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also a laminated notice on the epidural trolley itself advising against it being taken into the delivery suite room and that it should be wiped down after each use. After this, a re-audit will elucidate if our epidural trolley cleanliness practice has improved.

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P.108 Developing a guideline for escalation to seniors: a survey of current perspectives

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Introduction: The Ockenden report found examples of insufficient involvement of senior anaesthetists in the care of complex obstetric patients. In response it recommends the development of local guidelines for escalation to the anaesthetic consultant.¹ We surveyed our anaesthetists to determine whether there was consensus on when to escalate.

Methods: An online survey was distributed to 17 trainees/specialty doctors, and 17 consultants/associate specialists who cover obstetrics. We asked "In which of the cases below would you like to call a consultant to attend. (If you are a consultant/associate specialist, in which of the cases would you expect to be called to attend)." Pearson correlation coefficient was used to measure correlation.

Results: We received a response from 13 trainees/specialty doctors (76%) and 10 consultants/associate specialists (59%). Responses are displayed in the Table. Pearson correlation coefficient was 0.69.

Table: Proportion of anaesthetists who would expect the on-call consultant anaesthetist to attend.

Clinical Scenario	Trainee/ SD	Consultant/ AS
Operative delivery, regional BMI >40	15%	10%
Operative delivery, regional BMI >50	77%	60%
Operative delivery, GA, BMI >40	15%	60%
Operative delivery, GA, BMI >50	100%	60%
Difficulty inserting epidural	77%	80%
Difficulty inserting spinal	62%	80%
Epidural likely to be delayed < 30 min	23%	10%
Epidural likely to be delayed 30-60 min	46%	40%
Epidural likely to be delayed > 60 min	85%	50%
Theatre case, anticipated difficult airway	46%	80%
Woman going to theatre with EBL 500mL	0	0
Woman going to theatre with EBL 1L	31%	10%
Woman going to theatre with EBL 1.5L	77%	80%
Theatre case EBL up to 1.5L, controlled	8%	0
Theatre case EBL 1.5L, ongoing	100%	90%
CS for placenta praevia	46%	70%
Severe pre-eclampsia on obstetric unit	31%	70%
Severe pre-eclampsia going to theatre	69%	80%
Eclamptic seizure	92%	70%
Woman with severe sepsis	38%	70%
Woman with DKA	38%	50%

Discussion: Although our juniors and consultants have similar perspectives on when to escalate, there were differences which could be detrimental to patient safety. Whilst guidance for senior supervision exists for some situations such as high BMI and placenta praevia, it is difficult to be prescriptive for all scenarios. We plan to use our findings to increase awareness of difference of opinion within the department. Our guideline will focus on there being a clear line of communication with the supervising consultant and encouraging discussions regarding escalation at the start of each shift.

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P.109 Rapid sequence spinal - Encouraging open minded obstetric anaesthesia in the era of COVID-19

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Introduction: In 2010, Kinsella et al described the rapid sequence spinal (RSS) technique as an alternative to general anaesthesia (GA) for category 1 caesarean section (CS).¹ The practice of RSS has been reconsidered during the COVID-19 pandemic to avoid aerosol generating procedures, namely intubation or extubation, in a parturient who is COVID-19 positive.² In appropriate cases, RSS may be performed to minimise the spread of COVID-19 to staff and to preserve the respiratory function of the patient.

Methods: Following audit department approval, an online questionnaire was developed using the SurveyPlanet platform© and disseminated via email to 202 members of the labour ward team in July 2020. This included anaesthetists and obstetricians of all grades, midwives and operating department practitioners (ODPs). Statistical analysis was performed using percentages and chi squared test, with significance set at $P < 0.05$.

Results: Overall, 52 questionnaires were completed, giving a response rate of 25%. Of those who responded, 65% were anaesthetists, of whom 22.4% regularly practiced obstetric anaesthesia. From all the responses, 63.3% were familiar with the concept of RSS, with 31% reporting they had performed it themselves. Thirty percent understood positioning the patient was at the discretion of the anaesthetist and 61.8% were aware that it was acceptable to use opioids if it did not cause further delay to the block. Regarding block height, only 14.3% knew that T10 was the accepted minimum block. Non anaesthetists were more likely to choose a different block height to T10 ($P = 0.0013$). When asked if they would consider using RSS in a category 1 CS, 82% responded they would. Non consultant anaesthetists were more likely to consider a RSS than consultant anaesthetists ($P = 0.0297$). The free text comments recognised the intended safety benefits of the technique to both mother and baby irrespective of COVID-19.

Discussion: Even though the need for a GA for CS may never be eliminated completely, the notion of providing regional anaesthesia in an emergency situation needs to be developed further. Although the low response rate was a reflection of an anonymous online survey, our work highlighted that RSS should not be considered an anaesthetic only concept and that the wider multidisciplinary team should be involved in

the training and practice of the technique. The tendency for non consultant anaesthetists to consider RSS may reflect more frequent shifts on labour ward and different practices encountered in different units. We aim to build on this enthusiasm for RSS to develop a forum to deliver education and training to all staff on labour ward. We would hope to increase awareness, confidence and practice of the technique in the future, both during and outside of the pandemic.

