EXCEPTION REPORTING - LEARNING POINTS

Following discussion of the exception report summary at the Clinical Forum South meeting, the learning points detailed below have been identified:

March – May 2017

- **Evidence of in utero transfer of infants <27/40 to improve outcomes for the extremely preterm infants.**

  There appears to be increasing numbers of attempts to IUT babies from LNUs and SCUs to be delivered at NICUs which is very positive.

  Evidence shows that delivery in tertiary neonatal centre improves outcome. Also minimises mother-baby separation.

- **Example of best practice when reviewing babies born <27wks or <800g.**

  Some LNUs have added any <27 week and <801g exceptions to the agenda at their local perinatal meetings/maternity forum for wider discussion.

EXCEPTIONS INCLUDE:

LNU

- Babies <27wks or <800g in a LNU beyond 1 day of life
- Babies receiving intubated ventilatory support for greater than 48 hours beyond 1 day
- Babies receiving ventilation via a tracheal tube AND Inotrope, prostaglandin infusion, insulin infusion, a chest drain, or had an exchange transfusion in a LNU beyond 1 day
- Babies with hypotension, disseminated intravascular coagulation (DIC), renal failure, or metabolic acidosis
- Babies who received nitric oxide, HFOV, or therapeutic hypothermia

SCBU

- Babies <30wks or <1000g in a SCBU beyond 1 day of life (except London ODN which doesn't use the beyond 1 day of life criteria)
- Babies receiving IC in a SCBU beyond 1 day
- Babies receiving inotrope, prostaglandin infusion, insulin infusion, have a chest drain, or had an exchange transfusion in a SCBU beyond 1 day
- Babies receiving intubated ventilatory support for greater than 48 hours beyond 1 day
- Babies with hypotension, disseminated intravascular coagulation (DIC), renal failure, or metabolic acidosis
- Babies who received nitric oxide, HFOV, or therapeutic hypothermia

The Yorkshire and Humber Neonatal Operational Delivery Network

CLINICAL CASE DISCUSSION - LEARNING POINTS

- **Lessons learnt following review of 4 babies transferred from the Diana, Princess of Wales Hospital to the Jessop Wing.**

Reviewers: Dr Elizabeth Pilling
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Emma Spicer

1) Babies in intensive care to have hourly blood pressure monitoring initially. If stable can reduce to 4-6 hourly monitoring if still indicated.
2) Once decision has been made to give IV antibiotics, they must be given within the hour of that decision.
    - Do not wait to x-ray umbilical line before administering the IV antibiotic maintain asepsis.
    - Peripheral canular can also be used
3) Rising lactate suggest:
    - Hypotension and/or
    - Dead tissue
4) Sick babies to have blood gases monitored 1-2 hourly.
5) Start TV for volume guided ventilation - 5ml/Kg.
6) Avoid unnecessary fluid boluses of normal saline as this leads to hyperchloraemia which makes metabolic acidosis worse. Monitor base deficits of -6 to -8 in presence of reasonable blood PH.
7) Check ETT position at every shift. Push x pull ETT at each ward round and re-secure if required.
8) New feeding guideline
    - Encourage trophic feeding and early breast milk expressions.
    - Avoid rapid feed increases.
    - Transition from EBM to formula feeds slowly
9) Is gastroesophageal reflux an issue in preterm babies in intensive care/high dependency in first few days of life?
    - Probably no.
        - Avoid use of ranitidine in preterm babies as increases risk of necrotising enterocolitis.