90% of respondents reported knowledge of near miss definition, and similar proportion acknowledges that near misses should be reported (87%) (figure 1).

-Approximately two thirds of staff respondents were knowledgeable how to report near misses (63%) compared to 37% who did not (figure 1).

-Among variable scenarios 73-88% of respondents could identify the near miss events.

-Main suggested barriers to reporting near miss events were time constraints, lack of awareness of importance of near misses reporting and fear of adhering to the event.

**Abstract 1235 Figure 1** Demonstrating staff knowledge and attitude towards near miss reporting.

Conclusion There is a gap between staff intent to record a near miss occurrence and actual event reporting which could be either due to low incidence of near misses in the health organization or simply because of under reporting.

**REFERENCES**


**1232 INNOVATIVE ONLINE NEWBORN CARE POTENTIAL BENEFITS AND CHALLENGES OF ONLINE LACTATION CONSULTATION SERVICES WITH PEDIATRICIAN SUPPORT: A CROSS-SECTIONAL SURVEY STUDY**


**Aims** Telelactation, a virtual lactation support platform, is a convenient and effective way of providing virtual breastfeeding support services and communicating proper breastfeeding techniques to new mothers to address any breastfeeding challenges and boost overall maternal breastfeeding confidence all from the comfort of their homes. This Ontario Health Insurance Plan (OHIP) covered service benefits more to mothers in remote areas where in-person LC service is not easily accessible.

The objective of this cross-sectional survey study is to explore the feasibility, potential benefits, challenges, and level of patient satisfaction in virtual lactation consultation services available in Ontario, Canada.

**Methods** Patient satisfaction was assessed using a structured online survey as a part of a cross-sectional observational study that asked questions relevant to several independent demographic variables as well as specific Likert type scale questions to gauge patient satisfaction with virtual lactation consultation.

**Results** Data from 177 survey responses (n=177) was analyzed, of which the study revealed that 86.44% (153/177) were satisfied with the virtual lactation services they received. Patient satisfaction was found to be higher in the first-time mothers with high school or undergraduate education between the age group of 26-35 years living in the Greater Toronto Area (GTA). In terms of connectivity, participants from the GTA had a better experience overall compared to those living outside the GTA.

**Conclusion** OHIP covered telelactation is an innovative and feasible health care delivery platform for providing remote professional breastfeeding support to mothers of all socio-economic strata with great potential to further improve both patient experience and efficiency in patient care.

**1250 ORAL SUCROSE 24% FOR PROCEDURAL NEONATAL PAIN RELIEF QIP**

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**Aims** To improve prescription, documentation, and administration of sucrose usage for pain relief prior to painful procedures being carried to eligible infant in neonatal unit ICU and HDU by 50% by end of February 2022.

Neonates are often exposed to acute, repetitive, and chronic pain within the NICU setting because of procedures, surgeries, and disease processes. Preterm neonates, especially those <30 weeks gestation, are exposed to 10-15 painful procedures per day at a time when pain is developmentally unexpected. Pain in the neonatal period is often unrecognized and undertreated. In infants born extremely preterm (gestational age ≤29 weeks) greater numbers of painful procedures have been associated with poor early neurodevelopment, altered brain development, delayed postnatal growth and higher cortical activation.

**Methods** -Encourage junior doctors to prescribe sucrose for eligible infants as per local guidelines.

-Small cards with dosage and contraindication made available to junior doctors in the neonatal unit.

-Sucrose stocked near ICU and HDU rooms (Currently sucrose is stored in the back storeroom in special care unit), this was the main reason staff answered in survey to explore the barriers for using sucrose adequately as most respondents were either unaware of near ICU/HDU. Our unit Housekeepers/pharmacy were happy to help with extra stock and its distribution.

-Posters displayed to remind staff to use sucrose prior painful procedure.

**Results** -With introduction of project noted increased sucrose administration among junior doctor staff but still lack of compliance of prescription of sucrose for eligible infants.

-Pharmacy involved and agreed to have sucrose24% within single check drugs to help with compliance of administration documentation.

-Each week data collected based on number of infants eligible for sucrose 24% administration for procedural pain relief (figure 1).
- Variable level of prescriptions completed each week, each week eligible infants were assessed as well.
- Noted Zero prescription completed while QIP leads off site due sickness (so previous result still showed lack of sustainability).
- Challenges remain in lack of compliance of staff with prescribing and documentation of administration.
- The next step in the next PDSA cycle is preprint sucrose in the drug chart so staff would have to prescribe dose and date/time only and it would act for reminder. Along with increasing nursing staff engagement with project and encourage them being advocate for sucrose use for pain relief for their eligible infants (This is currently work in progress)

**Conclusion**
For all infants regardless their gestation but mainly preterm infants, pain among other noxious stimuli can cause long term adverse impact on their neurodevelopmental development.

Neonatal staff should be equipped with the knowledge and skill to recognize signs of neonatal pain and how to manage and minimize it appropriately.

**REFERENCE**

**Aims**
Early administration of parenteral nutrition in preterm infants is recommended with regional guidelines using absolute criterion based around gestation or birthweight to determine the need for this form of nutrition. In 2020, NICE updated their guidance for administration of parental nutrition in preterm neonates, advocating a gestational cut-off of less than 31 weeks and introducing an 8 hour administration window. We used the PDSA framework to guide the implementation of these changes. In this quality improve project, we describe the process and challenges of implementing these recommendations in our level two unit, which admits babies with a gestation greater than 27 weeks.

**Methods**
Prior to implementation, a GAP analysis was performed comparing local practice to the new NICE recommendations. This highlighted several areas that would need addressing if these guidelines were to be adopted.

Retrospective and prospective quantitative data was collected from 01/12/2019 to 30/9/2021 to identify the impact of any changes made. Forty-five neonates who were started on parenteral nutrition were identified and their records reviewed. Of these, twenty-three were excluded as they were ex-utero transfers or above the gestational age threshold.

**Results**
Figure 1 summarises the results of the GAP analysis, and steps taken to address each area in the PDSA framework. Following collaboration with multiple teams from trust governance, to pharmacy and infection control, a new standard operating procedure was created for the safe preparation and administration of neonatal parenteral nutrition.

Table 1 compares the management of these preterm neonates before and after the implementation of this operating procedure.

**Conclusion**
The results highlight the feasibility of application and adherence to the updated guidelines in a level two neonatal unit. Practical challenges from safe storage to prescription were addressed through collaborative working with the trust pharmacy committee allowing for a cost-effective, safe and successful protocol to be implemented. However, there is still room for improvement, with the average time for PN administration out of hours varying from 8-10hours. It would be interesting to compare our experiences to similar intensity units across the UK or tertiary neonatal units and share the good practice.