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Several factors related to the mother and the baby, however, have a negative effect on the initiation of breastfeeding. Mode of delivery is one of these factors. When delivery takes place by cesarean section, the mother becomes a surgical patient with all the inherent risks and problems. The cesarean rate in the world has started to rise. Many mothers have to cope with having a cesarean just as they are also trying to care for their newborn children. Cesareans delivery affect significantly is breastfeeding.

When we look according to delivery types, breastfeeding is affected by these reasons after the cesarean birth:

1. Maternal pain, fear and stress, fatigue, and prolonged recovery
2. Complications and separation of mother and baby
3. Delayed access to baby and supplementary feedings
4. Anesthesia and analgesia (delayed lacto genesis and poorer infant suck)

Cesarean section may limit mother's comfort in terms of positioning, but the baby's sucking stimulate mother's uterus contract more quickly, speeding up their healing. Researches show fewer women breastfeed their babies after having had a cesarean. Breastfeeding advocates have long promoted the idea that woman who has had a cesarean need extra support and help to establish breastfeeding.

114 STRATEGIES FOR INCREASING BREASTFEEDING SUCCESS

doi:10.1136/archdischild-2012-302724.0114

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Breast milk is the preferred nutritional source for all newborns and infants through the first six months of life and is widely recommended through the first year. It has significant health benefits for infants and mothers. Providing maternal support and structured antenatal and postpartum breastfeeding education are the most effective means of achieving breastfeeding success. Immediate skin-to-skin contact between mother and infant and early initiation of breastfeeding are shown to improve breastfeeding outcomes.

WHO/UNICEF were determined tens steps for increasing breastfeeding success. This steps are;

- Determining a written breastfeeding policy,
- Training all health care staff for implementing this policy,
- Informing all pregnant women about the benefits and management of breastfeeding,
- Helping mothers initiate breastfeeding,
- Showing mothers how to breastfeed and how to maintain lactation,
- Giving infants only breastmilk,
- Practicing rooming-in,
- Encouraging breastfeeding on demand,
- Giving no pacifiers or artificial nipples,
- Supporting mother with foster breastfeeding groups before discharge.

In this curriculum nurses can work as lactation consultants for teaching breastfeeding to new mothers. Lactation consultants help mothers for determining obstacles. And also teach some basic points for deciding timing of breastfeeding, using the experiences of others and being ready to start breastfeeding. Some social support systems like La Leche League International is also a great resource for sharing breastfeeding experience. More supported mothers continue breastfeeding more successfully. And more breastfeed child become healthier children.

115 BREASTFEEDING AND BONDING AFTER CESAREAN

doi:10.1136/archdischild-2012-302724.0115

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Breastfeeding is the most suitable and unequalled method of feeding, one that ensures the healthy growth and development of the infant. At the same time, breastfeeding is a vehicle of interaction that has positive biological and emotional effects on the health of both mother and child. Some mothers who undergo a cesarean birth have difficulty at the beginning with taking their babies in their arms and breastfeeding. For this reason, babies encounter problems at the breast.

Moreover, during the mother's stay at the hospital, the nurse should provide her with information about lactation and the mechanism involved, breastfeeding methods, baby care, problems that may be encountered and their solutions, breast care, personal care, nutrition and exercise.

Bonding is often an issue after a caesarean. Many mothers report feeling distant and detached from their caesarean babies. In part, this may be because the mother is not able to actually "see" the baby emerging from her body, and is usually one of the last people to get to hold and snuggle baby for any real time.

Lastly, starting off on a positive mother-baby relationship after a cesarean helps to instill a feeling of trust in the child and forms the foundation for the development of a healthy personality in later life. Nurses and other health professionals working with newborns have important responsibilities in helping to initiate this relationship.

116 ROLE OF NURSES IN MULTIPLE BABIES BREASTFEEDING SUCCESS

doi:10.1136/archdischild-2012-302724.0116

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Mother's milk is the most appropriate food for infants. There is no other food to replace it. The number of multiple-birth families has increased dramatically in the last several decades. It has always been wondered how to breastfeed multiple babies. A lot of questions come to mind such as what would be the best method for babies, the things that can be done for sufficient milk for each baby, the requirements for a comfortable breastfeeding period of mother.

Milk production is associated with the law of supply and demand and the amount of produced milk was found to be enough to feed all babies in previous studies. The families, especially mothers having multiple babies need support and information by the professional medical personnel on issues such as breastfeeding technique, increasing the milk supply and collection method of milk, duration and frequency of feeding and weaning.

It is commonly believed that breastfeeding of multiple babies is difficult, troublesome, and even impossible. Virtually all mothers can breastfeed one or more infants, provided that they have correct information and the support of their family and health care professionals. Nurses have an important function on infant feeding decisions. It is vital that nurses have the basic knowledge and skills to provide advice and assist in solving breastfeeding problems.

