NHS
East Midlands
Neonatal Operational Delivery Network

Minutes of Pharmacy Group

Tuesday 18 March 2025
10:00am – 11:30am

Via Microsoft Teams

Present:
Jane Gill (JG), Clinical Lead, EMNODN (Chair)
Lucy Stachow (LS), Network Pharmacist, EMNODN
Susan Chisela (SC), Education & Practice Development Nurse, EMNODN
Neha Shah (NS), Advanced Specialist Clinical Pharmacist, Woman and Children, ULTH
Adriece Al Rifai (AAR), Neonatal Pharmacist, NUH
Harriet Hughes (HH), Specialist Pharmacist, UHDB

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

	Subject	Attachment	Action
1.	**Apologies for Absence** Joanna Hurcombe (JH).		
2.	**Disclosures of Conflicts of Interest** None		
3.	**Minutes from the Previous Meeting**	A	
4.	**Matters Arising** KGH are back doing PN and WC had emailed the group regarding immunisations. All matters arising will be covered through the agenda.		
5.	**GIRFT Report and Actions** The recommendation in the GIRFT report for standardisation of drug and infusion practices at a national level has been addressed by the joint NPPG/BAPM framework of concentrations for neonatal and paediatric patients highlighted in the BAPM safety alert. This framework will need to be implemented across the network.		
6.	**Network Pharmacist Update** LS has now started in post as the Network Pharmacist, she will be working two days per week for the Network but also continue working at UHL. It was agreed that LS will now take on the chairing of these meetings in future.		

	LS is going to be looking at creating a standardised approach for all units to implement the new NPPG/BAPM framework.		
7.	**Monographs** The Prostin monograph has been completed. LS requested all units to send over their six monographs (adrenaline, dobutamine, dopamine, isoprenaline, noradrenaline, vasopressin) as a starting point, this will hopefully enable her to identify any gaps. AAR suggested an end user survey may be beneficial so that nurses can have some input. LS suggested creating a template, not with the view of implementing yet but with information as to what will be included with the aim of getting feedback from prescribers. JG confirmed that the Network guideline would be the minimum expected and then each unit can add to it if required. SC confirmed that the EMNODN Education & Practice Development Group are happy to be part of a pilot group. HH explained that UHDB nurses reported feeling overwhelmed from the Prostin monograph and believes a Network template would be beneficial. NS confirmed that at ULTH, they have a basic monograph detailing how to prescribe which makes reference to the relevant guideline, so if nurses or prescribers need further information, they can access the guidelines as needed. NS explained that staff are happy with their monographs and suggested a Network monograph is created which can be adapted locally by each unit. AAR explained that NUH carried out research approximately four years ago on monographs and guidelines etc conducted locally by prescribers and nurses. As a result, anything drug related was removed from guidelines and instead has to be included in the monographs instead. AAR and LS suggested starting with Dobutamine monographs as it will be less contentious to begin with.		**ALL** **LS**
8.	**Electronic Prescribing** There are no updates on electronic prescribing. EPR has now been rolled out at UHDB, UHL and NUH. QHB are currently using Meditech V6 and RDH are using Lorenzo, but UHDB will all soon be moving across to NerveCentre; however, neonates will be continuing with paper charts for now.		

	LS explained that recommendations from either BAPM or NNPG are that there should be one national neonatal system used across the UK but would be challenging because all trusts have invested in different systems. Additionally, neonatal systems should ideally be linked to other systems as otherwise it will cause issues if babies are later admitted to PICU.		
9.	**Significant Incidents & Shared Learning** LS discussed a phosphate incident at UHL. This was shared previously but shared again for those not aware. This incident resulted in new guidance on the management of severe hypophosphatemia and three new IV monographs. JG also shared an incident at another unit relating to an adrenaline overdose. ULTH use plastic bags with caution stickers reminding clinicians to check the strength of the adrenaline.		
10.	**AOB** JG discussed the BAPM safety bulletin which discusses standardised infusions and syringe sizes. A copy of the bulletin can be viewed here. AAR believes that BAPM still needs to provide recommendations regarding education for nurses and clinicians around the practicalities of administering some infusions. AAR also confirmed that following the safety bulletin, QMC will begin focusing on inotropes. NUH's infusion pump contracts are also changing and this needs completing before beginning to work on standardised infusions and syringe sizes. JG explained BAPM are unlikely to provide further guidance. Key stakeholders will be expected to work out how best to implement the safety bulletin, although the NPPG could potentially bring out further information. It is very important to have a plan of how each unit will implement the new BAPM alert. LS confirmed information is being created for how this can be implemented in practice nationally. Across the network we'll need to start with the six drugs particularly affected by height. There are around 20 drugs in total with recommended changes by the NPPG, this will be a long-term project. SC and the Network Education Team will also help to provide education and resources. NS addressed some concerns as a smaller unit around having the correct equipment to implement the safety bulletin and also around changes in practice, for example staff are historically		

	used to 50ml syringes and there will be changes to calculations etc. This will take time to plan and implement. LS explained that the ideal would be having a system with standardised concentrations in the right volume and syringes which can be moved up and down as well as having guardrails, but the changes can be implemented without guardrails and without drug libraries, it depends on what each unit can offer. If there are not the investments available for this sort of technology, the safety alert should still begin being considered and planned for. LS also advised the group to watch a recent NPPG webinar which may alleviate some concerns. UHDB are due a policy review for Vitamin K dosing and HH has found that most units are starting to follow 0.4mg per kilo. UHL follow 0.4mg per kilo but it is capped at a minimum of 0.4mg. ULTH calculate based on weight. NS will share ULTH's process with HH and SC. HH then discussed Benzylpenicillin dosing. Guidelines state that clinicians should be giving 25mgs per kilo twice a day and if more concerned this is increased to eight hourly but in practice, UHDB increase to 50mg per kilo and stick to twice a day. This is largely due to practicalities on the ward. HH asked what the other units do. AAR confirmed that NUH have always given 50mg twice a day. UHL used to give 50mg per kilo but changed to 25mg in line with NICE guidelines. AAR discussed gentamicin supply issues. NUH have not yet had any Datix's around this. They are using a higher concentration. Initially, NUH opted to use tobramycin, but this came with too many complexities with regards to prescribing. LS asked if the group are aware of Ibuprofen IV shortages that are likely until mid-April. It is not widely used and if UHL's supply runs out before it is available again, paracetamol will be issued instead.		**NS**
11.	**Date/Time of Next Meeting** The group discussed best dates/times for these meetings going forward. Dates will be looked at with LS and will be confirmed to the group as soon as possible.		