SOUTHAMPTON OXFORD
NEONATAL TRANSPORT

CLINICAL INCIDENT REPORTING

Background
A robust clinical governance process is an integral requirement for a nationally commissioned neonatal transport services

Reporting incidents and events

- Any incidents or events causing concern during transport should be reported through the OUH datix reporting system or UHS safeguard system in Thames Valley hub and Wessex hub respectively.

- There is a specific field for transport reporting - under heading "Exact location" please choose transport/ambulance. This allows all transport related incidents to be grouped together, separately from the neonatal unit incidents.

- Whilst any incident or event can be reported, please ensure the following more specific transport events are always reported

    - Clinical
        - Death During Transfer (also operational policy " Death in Transfer and complete "death notification form")
        - Patient dropped causing harm
        - Lines, drains, tubes accidentally dislodged resulting in harm
        - pH >7.5 (ventilated patient)
        - CO2<4kPa (ventilated patient)
        - Admission temperature at receiving unit <36 (in a non-cooled baby)

    - Organisational/administrative
        - Delayed dispatch >60 minutes for Time Critical transfer
        - Confidential patient information misplaced
        - Nurse/doctor taken off transport shift to work on neonatal unit

    - Equipment/vehicle
        - Road traffic collision in vehicle
        - Dangerous driving
        - Vehicle breakdown
        - Insufficient gas supply
        - Critical equipment left behind
        - Critical equipment malfunctioning

Review of Incidents

- Incidents will be reviewed through the OUH or UHS governance framework with governance leadership provided through the clinical governance structure for OUH Children's Directorate or UHS Women & Newborn Directorate. Incidents are discussed and reviewed at the monthly neonatal clinical governance meetings. Common themes and lessons learnt from this are sent out to all transport staff in a monthly "at a glance" bulletin.
- Transport incidents/events that trigger a SIRI (as determined by the governance arrangements within the relevant hub) will be reported to Network and Commissioners
- Where incidents cross boundaries with different organisations, the transport lead consultant at the relevant hub will report these to the neonatal network and work with the relevant organisations and the neonatal network to support the governance process led by institution with primary responsibility for the patient. Any wider learning will be disseminate, both regionally and nationally, where appropriate.
- A summary of learning from incidents will be included in SONeT Annual Report.