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.
http://www.noeccn.org.uk/Resources/Documents/Transfer%20group/Transfer%20resources%20and%20documents/CRITICAL%20INCIDENT%20REPORT%20FORM.docx

Process

Action	Time Frame	Responsibility
Complete NoECCN (TCIF 1) and send to the NoECCN	Within 48 hours of the incident	Professional reporting the incident
NoECCN Administrator record the incident on the Excel Critical Incident Database (TCIF log) and inform NoECCN Transfer Clinical Governance Lead Sub Group	Within 48 hours of receipt	NoECCN Administrator
Standard email response (TCIF 2) that incident has been received by the NoECCN and is being reviewed	Within 24 hours of receipt	NoECCN Administrator
Complete a Concise (TCIF 3) Investigation Report Form, **and** for: **Green & Yellow** Incidents: Send standard closure email (TCIF 5) **Red & Orange** Incidents: Complete a Comprehensive RCA Investigation Form (TCIF 4)	According to severity of incident within 1 week	NoECCN Administrator NoECCN Transfer Clinical Governance Lead Sub Group
Recommendations/feedback to organisations involved and develop action plan if appropriate or close event on incident database	According to severity of incident (green - red)	NoECCN Transfer Clinical Governance Lead Sub Group
Following investigation of red & orange incidents. Send standard closure email (TCIF 5)	Within 24 hours of closure of incident	NoECCN Administrator

Feedback at Transfer Group	Quarterly Transfer meetings	NoECCN Transfer Clinical Governance Lead Sub Group

Timescales are referred to 'normal' working days (Monday – Friday 09.00 – 17.00, not including Bank Holidays).

Feedback to NEAS any relevant transfer related incidents as they happen and also a summary on a monthly basis. Link is Kristofer Bushell kristofer.bushell@neas.nhs.uk Operations Manager.

Feedback at the NoECCN Transfer Group Meetings

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)