Results: 37 deaths were identified in this period (excluded 3 cases- brain death). The CPR was not performed in 50% of children. In 10 of 17 patients not reanimated, the plan for LSL was not recorded in the medical charts. In 80% patients of the "no CPR" group, the vasoactive drugs infusion and ventilator parameters were maintained/increased without differences when compared to "full CPR" (p=1,0 e p=0,6). The nurse's practices evaluated using NAS score in the last 24 hours of life didn't differ even when the patient wasn't reanimated. When nurses were asked about participation on EOL decision, only 30% confirmed it.

Conclusion: Brazilian studies have demonstrated that EOL practice has been a process centralized on the medical perspectives. We observed that nurses and medical attitudes before death didn't change even when the patients were considered terminal illness and the nurses rarely participated on the decision making process.

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BENEFITS OF STRUCTURED MULTI DISCIPLINARY MEDICAL ETHICAL DECISION MAKING

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Background/aim: Until 2008, medical ethical decision making (MEDM) in the NICU lacked structure. Moral deliberation and effecting ethical decisions were not up to standard. A guideline to improve MEDM was developed, and evaluated one year after implementation.

Method: The guideline consisted of multidisciplinary meetings presided by an independent chair, and uniform preparation and report. Meetings were structured following a five phase model: 1) exploration, 2) agreement on the ethical question, 3) analysis, 4) evaluating possible solutions, decision-making, 5) planning actions. Initially, health care workers (HCW) of the NICU were trained in ethical/ legal aspects and practiced the method with a historical patient case. Before the training, HCW completed a 15-item questionnaire on 'structure', 'role participants', 'parental representation', 'problems, solutions and deliberation', and 'decisions and documentation'. One year and 22 structured meetings after introduction, the same questionnaire was completed again.

Results: Response before and after introduction of the guideline was 91/114 (80%) and 85/123 (69%) respectively. Nurses and physicians were equally represented in the two samples (N=63/63, and N=19/14; X^2=.601; p=.438). Evaluation of the guideline showed improvement in 'structure of MEDM' (p< .000 for all 5 items), 'role participants' (p< .000 for all 3 items), 'parental representation' (p< .000, for 1 item), and 'problems, solutions and deliberation' (p< .000, for 2 items; the 3rd item treatment options did not improve, p=.932). 'Decisions and documentation' showed no improvement (3 items, p=.215, p=.412 and p=.066 respectively).

Conclusions: Ethical deliberation significantly improved after implementation of structured MEDM. Ongoing attention will be paid to 'documentation of the decisions'.

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SEMI-STRUCTURED INTERVIEWS WITH GRIEVING PARENTS AFTER THE DEATH OF THEIR NEWBORN INFANT IN THE INTENSIVE CARE UNIT

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Background/aims: To obtain empiric data on parent's experience of death of their newborn infant and to identify variables influencing the grief reaction.

Methods: Parents of all infants who died during a 5-year-period were asked to complete a standardized questionnaire and/or to participate in a semi-structured interview. Interviews were recorded and later transcribed. The questionnaire (242 questions, 21 pages) included the Perinatal Grief Scale (PGS).

Results: 31 mothers and 19 fathers of 48 children participated. The interviews lasted 2.6 hrs on average. PGS-Scores were higher (i) for mothers vs. fathers, (ii) if the couple had previous children, (iii) with increasing time after the infant's death.

Grief intensity was not higher if there was parental involvement in the decision to withdraw life-sustaining therapy. 95% of parents involved in a decision to restrict intensive care felt their involvement was adequately handled by medical staff. 92% of these