Abstracts

Palliative care is on the nursing and medical students syllabus. Senior staff were keen for more training. Topics that staff felt anxious about were breaking bad news, anticipating palliative needs and use of medication.

Conclusions The establishment of a training and mentoring service for staff in palliative care is required and desired. Paediatric diagnostic facilities need improved including equipment and access to specialist opinions eg an echocardiogram. in the main hospital in Banjul.

The use of online Palliative training through lectures and modules, supported by scheduled in person visits is thought to be a good solution particularly in the current Covid-19 situation. 1 online lecture session has already taken place for 30 participants, supported by the MoH. This had good media coverage and promoted CPC awareness within the country. M.Sowe is currently undertaking a Palliative Care Diploma in Uganda partly funded by this grant. The World Bank has recently provided funding for specialist paediatrician secondment to The Gambia to improve paediatric services and a memorandum of understanding for patient pathways has been signed with the much larger neighbouring country of Senegal.

Quality Improvement and Patient Safety

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BABY, IT'S COLD OUTSIDE! REDUCING ADMISSION HYPOTHERMIA FOR NEWBORN BABIES QIP

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10.1136/archdischild-2021-rcpch.155

Background Newborn babies are regularly admitted to neonatal units hypothermic ($<36.5^{\circ}\text{C}$). Hypothermia is associated with an increased risk of morbidity and mortality. Baseline data from January-June 2019 at our unit showed that 16% of premature ($<36/40$ gestation) and 6% of term ($\geq 36/40$ gestation) neonates were admitted hypothermic.

Abstract 710 Table 1 PDSA cycles tested from November 2019-May 2020

PDSA Test	Date	Plan	Do	Study	Act
1	03/11/19	Thermal care education	Targeted teaching session to junior doctors	Improvement- likely transient	Again - at new starters induction
2	17/01/20	Reduce evaporation as form of heat loss using hats	Appropriately sized hats on resuscitaire for premature babies	No improvement- lack of appropriately sized hats readily available	Adapt- find a supply of hats
3	03/03/20	Ensure supply of appropriately sized hats	Red Hats initiative. Social media campaign for supply of knitted red hats. MDT collaboration.	Improvement	Continue

Abstract 710 Table 2 Admission temperatures before and after PDSA cycle interventions

Gestational age	Data set	Total number of eligible babies	Temperature on admission:			Average percentage of hypothermic admissions
			$<36.5^{\circ}\text{C}$	$36.5-37.5^{\circ}\text{C}$	$>37.5^{\circ}\text{C}$	
All preterm ($<36/40$)	Baseline data	102	16 (16%)	80 (78%)	6 (6%)	15%
	PDSA 1	28	3 (11%)	25 (89%)	0 (0%)	11%
	PDSA 2	13	2 (15%)	10 (77%)	1 (8%)	15%
	PDSA 3	32	4 (13%)	26 (81%)	2 (6%)	12%
	Cumulative PDSA	73	9 (12%)	61 (84%)	3 (4%)	12%
Very preterm ($<32/40$)	Baseline data	21	5 (24%)	13 (62%)	3 (14%)	24%
	Cumulative PDSA	9	1 (11%)	6 (67%)	2 (22%)	11%
Term ($\geq 36/40$)	Baseline data	219	13 (6%)	196 (89%)	10 (5%)	6%
	PDSA 1	48	3 (6%)	44 (92%)	1 (2%)	6%
	PDSA 2	22	1 (5%)	20 (91%)	1 (5%)	5%
	PDSA 3	88	2 (2%)	82 (93%)	4 (5%)	2%
	Cumulative PDSA	158	6 (4%)	146 (92%)	6 (4%)	4%

Objectives We initiated a QIP to reduce the number of hypothermic admissions in November 2019. Our primary aim was to reduce the number of premature babies admitted with hypothermia from 16% to 5% by the end May 2020. Our secondary aim was to reduce term hypothermic admissions from 6% to $<5\%$.

Methods We included all premature and term babies admitted to SCBU for their first episode of care. We excluded all second episodes of care and external place of delivery.

Our outcome measure was the first axillary temperature on admission recorded on BadgerNet. Our balancing measure was to monitor the number of hyperthermic ($\geq 37.5^{\circ}\text{C}$) admissions.

We ran a series of PDSA cycles over a 6-month period from November 2019-May 2020 (table 1).

Results There was a reduction in hypothermic admissions for all premature babies from 15% to 12% (table 2). When sub-categorised into very preterm ($<32/40$) we noted a marked reduction from 24% to 11%. We reduced hypothermic admission for term babies from 6% to 4%. Overall, we did not see an increase in hyperthermic admissions.

Conclusions Our QIP has led to a reduction in the number of hypothermic admissions for term and preterm infants, with the most notable decrease for very preterm infants.