South Yorkshire and Bassetlaw
Critical Care Operational Delivery Network

South Yorkshire & Bassetlaw Critical Care Network

Standard Operating Procedure

Critical Care Transfer Incidents

Version 1.0

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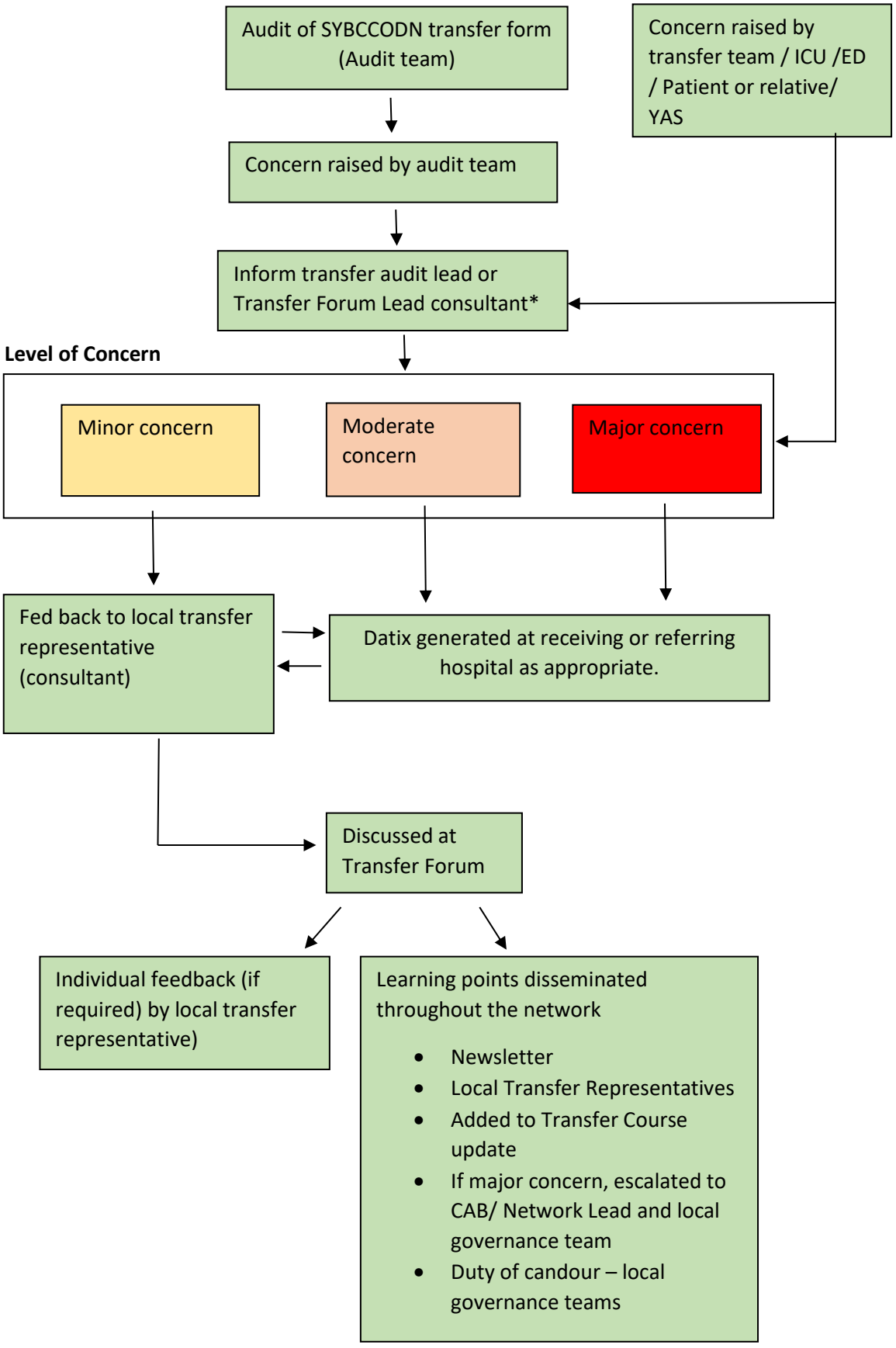
Critical Incidents on SYBCCODN Transfers: Reporting, investigating and shared learning



Aim of this Standard Operating Procedure (SOP)

The aim of this SOP is to outline the pathway for managing reports of critical incidents occurring on critical care network transfers. It will include;

- What is considered a critical incident
- How critical incidents are identified
- Process of investigation
- Duty of Candour
- How learning points occurring on Network Transfers will be disseminated

What is a critical incident?

