Standard Operating Procedure:
CoMET & CenTre Incident Reporting

This Standard Operating Procedure (SOP) is for use by healthcare staff, at CoMET & CenTre undertaking critical care retrieval, transport and stabilization of neonates and children.

CoMET and CenTre are hosted by the University Hospitals of Leicester NHS trust working in partnership with the Nottingham University Hospitals NHS Trust.

This SOP supports decision making by individual healthcare professionals and to make decisions in the best interest of the individual patient. This SOP represents the view of CoMET and CenTre, and is produced to be used mainly by healthcare staff working for the transport services.

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Education and Training

1. Annual Transport team update training days

Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Incident reporting	Review related Datix	CoMET/CenTre Team Leader/ Matron	Monthly	Monthly via exception report distributed via e-mail **Quarterly** CoMET: Presented via NUH QRS meetings for Childrens Hospital, and Children's Board for UHL CenTre: Presented at Neonatal QRS and UHL Women's and Children's Board
Documentation Compliance	Documentation Audit	CoMET/ CenTre Team Leader/ Matron	Monthly	Team meeting/ Senior Team meeting

Standard Operating Procedure (SOP)
CoMET and CenTre Incident Reporting Process

1. Introduction and Background

CoMET and CenTre have now been centrally relocated to Castle Donington. Both services are hosted by University Hospital Leicester (UHL) in partnership with Nottingham University Hospital (NUH) via a Service Level Agreement (SLA). All NUH staff working for the services have letters of authority/honorary contract with the ability to access UHL IT systems. In order to streamline processes now that we have a single site model it is anticipated that all incidents are reported through UHL with some caveats meaning records are duplicated and reported through NUH Datix system for oversight.

2. Scope

This SOP sets out the reporting process for incidents relating to CoMET and CenTre. It also provides an oversight of the governance process for sharing information between the two trusts- UHL and NUH.

3. Education and Training

As part of induction the education and training of the activities in this SOP will be provided and fully explained to transport staff to ensure the appropriate actions are undertaken. Line managers are responsible for ensuring staff under their guidance have read the SOP and have signed to acknowledge they have understood and will follow the SOP. Staff are reminded that it is their responsibility to ensure they have read any new or changed SOPs.

4. Procedure

4.1 Governance

4.1.1 All NUH staff working for CoMET/CenTre will be issued with a letter of authority to enable them access to UHL systems and Datix reporting.

4.1.2 UHL to ensure up to date information sharing agreement is in place via SLA.

4.1.3 Learning will be shared with the transport teams and with NUH. This will be undertaken in a number of different ways:

4.1.4 **CoMET:**

- A summary of all incidents will be included in the monthly exception report and this will be shared with the family Health governance team at NUH.
- A Quarterly report incorporating a summary of datix's will be prepared and presented at the Childrens Board at UHL and Children's Hospital QRS at NUH in July, October, January and April.
- Learning will also be shared at the monthly team meetings with a summary being provided via the EOLAS app and via e-mail communication with the team.

4.1.5 **CenTre**

- A summary of incidents will be presented and reviewed at the weekly huddle meeting
- A summary of all incidents will be included in the monthly senior team report and this will be shared with the governance team at NUH.
- A Quarterly report incorporating a summary of datix's will be prepared and presented at the Women's Board at UHL and Neonatal and Paediatric (Quality, risk and Safety) QRS at NUH in July, October, January and April at NUH

4.1.6 All equipment is now owned and maintained by UHL. As part of the MOC process and the move to Castle Donington all assets which sat with MESU at NUH were transferred to UHL.

4.1.7 Although all assets now sit with UHL, the trolley system for the new Paraid paediatric and neonatal system was manufactured by Clinical Engineering at NUH and as a result they have requested oversight of any incidents affecting these as a whole system.

4.2 Datix Reporting Process

4.2.1 All untoward incidents and adverse events will be recorded in the patients transfer notes. In addition a Datix form will be completed on-line for investigation, with the appropriate members of the CoMET and CenTre senior team being made aware.

