The Yorkshire and Humber
Neonatal
Operational Delivery Network

NHS

Mortality Review Group (MRG) South
Shared Learning Points – October 2019

- Be aware of falsely high temperature readings from the skin probe (e.g. it could be reading the temperature of the transwarmer). Antibiotics should be given within the 1st hour. Once the UVC is placed, give antibiotics, do not delay for XR confirmation.

- LISA is not appropriate for very small babies for technical impracticability (e.g. small mouth, difficulty getting a good view of the cords). It can be considered for babies >25/40 (beware of those with IUGR though). It is most likely to benefit 25-28/40. <26/40 require special expertise.

- Remember to assess a baby's pain and give analgesia to provide comfort appropriately, especially in cases with a known obvious source of pain, e.g. fractures, wound, skin conditions.

- In a patient with low platelets and evidence of bleeding, platelet infusion should be given pre-transfer to tertiary care and if remaining on a unit. Clotting should also be tested.

- In skin conditions that compromise thermoregulation, consider nursing patients in plastic bags, especially in the initial resus/stabilisation phase.

- When intubating, if you are 100% confident that you have seen the ETT go through the cords and the length of the ETT seems appropriate for the baby, when there is no colour change when using the neopuff set to 20/4, increase the PIP +/- use direct larynoscopy to confirm ETT position before removing it and reintubating.

- In multiples, appropriate entries should be made in a sibling's notes, if the other sibling is deteriorating. This is because of the affect it has on the family and it can result in an alteration in the management for the well baby (i.e. delay in extubation).