Results We found that there was a reduction in median invasive ventilation days (0 vs. 2 days), non-invasive respiratory support days (0 days vs. 39 days) and total oxygen days (5 vs. 34.5 days) in the LISA cohort compared those receiving surfactant via endotracheal tube. One infant required home oxygen in the LISA cohort vs. eight in the non-LISA. There was a 9% reduction in BPD rates after introduction of LISA according to NNAP data. Eight babies required intubation following unsuccessful LISA. Compared to their successful counterparts median invasive ventilation days, non-invasive respiratory support days and total oxygen days were 1.5 days, 17.5 days and 10 days respectively. Of the babies who required intubation five had a complete course of antenatal steroids, and three an incomplete course.

Conclusions Following the introduction of LISA we successfully saw a reduction in total ventilation days, total non-invasive ventilation days, total oxygen days and bronchopulmonary dysplasia rates. With LISA becoming a standard of care for infants requiring surfactant and part of a package aimed at reducing BPD rates in our unit, we hope to see a sustained reduction in ventilation days and BPD rates. As no discriminating factor amongst those infants requiring intubation post LISA could be identified no changes have been made to the eligibility criteria for LISA.

Quality Improvement and Patient Safety

574 IMPROVING INFORMATION PROVIDED BY LABOUR WARD STAFF WHEN REQUESTING NEONATAL ATTENDANCE AT DELIVERIES – A QI PROJECT

¹Jennifer Mitchell, ²Rachael Ferguson, ¹Ivory Huang, ¹Hilary Conetta. ¹NHS Greater Glasgow and Clyde; ²NHS Ayrshire and Arran

10.1136/archdischild-2021-rcpch.76

Background Handover is an essential component to ensuring patient safety. It was noted by neonatal staff that there was variation in which team members were being contacted and the information provided by Labour Ward and Theatre staff when requesting neonatal attendance at a delivery.

Objectives Our aim was to assess the handover provided to identify areas where this could be improved.

Methods We devised a data collection form, and collected information for each phone call we received over a two week period. We collected data on which staff were called/paged to attend, and the information provided.

Results We found that there was a wide variation in relation to which team members were being called/paged. The registrar was only paged 64% of the time, and 23% of the time neither doctor was paged and only the neonatal unit ward phone called. We were informed of gestation 38% of the time, and reason for attendance 87% of the time.

It was decided that the registrar and FY2 were required to be contacted for a delivery, and the neonatal unit did not need to be called separately. Signs were put above phones in labour ward and theatre informing staff of the page numbers to be contacted, and the information required. Senior staff on Labour Ward disseminated this information to their staff and included it in daily safety briefs.

We performed a second round of data collection six weeks following this intervention. There remained some variation in who was contacted, however there was improvement with the registrar now being paged 79% of the time, and only the neonatal unit ward phone being called reduced to 10%. We were now informed of the gestation 59% of the time, and reason for attendance had increased to 100%.

Conclusions This project showed that a simple intervention can make an improvement in the quality of information provided between teams. By ensuring that the correct team members were contacted this allowed for the necessary staff to attend a delivery with minimal delay. By providing important information to the neonatal team it allowed the registrar to decide if a neonatal nurse was also required to attend a delivery, thereby ensuring that their resources and staff were being utilised effectively.

Child Protection Special Interest Group

575 HEAD INJURY <1 YEAR OLD AND THE EMERGENCY DEPARTMENT MANAGEMENT. DID SOMEONE HIT EM?

¹Patrick Aldridge, ²Fran Franks, ²Heather Castle, ²Nicola Onanion, ²Rachel Parish. ¹Frimley Hospital; ²Frimley Park Hospital

10.1136/archdischild-2021-rcpch.77

Background Infants presenting with injury are known to be a high-risk group for Safeguarding concerns. National guidance highlights the importance of adequate processes to identify and assess this group. Locally a bi-weekly multi-disciplinary Safeguarding meeting reviews all high risk or concerning presentations to quality assure internal processes. In our Paediatric Emergency Department (PED) a 'Safeguarding information sharing form' (SIF) triggers this review. Submission is the joint responsibility of medical and nursing staff. Local practice review in 2017–18 highlighted areas for improvement with a quality improvement project (QIP) January 2018-December 2019. We wanted to establish whether changes implemented had become embedded using a separate analysis method to the original QIP.

Objectives 1. Improve & sustain documentation of 'the safeguarding triad' (SFT) in <1 year olds presenting with head/ facial injury:

- Full exposure
- Absence/presence of bruising or marks
- Developmental stage

2. Improve & sustain submission of SIF for these infants

Methods All infants aged <1 year who attended our PED (28,000 total attendances/year) with 'head or facial injury' as the initial complaint between 01/01/2017 to 31/01/2021 were retrospectively included. Using random number generation in *Microsoft Excel*, 5 infants per month were selected as a truly random selection should fairly reflect processes over time. Clinical notes of selected patients were reviewed for documentation of all 3 parts of SFT and whether a SIF was submitted to the Safeguarding team. Data was entered into monthly run charts with pre-intervention median calculated January-December 2017. Interventions were noted on the run charts. A