Phase 3 We commenced a ‘Tea Trolley Teaching’ programme inspired by the results from the micro-narrative work, entitled ‘Have Courage – Don’t Panic – Delay Clamping’. This included clarifying the small number of situations where DCC is contraindicated. Following this intervention, on average >80% of babies <32 weeks received DCC (figure 1).

Phase 4 We carried out an in-depth investigation of the reasons for not achieving DCC in three very preterm babies. This phase demonstrated that DCC was always considered, even if 1 minute was not achieved. The main reason for not carrying out DCC was the condition of the baby, and was usually a consultant decision.

Conclusion We have successfully improved rates of DCC on our unit, improved staff’s understanding of the importance of the intervention, and enjoyed carrying out a project as a peri-natal team. Clear understanding of the benefits of DCC, experience in delivering it, and effective teamwork and communication (including a pre-delivery huddle) are the key to successful outcomes.

Abstract 763 Figure 1 Proportion of babies <32 weeks receiving DCC (≥1 minute)

Abstract 900 Figure 1

SIDE LYING KANGAROO CARE: ALL THE BENEFITS WHILST STILL MAINTAINING MIDLINE HEAD POSITIONING

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Aims Extremely premature infants are at higher risk for intracranial ischaemic and haemorrhagic injuries, which often occur in the first 72 hours after birth. Intraventricular haemorrhages (IVHs) are associated with increased risk of death and adverse neurodevelopmental outcomes. There are various postnatal strategies aimed to reduce IVH risk, including midline head positioning. Maintaining a midline (neutral) position is thought to avoid jugular venous obstruction, reduce ipsilateral venous congestion, thus potentially lower the risk for IVH.

For extremely preterm babies, Kangaroo Care (skin-to-skin), offers a wide range of benefits including decreased mortality, an improvement in physiological parameters, pain-relief, and improved long-term developmental outcomes. It also empowers parents to play a role in their baby’s care; improves bonding and increases breast-milk supply. The traditional method of carrying out Kangaroo care involves the baby’s body being placed on a parent’s chest with their head turned to one side; therefore is not kept in the midline as recommended for IVH early prevention care.

Our objective was to find a method that allows the positives of Kangaroo care while reducing the risk of IVH by keeping the baby’s head in the midline position.

Methods We implemented a method of carrying out Kangaroo Care in side-lying position in the early management of extreme preterm babies, which ensures the baby’s head is kept in the midline during skin-to-skin. As part of IVH prevention bundles, nurses and medical staff were educated on how to perform side-lying kangaroo care with clinically stable extreme preterm babies in the first 72 hours of their life. Education was incorporated into the unit’s simulation training and photos were displayed showing the correct positioning (figures 1 and 2).

Results Feedback from staff and parents who had been involved in side-lying kangaroo care has been very positive. It is felt that the practice is aligned with the Family Integrated Care and developmental care cultures, whilst being clinically safe. Parents reported early Kangaroo care aided bonding and enhanced their breast-milk production.

Abstract 900 Figure 2
Conclusion Kangaroo Care in extreme preterm babies in the first 72 hours of life can be carried out safely using the side-lying technique. This allows babies and parents to experience the benefits of Kangaroo Care, whilst still maintaining the principles of IVH prevention with regards to midline positioning of the head. Staff education can ensure that side-lying Kangaroo Care can be carried out safely.

Figures 1 & 2: Manikin baby is nursed side-lying to allow the head to remain in midline position during Kangaroo Care as part of unit teaching aid.

REFERENCES

Reducing procedural pain in neonates
Laura Harrison. Oxford University Hospitals NHS Foundation Trust, Oxford

Aims Neonates may experience over 200 painful procedures during their first 14 days of life. Neonates are hypersensitive to painful stimuli and poorly treated pain may lead to adverse physiological effects including to brain structure, which can be life threatening and have long-term effects. Non-pharmacological treatments such as non-nutritive sucking and kangaroo care may be beneficial in alleviating a neonate’s pain. Pharmacological treatments in neonates are well established and include opioids and non-opioid analgesics. The aims of this study were to establish the average number of painful procedures undergone by neonates in the NICU in the first 5 days of life and identify ways to reduce procedures without compromising patient care.

Methods All the inborn neonates present in the ICU and HDU nurseries on the day of data collection, who were more than 5 days old were included. A retrospective review of records was undertaken to ascertain procedures undertaken including blood tests, intubation, cannulation, insertion of umbilical lines, long lines, peripheral arterial lines and chest drains.

Results 18 babies were included in the study, with gestational ages at birth ranging from 23+5 weeks to 40+1 weeks. The average number of procedures undergone by each neonate in the first 5 days of life was 24.4 (the range was 14 to 48), an average of 4.9 per day. However, the number of painful procedures was lower than this when blood tests taken from arterial lines were taken into account. Blood tests were the most common procedure, followed by cannulation and insertion of venous lines (UVs and long lines). It was noted that many babies had different blood tests (e.g. blood gases, formal laboratory bloods and SBs) performed at different times of the day but within a few hours of each other.

Conclusion Many neonates receiving intensive or high dependency care, still undergo a significant amount of painful procedures in the first few days of life and there is room to reduce these while maintaining the highest standards of medical care. Recommendations include combining blood tests, doing tests at time of cannula/line insertion, use of indwelling lines where appropriate and more focused, consultant-led, MDT planning of daily bloods on ward rounds. Where procedures cannot be avoided, reducing procedural pain should be a priority. Recommendations for this include the use of sucrose, skin-to-skin/kangaroo care, non-nutritive sucking, swaddling and parental presence.

References