117 ACCREDITATION OF MEDICAL TRAINING IN THE US: ARE PROGRAMS CREATING COMPETENT TRAINEES?

doi:10.1136/archdischild-2012-302724.0117

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The assessment and accreditation of medical education training in the United States is rapidly moving from experience-based to

competency-based measurement. The Accreditation Council for Graduate Medical Education (ACGME), the governing body for this process in the United States, is transitioning to a system of collecting annual program performance and attainment of competencies by trainees as key measures of training program performance. This presentation will describe this new accreditation system and introduce, with examples, the concept of achieving "milestones" based on six core competencies. These competencies include: patient care, medical knowledge, practice-based learning and improvement, interpersonal/communication skills, professionalism, and systems-based practice. This new approach recognizes that process measures and relying on clinical exposure alone may not be adequate in assuring that trainees have acquired the skills to practice independently in their field.

118 CONTROVERSIES IN BREAST MILK FORTIFICATION

doi:10.1136/archdischild-2012-302724.0118

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Inadequate nutrition has been associated with impaired brain development among preterm infants. Especially low protein intake has been proven to be the primary limiting factor responsible for growth failure among preterm infants during the first critical week(s) after birth. In order to recover or catch-up after these first weeks, feeding has to replace both the deficit accumulated and to meet the requirements for normal growth.

Human milk (HM) has many advantages in the nutrition of preterm infants. Protein-concentration in HM is though variable and decreases with the duration of breastfeeding.

Fortification of HM with a multicomponent fortifier makes it possible to increase the concentration of nutrients - especially protein to meet the nutritional requirements of the preterm infants.

Fortification of HM can be achieved by standard fortification or individualized fortification. With individualized target fortification, the fortification method is based on HM analyses, adding protein to reach the targeted intake.

Fortified HM is easily fed as long as the preterm infant has a nasogastric tube during hospitalization. After hospital discharge fortification of HM becomes a challenge, but can be established using a bottle with fortified HM as supplementation while breastfeeding.

Among "healthy" preterm infants catch-up growth can be achieved before discharge, while "sick" and small for gestational age preterm infants might not achieve catch-up growth until months or years after discharge. A gradual return to normal for all growth variables while avoiding excessive weight gain should be the goal for nutrition of very preterm infants during and after hospital discharge.

119 CHALLENGES IN PEDIATRIC TRIAGE AT THE EMERGENCY DEPARTMENT

doi:10.1136/archdischild-2012-302724.0119

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Triage aims to identify patients in the emergency department who need immediate care and those who can safely wait in order to decrease mortality and morbidity. The Manchester Triage system (MTS) is based on expert opinion. It is based on flowcharts and specific decision rules which allocate urgency level (1 to 5) for a broad population visiting the emergency department. The reliability is dependent of the clinical experience and MTS training of the triagist, unambiguous of the system and diversity in flowcharts and discriminators to match the patients. The fundamental

problem in studies to validate triage tools is the lack of consensus of the reference standard for "true urgency". Does the MTS urgency predicts true urgency? A proxy reference standard can be a combination of vital signs, disease severity, resource use and follow-up or just hospitalization. The validity of the MTS in a large prospective study of 17600 children in the Netherlands was moderate and low for febrile children compared to the combined reference standard. Age related fever modifications were validated in a new sample and improved specificity while sensitivity remained similar. The modified MTS agreed in 37% with the reference standard of urgency and 36% were overtriage and 13% undertriage (2% by > 1 category). Over and undertriage need to be balanced to have a safe triage system. Performance of the MTS in different settings and in large populations need to be studied. New modifications on flowchart or subgroup level might further improve the MTS.

120 PROCEDURAL SEDATION AND ANALGESIA IN THE PAEDIATRIC EMERGENCY DEPARTMENT

doi:10.1136/archdischild-2012-302724.0120

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Pain is one of the most common reasons for which children visit the emergency department (ED). Nevertheless, pain is frequently under-recognized and under-treated in this setting. Ongoing evidence continues to show the harmful effects of pain on children's behavior and development.

The treatment of acute pain and anxiety in children undergoing therapeutic and diagnostic procedures in the emergency department has improved dramatically over the last few years. The availability of noninvasive monitoring devices and the use of short acting sedative and analgesic medications enable physicians to conduct safe and effective sedation and analgesia treatment. In today's practice of paediatric emergency medicine, sedation and analgesia has been considered as the standard of care for procedural pain.

This lecture will be focused on the basic principles of paediatric procedural sedation and analgesia in the paediatric ED.

121 SPECIAL ATTENTION FOR LONG-STAY PATIENTS?

doi:10.1136/archdischild-2012-302724.0121

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Background and aims PICU admission is a major event for children and their parents. Therefore our guidelines dictate that a primary care nurse is assigned to (expected) long-stay patients in any case after two weeks. The primary care nurse coordinates nursing care, informs and supports parents, and organizes multidisciplinary meetings. Because this guideline was not always followed we organized an awareness week. This study evaluates the effectiveness of this intervention.

Methods Data were collected retrospectively over two three-month periods: before and after the awareness week. Background variables including the presence of a primary care nurse were collected for all patients admitted > 2 weeks. The two periods were compared using chi square tests, Fisher exact tests and Mann-Whitney tests.

Results The percentage of patients assigned a primary care nurse dropped statistically significantly from 56.8% to 33.3%, $p=0.024$). Length of stay was statistically significantly shorter in the after period.