intensive care units (NICU) exhibit effects of being separated, difficulty bonding, feelings of inadequacy and guilt which many feel unable to verbalise or feel misunderstood by their usual family/friends network.² Peer support from other NICU parents who have struggled and survived similar challenges, was an area of family-centred care we were keen to explore.

Objectives

1. Facilitate weekly in-hospital peer support groups for current and discharged NICU parents.
2. Develop an online support network for local parents to build friendships, grow in confidence and share resources.
3. Co-produce basic life support training and parent education to help empower parents and increase child health knowledge.
4. Collaborate with parents to improve our holistic care, listening to their needs and learning from their feedback.

Methods Parents were invited to a community outreach session every Thursday for 16 weeks on NICU. Parents 'On NICU' and 'Discharged' had refreshments together with a neonatal nurse, Bliss Volunteer, Community Sister, Paediatric Registrar and/or trainee psychotherapist. BLS training and an education programme were developed. Parents were encouraged to join a Whatsapp group and share experiences/advice using social media.