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P.110 Never confuse a single defeat with a final defeat: what to do when the drugs don't work

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Introduction: Spinal anaesthesia is the commonest anaesthetic technique for caesarean section (CS) in the UK. The RCoA recommended standard is for >85% of category 2 and 3 CS to be performed under neuraxial anaesthesia.¹ Adequacy of block remains controversial in terms of what modality is tested. However block of cold sensation to at least T4 seems to be universally accepted as the minimum requirement. What do you do if the block is not adequate, but time or clinical circumstance does not mandate conversion to general anaesthesia (GA) prior to starting.

Methods: We performed a literature search and found one local guideline with advice for failed regional pre-incision.² We then developed a survey for anaesthetists in our department. We presented two clinical cases with three possible outcomes. The first was a low-risk woman having a category 2 or 3 CS who had been administered a subarachnoid block (SAB) with 0.5% hyperbaric bupivacaine 2.5 mL and diamorphine 300 µg. The second case was also low-risk but with working labour epidural topped up with 0.5% bupivacaine 20 mL. We then asked what they would do if faced with either no block, cold block below T8 or cold block above T8. We picked T8 somewhat arbitrarily, based on use in the aforementioned local guideline.²

Results: We collected 15 responses. 9 consultant and 6 non-consultant grades. 73% would repeat SAB if no block developed after 20 min. 20% would perform a CSE and 7% would perform a GA. If faced with partial block above T8, the results were more varied. 40% would repeat SAB with varying reductions of dose. 33.3% would perform a CSE, 13.3% would perform GA, and 13.3% chose for 'other' (Call consultant). In the second case, 93% of responders would remove the catheter and perform a SAB if no block developed. With a partial block above T8, 40% would continue to top up. 53% would remove the catheter and perform SAB; and 7% would convert to GA.

Discussion: Our small numbers show a variety of responses to different clinical scenarios. Despite the high percentage of practitioners who would repeat SAB, there was a spread of doses. With partial block above T8, there was more of a divergence in practice. Given the apprenticeship style of training in anaesthesia perhaps our results should not be surprising. Is this important? Repeated neuraxial techniques involve risk of complications, unnecessary general anaesthetics increase risk. Perhaps a guide, similar to the OAA failed intubation guideline, with various different situational factors to consider, may aid in decision making if faced with a failed regional technique prior to starting a case.

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P.111 Anaesthesia for the pre-term parturient: A local survey of anaesthetic and obstetric practice

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Introduction: Pre-term live births below 37 weeks accounted for 7.8% of all births in England and Wales in 2019¹ and improving outcomes for these infants is a major national driver. Prematurity has significant implications for obstetric and neonatal care, however the impact on anaesthesia for caesarean section or assisted delivery is not so clear. We identified a lack of available educational material on the subject. We undertook a survey to evaluate understanding of prematurity and its impact on anaesthetic care.

Methods: We conducted an electronic anonymous local survey inviting anaesthetists and obstetricians in a district general hospital maternity unit with over 4500 annual births. Questions assessed knowledge of the prevalence of pre-term births, modifications to anaesthetic technique for caesarean section or assisted delivery, wider implications for obstetric and neonatal care and knowledge of our regional perinatal care bundle for premature infants.

Results: 27 responses were received, 17 from anaesthetists and 10 from obstetricians. Only 29% of anaesthetists reported that prematurity made a significant impact on their practice. Most anaesthetists (88%) do not routinely change their intrathecal bupivacaine dose due to prematurity alone. By comparison, 100% of obstetricians reported that prematurity had a significant impact on their decision making and caesarean section technique. Specific examples included preparing for difficult extraction and delivery to a mobile warming plate facilitating delayed cord clamping. 24% of anaesthetists anticipated a potentially difficult extraction and ensured sublingual glyceryl trinitrate was immediately available. 100% of obstetricians were aware of the local neonatal care bundle in contrast to only 41% of anaesthetists.

Discussion: Pre-term birth is the most significant factor associated with neonatal mortality and morbidity in the UK.² Our survey demonstrates that although all obstetricians report a significant change of technique and decision making for pre-term birth, locally the majority of anaesthetists are unfamiliar what these differences may be. We believe all anaesthetists should be aware of the impact of prematurity. Our unit has implemented a perinatal care bundle for pre-term infants including antenatal maternal corticosteroids and magnesium. Anaesthetists should be aware of potential secondary maternal complications such as hyperglycaemia due to corticosteroid administrations and magnesium toxicity. The anaesthetist should ensure that additional room is available in theatre to allow delivery onto a mobile warming plate. Finally, it is vitally important to consider the wider emotional environment in theatre. Parental and staff anxiety may be high and anaesthetists can have a key role in reassuring parents. As a result of our survey, we plan to raise awareness of the important differences for pre-term birth and we are interested in performing a national survey to gain further informa-