

Thematic Review of Neonatal Mortality 2015 – Jan 2016

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8th Feb 2016

Attendees:

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|-----------------|---------------------------------|
| 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:

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| C Green | Pharmacy |
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8th Feb 2016

Purpose of Meeting:

There was a higher than expected mortality rate on NNU in 2015. 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
- Discuss if further action is required

Patient electronic record, written notes, radiology images and Meditech entries in addition to previous reviews were available. It was noted by NS that there was a clear and strong governance culture in CoCH which was evident at the meeting and that the number of PMs undertaken was impressive and indicated a willingness to learn and improve.

Summary of mortality cases discussed

| Case: | Date of death: | Diagnosis and summary of discussion: | Actions: | Date complete: |
|-------|--------------------------|---|----------|----------------|
| PD | 5 th Apr 2015 | Severe HIE. Baby transferred to Arrowe Park for continued cooling but died there on day PD. Obstetric review identified some areas of care improvement. PMM agreed neonatal care before transfer was appropriate and timely. 2015 audit of HIE identified excellent neonatal care in the 4 cases of HIE and good outcomes in 3 cases. CoCH actively cool babies prior to transfer. | Nil | |

8th Feb 2016

Themes identified during discussion of all cases

There was no common theme identified in all the cases. One baby had severe HIE and the Trust's rate of HIE in 2015 was low and similar to previous years. One baby had severe multiple congenital abnormalities with a very poor prognosis. One baby had a significant congenital heart disease and probable sepsis. 2 babies (possibly 3 pending PM result) died of sepsis despite timely antibiotic treatment. 2 babies (possibly 3 depending on PM result) the cause of death is uncertain despite having PMs. Themes identified in more than one baby reviewed included:

1. Sudden deterioration

Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM.

2. Timing of arrests

6 babies (from 9 deaths reviewed) 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.

3. 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**

4. Ranitidine in preterm babies

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