NHS
East Midlands
Neonatal Operational Delivery Network

Minutes of Pharmacy Group

Tuesday 25 April 2023
2:00pm – 3:30pm
via Microsoft Teams

Present:
Jane Gill (JG), Clinical Lead, EMNODN, South Hub (Chair)
Neha Shah (NS), Advanced Specialist Clinical Pharmacist, Woman and Children, ULHT
Lucy Stachow (LS), Advanced Specialist Neonatal Pharmacist, University Hospitals of Leicester
Harriet Hughes (HH), Advanced Pharmacist, Women's & Children's, Royal Derby Hospital
Adreice Al Rifai (AA), Neonatal Pharmacist, Nottingham University Hospitals

In Attendance:
Linsay Hill (LSH), Office Manager, EMNODN (Minutes)

	Subject	Attachment	Action
1.	**Apologies for Absence** Sarah Pilling (NGH), Demisha Vaghela (KGH), Julie Vanes (QHB), Kevin Inglesant (KMH)		
2.	**Disclosures of Conflicts of Interest** None		
3.	**Minutes from the Previous Meeting** The minutes from the previous meeting were accepted as an accurate record of proceedings.	A	
4.	**Matters Arising** None.		
5.	**GIRFT Report and Actions** Pharmacy actions within the GIRFT action log. **Action 12b - Increase the use of ready-to-use standardised concentrations of drugs and infusions, prepared in pharmacy aseptic services or by external suppliers, and reduce local drug preparation in neonatal units.** Aseptic services in Derby & NGH. No aseptic suite at Burton. NUH don't have aseptic services. Use three drugs which are purchased in from aseptic units. They are Standard concentrations but not necessarily the NPPG standardised concentrations, Heparin bicarb, continuous vancomycin and the intermittent vancomycin.		

	UHL no aseptic services ULHT no aseptic service. Don't use standardised concentrations, or order anything in at the moment. Currently everything is made up on ward level. JG suspects this is in the network level GIRFT as there are hints in other sections around buying power. Insulin made at Derby would be interesting to see what concentrations they are using. HH made up on patient basis but is usually the same. JG asked if all have a link Neonatologist who they would link with for updating monographs? In NUH there are a number of consultants. AA will ask Dush Batra. All to go back and ask if there's appetite for medical representation at this meeting. **Action 12c - Adjust, where applicable, trust or network-developed drug calculators to ensure they are updated against MHRA advice and can be used across networks. Existing drug calculators should not be removed until a safer sustainable alternative is in place.** None at UHL, RDH or ULHT. AA confirmed not allowed to use shared calculators in NUH due to legislation around them being classed as medical devices. JG/WC to take and investigate at Network level. **Action 12d – Ensure standardised parenteral nutrition (PN) bags are available for both initial and maintenance PN in all NICUs and LNUs and consider network-wide standardisation (see also our recommendations about procurement). PN bags should comply with national nutritional recommendations for neonates as well as safety standards, including mechanisms to avoid accidental lipid over-infusion.1** ULHT use Baxter bags as standard. NUH get patient specific bags for most babies and have standard stock bags with a number of regimes where missed time slot for ordering out of hours – made in house. RDH made in house, standard bag but can make additions to bag of certain things if required. UHL standard concentrated PN from day 1 for any baby on NNU. Buy in from ITH pharma. NGH have adopted UHL guideline and also buy in from the same place.		**AA** **ALL** **JG/WC**

