Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group Meeting	26/09/16 1.30pm Whiston Hospital

Present	Key	Title and Organisation
Nim Subhedar	NS	Clinical Lead, NWNODN (Chair)
Caroline Travers	CT	Network Facilitator, NWNODN
Carol Jackson	CJ	Transport Consultant, CMNNTS
Karen Wareing	KW	Unit Manager, Ormskirk District Hospital
Jacqui Morgan	JM	Unit Manager, Arrowe Park Hospital
Eirian Powell	EP	Unit Manager, Countess of Chester Hospital
Jane Crowther	JC	Unit Manager, Macclesfield Hospital
Eirian Lloyd-Powell	EL	Unit Manager, Countess of Chester
Janet Smith	JS	Unit Manager, Leighton
Rachel Tennant	RT	Glan Clywd
Catherine Hargreaves	CH	Unit Manager, Whiston Hospital
S. Rath	SR	Consultant Paediatrician, Arrowe Park Hospital
Tim McBride	TM	Consultant Paediatrician, Ormskirk District General Hospital
Roz Garr	RG	Consultant Paediatrician/Neonates, Whiston Hospital
In Attendance		
Karen Mainwaring	KM	Quality Improvement Lead Nurse, NWNODN
Laura Kearns	LH	Team Coordinator, NWNODN (Minutes)

Minutes

Agenda Item	Summary of Discussion	Action	Lead
1	**Welcome and apologies for absence** Apologies were received from Neil Caldwell, Steve Brearey, Saravanan Jayachandran, Kiran Yajamanyam and Deborah Weaver.		
2	**Minutes of the meeting on 12th July 2016** The minutes were recorded as a true record		
3	**Review of Action Log**		
4	**Declaration of any other business** • **Bliss Audit**		
5	**Matters not arising** None		
6 6.1	**Audit – Hypoglycaemia** GW not present at meeting, defer to next meeting. **Antenatal Audit** Due to changes in transport and lack of 24hr Cot Bureau there is no longer enough resources to carry out this audit. On hold and remove from agenda and actions.		

7	**Term Admission CQUIN** Deferred to the next meeting. Units were reminded to complete this section within the incident reporting template.		

8. Incident Review

	% High Incidents June/July	Details/Lessons from High incident/ Points of learning to share from incidents.
I&S		
8.4 CoC	0	One issue that stands out was the incorrect EBM that was given to the wrong baby. We now have to have a co-signature on the feeding form of the x2 staff checking the EBM PRIOR to commencing the feed at the bedside. (it is now treated in the same manner as a blood product)
I&S		

9. Mortality Review

BADGER ID	REPORTED	Comments of note	Cause of death on death certificate
		I&S	
9.2 Countess of Chester			
Child O	YES	33^{+2} triplet 2, generally well and stable on optiflow and enteral feeds until day 3 when he suddenly deteriorated with apnoea, bradycardia and abdominal distension. Did not respond to resuscitation. Subsequent PM showed a ruptured sub-capsular haematoma of liver. **Lessons Learnt** 1. No definite indication for commencing iv antibiotics after birth. Reason given was respiratory distress in preterm infant requiring CPAP. Cautious approach to starting antibiotics would not have caused harm. 2. There is uncertainty regarding cause of death as Child O deteriorated and received antibiotics, blood tests and an AXR which did not seem to show any evidence of hepatic enlargement at that time.	**1a Fresh bleeding into abdominal cavity due to** **1b Rupture of sub-capsular haematoma of liver** **1c To be established on full histology** **Inquest has been opened.**
Child P	YES	33+2 triplet 1, generally well and stable on optiflow and enteral feeds until day 4 when he suddenly deteriorated with apnoea, bradycardia and abdominal distension. Did not respond to resuscitation. Transport consultant present during resuscitation. **Lessons Learnt** 1. No definite indication for commencing iv antibiotics after birth. Reason given was respiratory distress in preterm infant requiring CPAP. Cautious approach to starting antibiotics would not have caused harm. 2. Awaiting PM report but no clear cause of death identified from review.	