Although there is no universally accepted definition or list of what constitutes a critical incident, it is generally considered to be; *"an incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death, harm or injury to patient, carer, staff or visitor"*[1] . The definition is often extended to include near misses or risk of potential harm. The 'Serious Incident Framework'[2] produced by NHS England provides a description of 'serious' or 'critical' incidents including those considered 'never events'[3].

How concerns might be reported

There are a number routes through which an incident occurring on a critical care transfer may be reported.

- Documentation on the SYBCCODN transfer form
- Report to Local Risk Management System (Datix)
- Verbally to a member of staff in the receiving or referring hospital (ED, ICU, YAS)
- Via a patient, relative though PALS

3 Local Risk Management Systems (DATIX)

Healthcare workers are encouraged to report incidents via their Local Risk Management System (LRMS). This enables the incident to be investigated and changes instigated to improve care and prevent the same incident from occurring again. It is also important that learning points are shared with all members of the healthcare team. This occurs through direct feedback, local governance meetings and through sharing of data with the National Reporting and Learning System.

3.1 As the SYBCCODN does not have its own LRMS, any moderate or serious incidents occurring on transfers will need to be reported via the LRMS at the receiving or referring hospital.

3.2 Incident reports via the LRMS should be reported as soon as possible after the incident has occurred.

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[1] NHS England » Incidents
[2] serious-incidnt-framwrk.pdf (england.nhs.uk)
[3] Revised-Never-Events-policy-and-framework-FINAL.pdf (england.nhs.uk)

3.3 Local governance teams to investigate as per local guidance and share report with the local Transfer Representative.

3.4 Transfer Representative to present a brief, anonymised report for discussion at the next appropriate Transfer Forum. This will include; a brief description of the critical incident, actions (implemented/ suggested) and learning points to be shared as described below

4. Incident reported on SYBCCODN Transfer Form

4.1 Where an incident is documented on the SYBCCODN Transfer Form, the audit team should escalate to the Audit Lead. A copy of the SYBCCODN Transfer Form should be sent to the Audit Lead.

4.2 The Audit Lead will review the form and determine the severity of the incident and if the incident requires reporting via a LRMS.

4.3 If the **incident does not reach the threshold** for reporting via LRMS then the Audit Lead should either prepare a brief report of the incident for discussion at the next appropriate SYBCCODN Transfer Forum, or delegate the task to a Transfer Representative. The report will include; a brief description of the incident, actions (implemented/suggested) and learning points to be shared as described below.

4.4 If the **incident does reach the threshold** for reporting via the LRMS and **has been reported**, follow steps in 3 above.

4.5 If the **incident does reach the threshold** for reporting via the LRMS, **but has not yet been reported**, Audit Lead to inform the appropriate local Transfer Representative. The Transfer Representative should ensure incident is reported through the LRMS and then follow steps in 3.

5. **Other Routes**

5.1 Staff receiving a complaint or concern about a Network transfer should use the LRMS to document the details.

5.2 PALS complaints should be managed as per local governance arrangements and the report shared with the Transfer Representative. The Transfer Representative will prepare a brief report of actions and shared learning to be discussed at the next appropriate Transfer Forum.

6. Shared Learning

The SYBCCODN recognises the importance of shared learning in improving patient safety. Patient confidentiality and the importance of a 'no blame' culture is also recognised. All learning points will be disseminated with this in mind.

6.1 Discussion of incidents at the Transfer Forum – agreed action plan and learning points to be disseminated.

6.2 If required, one to one feedback will be delivered by the Transfer Representative -either in person or via a line manager of clinical/ educational supervisor (as appropriate)

6.3 Learning points shared by Transfer Representatives through local mechanisms (department meetings, safety briefings, governance)

6.4 Shared learning through SYBCCODN Transfer Newsletter

6.5 Incidents occurring on transfers will be used to inform learning on the SYBCCODN Transfer Course/ Educational programmes

Glossary

PALS – Patient Advice and Liaison Service

YAS – Yorkshire Ambulance Service

ICU – Intensive Care Unit

ED – Emergency Department

SYBCCODN – South Yorkshire and Bassetlaw Critical Care Operational Delivery Network

SYBCCODN Transfer Form – A3 carbonated transfer form (appendix 1)

Examples of level of concern

Minor	**Intermediate**	**Major**
Poorly completed forms (10/20 or less)	Any incident documented in the critical incident box on the form Any incident occurring that had the potential to cause harm to the patient or staff Broken, damaged or faulty transfer equipment Loss of minimum standard of monitoring en-route Significant ambulance delay but NOT caused patient harm	Any documented harm to the patient or staff on the transfer Unexpected/ Unanticipated arrival on receiving unit secondary to communication failure Significant ambulance delay resulting in patient harm (eg. Missed window for Mechanical Thrombectomy)