	Action 12f - Enabling staff in all units to regularly practise preparing drugs and infusions commonly used in neonatal intensive care. Is there an annual drugs test or competency packs that are regularly reviewed with staff in the units? NUH have just reviewed their Trust wide mandatory update around IVs and the neonatal PDNs are just waiting for this to be published. AA suggested WC contact them directly. NS to ask the ULHT Education team what competencies they do and feedback to WC. HH would direct to Matron or Clinical Educators. LS in UHL they do updates but unsure of the details. Dropped calculations/maths tests but unsure why. WC to pick up with Davina and Judith. **Action 12h - Implement smart pump technology in conjunction with advice and recommendations found in HSIB smart pump report94 and audit the impact on medication errors in neonates.** NUH use smart pumps but can't update them remotely, they have to be taken off the unit which isn't practical. Gone back out to procurement for new pumps. AA to check what pumps are? RDH have Syromed pumps, can only update every two years when the rest of the Trust is ready to update. Currently implementing new Baxter Wi-Fi pumps, these are going to QHB first then will go into RDH. No smart pumps in UHL or ULHT.		**WC** **NS**
6.	**Network Pharmacist Discussion** A small possibility that we may have the money for a Network pharmacy post in this financial year. 1 year secondment. Other AHP posts are still doing their clinical role in trust then coming to us for a couple of days per week. Scoping exercise what this person could add at unit level and good things for them to be doing: • Work around drug calculators • Having standardised things to help and support in medications not used to using; education for team. Know what setting up when know where sending a baby • Appreciation of how each centre works, by visiting units		

	• Role for coordinating Network responses, drugs shortages, new guidance etc to try to eliminate duplication of work In summary there is appetite for this role.		
7.	**Monograph - Prostin** Decided that the first Network monograph would be Prostin and this is based on some existing guidance. HH asked around the dosage section, have started to get Burton to use Derby monographs they wanted caveats adding because they don't want to give the same doses as Derby, for atracurium they wouldn't want to go higher than 600 mcgs/kg, Debry go up to 1200 mcgs/kg. Would there be something like this in these monographs where some of the smaller units wouldn't want to go up to the higher doses? JG said there wouldn't be any upper limit because babies would need as much as they need. JG to take this away to think about. JG in terms of Prostin because it's being guided by cardiology you give as much as cardiology tell you to give. Basic outline looks ok and all happy to take a closer read and send any comments by end of May. LS to share medusa monographs.		**ALL** **LS**
8.	**Electronic Prescribing** None of our units have electronic prescribing in neonates.		
9.	**Significant Incidents & Shared Learning** Opportunity for sharing any incidents: JG aware of a drug incident at KGH during a resuscitation where the wrong dose and strength of adrenaline was administered to a baby, part of the risk identified around was that 1 in 1000 adrenaline was in the drug box, also the issue of using an emergency drug calculator or having the dosage immediately available. Risks of working particularly in a smaller hospital where they are not commonly given. HH said in RDH they have separate boxes, neonatal, paediatric, and adult. This is the case in UHL and ULHT. In RDH the dosages are laminated and placed in the lids of the boxes. All to consider implementing also. LS shared incident with Chlorhexidine nearly going in an incubator as mistaken for water due to the packaging being really similar. Are others units using the large bottles of chlorhexidine? ULHT still have sachets left. UHL switched to 1 litre pour bottles of 0.05% chlorhexidine, in the emergency		

	switch they look very similar to the litre bottles of water, incident where incubator with filled with chlorhexidine instead of being filled with water. HH to send information on where RDH purchase 0.5 % bottles from. LS and JG to take back to UHL the issue of single use items based on recent regional alert.		**HH** **LS/JG**
10.	**AOB** Antifungals with antibiotics? Gestation or duration. Hardly ever use in Derby. NICE Guideline states: **1.12 Antifungals to prevent fungal infection during antibiotic treatment for late-onset neonatal infection** 1.12.1 Give prophylactic oral nystatin to babies treated with antibiotics for suspected late-onset neonatal bacterial infection if they:have a birthweight of up to 1,500 g **or** were born at less than 30 weeks' gestation. **[2021]** If oral administration of nystatin is not possible, give intravenous fluconazole. In April 2021, this was an off-label use of fluconazole. See NICE's information on prescribing medicines and use clinical judgement to determine the dosage. **[2021]** For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on antifungals to prevent fungal infection during antibiotic treatment for late-onset neonatal infection . Full details of the evidence and the committee's discussion are in evidence review I: antifungals. Making decisions using NICE guidelines | NICE guidelines | NICE guidance | Our programmes | What we do | About | NICE		
12.	**Date/Time of Next Meeting** Tuesday 13 June 2022, 2:30pm – 4:30pm via Microsoft Teams		