NoECCN
North of England Critical Care Network

Management of Transfer-related Critical Incidents
Standard Operating Procedure

Introduction

A critical incident is any event or circumstance that caused or could have caused (referred to as a near miss) unplanned harm, suffering, loss or damage. The purpose of incident reporting is to learn from the incident to improve practice and safety (ICS, 2006).

Responsibility

Any professional who is involved in the care of the patient during the critical care patient transfer has a responsibility to report incidents either by email or post to the Network Administrator at the relevant locality office who will in turn inform the NoECCN Transfer Clinical Governance Sub Group.

Documentation*

All incidents should be reported using NoECCN **Transfer Critical Incident Form (TCIF 1)**. The report should be completed as comprehensively as possible, including the patient ID and names of staff involved. The documentation should be completed with 48 hours of the event occurring.

Process

Action	Time Frame	Responsibility
Complete NoECCN (TCIF 1) and send to the NoECCN	Within 48 working hours of the incident	Professional reporting the incident
NoECCN Administrator record the incident on the Critical Incident Database (TCIF log**) and inform NoECCN Transfer Clinical Governance Lead Sub Group	Within 48 working hours of receipt	NoECCN Administrator
Standard email response (TCIF 2) that incident has been received by the NoECCN and is being reviewed	Within 24 working hours of receipt	NoECCN Administrator
Investigation and reporting: For **Green & Yellow** incidents complete a Comprehensive RCA Investigation Form (TCIF 3) For **Red & Orange** incidents complete a Comprehensive RCA Investigation Form (TCIF 4)	According to severity of incident and complexity of investigation: - within a week for **Green & Yellow** - within a month for **Red & Orange**	NoECCN Administrator or Transfer Clinical Governance Lead Sub Group NoECCN Transfer Clinical Governance Lead Sub Group
Recommendations, feedback and action plan if appropriate, to organisations involved.	According to severity of incident and complexity of investigation.	NoECCN Transfer Clinical Governance Lead Sub Group
Following investigations, reporting and recommendations send standard closure email (TCIF 5). Closure of event on incident database.	Within 24 working hours of closure of incident	NoECCN Administrator
Feedback at Transfer Group	Quarterly Transfer meetings	NoECCN Transfer Clinical Governance Lead Sub Group

Feedback

- Feedback to NEAS any relevant transfer related critical incidents as they happen and also a summary on a monthly basis. NEAS link is Gary Molloy, Operations Manager (gary.molloy@neas.nhs.uk).
- Feedback at the NoECCN Transfer Group Meetings.
- Feedback of investigation, recommendations and action plan to relevant critical care units involved in critical incident.

References

- NoECCN Guidelines for the safe transport of the critical care patient (2013)
- National reporting and learning Service. Root Cause Analysis Investigation Tools NPSA (2008)
- Standards for critical incident reporting in critical care. Intensive Care Society Standards and Guidelines (2006)

Transfer Incidents Form Codes

- *Management of Transfer-related critical incidents SOP*
- *Excel Critical Incident Database (TCIF log)*
- *Transfer Clinical Incident Form (TCIF 1)*
- *Standard response email – incident received (TCIF 2)*
- *NoECCN Concise Investigation Report Form (TCIF 3)*
- *NoECCN Comprehensive RCA Report Form (TCIF 4)*
- *Standard response email closure of incidents (TCIF 5)*

***Example of Incident numbering log**

Incident Log no:

- *CI (month)(year)/(number), e.g. CI0413/01*
- *Date of Incident: 240413*