Conclusion Only 60% of the total transfer were recorded in the transfer book. 67.6% of patients in our DGH had no feedback letter summarising care given at the receiving hospital and 45% of patients had no local follow-up post transfer. All of which have impact on continuity of care at our local DGH. Following on from this survey, clear pathways are underway to ensure all patients transferred are captured in the book as well as an automatic system of follow-up post transfer and a system of regular review of transfers to share learning and continually improve patient care.

1186 SERVICE EVALUATION PROJECT IN A BUSY DGH TO ASSESS READMISSION OF NEONATES TO CHILDREN’S ASSESSMENT UNIT WITH JAUNDICE AND WEIGHT LOSS WITHIN 48 HOURS OF DISCHARGE

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Aims Neonatal jaundice and weight loss are one of the commonest reasons of readmission to the Children’s assessment unit and make up bulk of hospital admissions almost every day of the week irrespective of the time of the year. The main aim of this service evaluation project was to investigate the reasons for these immense readmissions to the paediatrics unit but also to try creating new pathways or protocols that would not only help not only reduce patient load on clinicians but, also reduce the added stress on exhausted mothers who suffer the guilt of ‘failing their new born babies’.

Methods To achieve our objectives, a retrospective study of all neonatal admissions to Children’s assessment unit between the months of April to December 2020 was conducted using a questionnaire drafted for this purpose Our selection criteria included only those babies who were readmitted within 48 hours of discharge home since birth. All other causes for readmission were excluded. Our sources for data collection were from widely used software within neonatal units across the country called ‘Badgernet’ and local trust records of neonatal and paediatric handover sheets from 2020.

Results 60 patient notes from April to December 2020 were reviewed of which only 42 met our selection criteria, and hence the remaining 18 were excluded from the project. All 42 babies 37 were admitted from either the postnatal ward 3 from SCBU and 2 from transitional care.

26 of 42 neonates were seen within 48 hours of discharge from hospital which made up 62% of all readmissions, of which 3.7% were within 24 hours. The remaining 38% were admitted between 72 hours and 96 hours which were beyond the realm of this project (figure 1). The commonest reason for readmission was observed to be jaundice in 11 out of 26 neonates making up almost half of the readmissions. The other causes were weight loss seen in 9 out of 26 babies followed by combined jaundice and weight loss in 6 of 26 neonates (figure 2). Of the cohort of jaundice and combined symptoms 12 were found to require phototherapy with 2 of these neonates needing intensive and triple and quadruple phototherapy.

Weight loss was assessed as percentages which included those less than 10%, between 10 and 12.5% and those more than 12.5%. The maximum weight loss observed was 17% and secondary to poor feeding. It was surprising to find no documented feeding plan for babies discharged from the postnatal unit and is being investigated further.

Conclusion From the data collected it was evident that these large number of readmissions occurred throughout the year, with exhausted parents spending hours waiting to be reviewed only to be informed of readmission.

The solution is far from simple, yet achievable by developing direct referral pathways to postnatal wards bypassing the hectic children’s assessment unit and by creating a proforma...
which reminds midwives and doctors to discuss and document feeding plans, as well as assess jaundice using a transcutaneous bilirubinometry for visibly jaundiced babies to reduce readmission.

**Aim**

Babies at risk of hypoglycaemia should be identified at birth and placed on a care pathway that includes early commencement of feeds, regular glucose monitoring and clinical assessment. Our hospital has a hypoglycaemia policy for managing these babies and this project aims to examine current local practice through auditing against local hypoglycaemia guidelines. Also, we attempted to identify possible correlation between hypoglycaemia and sepsis screen and make recommendations about future clinical practice.

**Methods**

Medical handover lists and tracking lists completed by midwives were used in postnatal ward (PN), delivery suite (DS) and neonatal unit (NNU), in order to identify all the babies less than one week old, who were on the hypoglycaemia pathway or who were screened for sepsis between first to thirtieth of November two thousand twenty one. The patient records were examined during admission to extract: patient demographics, if hypoglycaemia pathway was printed and put in the notes, details of the feeds offered, details of the management of hypoglycaemia when occurred and the blood glucose (BM) at the time of the sepsis screen. Babies who were born in poor condition and required transfer in another hospital were not included.

**Results**

37 babies were commenced on hypoglycaemia pathway.

- 33 babies were in PN/DS and 4 babies were in NNU.
  - None of the babies in NNU had the hypoglycaemia pathway printed (100%).
  - 4/33 babies in PN/DS (12%) were missed and hypoglycaemia pathway was not commenced.
  - 22/33 babies in PN/DS (66%) had the hypoglycaemia pathway printed. 19/22 babies completed correctly all the hypoglycaemia pathway, with correct documentation of blood sugars, feeds offered and glucogel use. 2 babies had the pathway left blank. 1/22 baby was transferred in NNU from PN and hypoglycaemia pathway was discontinued after 2nd feed.
  - 7/33 babies (21%) were not identified as inpatient and data collection attempted in retrospect from electronic records. In all 7 babies the hypoglycaemia proforma was not scanned and uploaded in the electronic records. (figure 1)
  - 42 babies were screened for sepsis. (figure 2). At the time of the screen 3/42 babies had a BM ≤ 1.9, out of which 2 babies were not on hypoglycaemia pathway - incidental hypoglycaemia during sepsis screen.
  - 5/42 babies had a BM 2-2.5 and 15/42 babies had a BM ≥2.5.
  - 9/42 babies did not have a documented BM.

**Conclusion**

PN/DS are doing well in following the hypoglycaemia pathway. However, a few babies are still missed and not monitored. For this reason, we are going to implement hypoglycaemia training for staff and add hypoglycaemia reminders in the wards. Hypoglycaemia pathway is not used in NNU, so we will create a hypoglycaemia proforma for NNU.

Sepsis is a risk factor for hypoglycaemia. Babies who are screened for sepsis should have their BM checked at the time of the screen and commence the hypoglycaemia pathway if it is low.

**Aim**

The intention is that any staff member, irrespective of role, grade, seniority, or experience, can call ‘Stop the Line’ if they see that required safety procedures and checks are not being followed.

‘Stop the Line’ is a well-known control mechanism with the primary aim of promoting patient safety. All members of staff are encouraged to ‘Stop the Line’ if they notice a series