

Thematic Review of Neonatal Mortality 2015 – Jan 2016

8th Feb 2016

Attendees:

S Brearey	Neonatal lead
Doctor V	Consultant
N Subhedar	LWH consultant
E Powell	NNU manager
A Murphy	Lead nurse Children's services
L Eagles	NNU nurse
D Peacock	Quality improvement facilitator

Apologies:

C Green Pharmacy

Purpose of Meeting:

There was a higher than expected mortality rate on NNU in 2015. All these cases have been reviewed at NNIRG, perinatal mortality review or neonatal review meetings and action plans have been made (See **Appendix 1**). An obstetric thematic review did not identify any common themes or identifiers that might be responsible for the rise in mortality in 2015. The aim of the neonatal meeting was to review the cases again as a multidisciplinary team with an external reviewer and tertiary level neonatologist to assess:

- Were all action points completed
- Any new areas of care improvement
- Any possible common themes

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Themes identified during discussion of all cases:**1. Delayed cord clamping in preterm deliveries**

3 babies had delayed cord clamping when hospital guidance says this is only for term babies. There is national recommendations and evidence to support delayed cord clamping in preterm babies but the obstetric, midwifery and paediatric teams have not yet been able to ensure adequate temperature control for all preterm babies close to Mum during delayed cord clamping. Hypothermia is associated with increased neonatal preterm mortality. However, there were no cases of severe hypothermia and only one case of mild hypothermia in the cases reviewed.

Actions: Teams have already agreed and disseminated current policy
Multidisciplinary work to enable safe delayed cord clamping in preterm babies

2. Ranitidine in preterm babies

NS advised group of increased risk of death in preterm babies given ranitidine. 2 babies in CoCH were given ranitidine. It is still in common usage in most neonatal units and CoCH are unlikely to be an outlier in its use.

Action: NS to send paper re risk of ranitidine in preterm babies. Practice change based on this evidence.

3. UVCs in preterm babies

3 babies had care issues around UVCs. One was used when too low, one was used when too high and one was displaced and came out. NHS England has recently reviewed UVC incidents and BAPM has recently published draft guidance. CoCH guidance could be improved by revising guidance to include correct position and standardising fixation.

Action: Revise UVC guidance once BAPM draft guideline finalised

4. Timing of arrests

6 babies had arrests between 0000 – 0400.

Action: SB and EP to review all these cases focusing on nursing observations in the 4 hours before the arrests. Aim to identify if unwell babies could have been identified earlier. Identify any medical or nursing staff association with these cases.

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