4.2.2 UHL as the host Trust for both transport services will take the lead on investigation unless agreed with NUH to undertake a joint investigation or that NUH will lead

4.2.3 Outcomes will be shared across both UHL and NUH Trust's and where appropriate the paediatric and neonatal network and commissioners

4.2.4 Shared learning and actions will be shared across both Trust's through the quarterly meeting as outlined above and across the East Midlands neonatal and paediatric network and Specialist Commissioning Teams. It will also be shared with National Transport Groups where appropriate.

4.2.5 A datix is required (but not limited to) when the following occur:

CenTre

- Axilla temperature <36.5°C or >38°Con arrival at end of transfer unless being passively cooled or a pre-existing pyrexia is present.
- $PaCO_2$ <4kPa on blood gas analysis at end of transfer in any neonate/child having CPAP/ High flow or mechanical ventilation**.**
- **$PaCO_2$ >7kPa** and **pH <7.2** in a ventilated infant at the end of transfer *(NTG benchmark*[1]
- Unexpected **change** in **$PaCO_2$ >3kPa** in either direction on blood gas analysis from start of journey to end of journey in any baby receiving respiratory support
- Blood glucose >12mmol/L at the end of a transfer

CoMET

- On arrival at receiving centre if the axilla temperature is found to be <35.5°C.
- Child requires intubation in transit

[1] Neonatal Transport Group (2024) NTG Data Set www.bapm.org/pages/ntg-dataset (Accessed on 4/4/24)

- Complete ventilator failure
- Mobilisation time <30minutes for an acute unplanned transfer

CenTre & CoMET

- Blood glucose <2mmols/L at the end of a transfer.
- Theft of CoMET/CenTre Transport Service belongings / equipment from the ambulance
- Call centre breakdown / failure / misdirected calls e.g. advice call going to transport consultant instead of PICU/NICU consultant
- Verbal or physical abuse towards a member of the CoMET/CenTre
- Delay/Lack of Ambulance
- Unexpected lack of CoMET/CenTre medical, nursing or ambulance staff
- Ambulance breakdown / accident
- Equipment breakdown / failure
- Any drug error
- Any transfer where there is an unexpected stop of the ambulance.
- Any deterioration of the child/baby which requires diversion of the team to the nearest available hospital, or return to referring hospital.
- Unexpected/unplanned removal of tubes or lines e.g. ETT, central line, umbilical catheter, chest drain etc.
- Loss of medical gas supply
- Cardiac arrest

4.2.6 Some incidents are more serious and will require case review in in line with the Patient Safety Incident Response Framework (PSIRF). In such instances the on call CoMET/CenTre consultant and manager should be made aware as soon as possible. During office hours please ensure that the CoMET/CenTre Matron is also made aware. Examples of these incidents are given below. This is not an exhaustive list.

- An incident where a neonate/child is or becomes acutely unwell because their deterioration was not recognised or acted upon sufficiently quickly
- Death of a neonate/child in transit
- Equipment failure resulting in harm to or death of a neonate/child in the care of the CoMET/CenTre.
- A 10 times more or less drug error that is administered or checked by a member of the CoMET/CenTre to a child/neonate regardless of whether it resulted in harm or not
- Misplaced naso or oro gastric tube not detected prior to use*
- Mis-selection of strong potassium containing solutions*
- Administration of medication by the wrong route *
- Mis-selection of high strength midazolam during conscious sedation*
- Unintentional connection of a patient requiring oxygen to an air flow meter*
- Undetected oesophageal intubation*
- Transfer of the wrong child/neonate
- Ambulance accident involving members of CoMET/CenTre
- Transfusion-related incidents- unintentional transfusion of ABO incompatible blood components*
- Overdose of insulin due to use of abbreviations or wrong device*

Items marked with * are identified in the Never Events list 2018[2]

4.2.7 Where there is an incident involving equipment, it is **ESSENTIAL** that on completion of transfer that the transport trolley/equipment and all its components are left exactly as they were during the transfer. Do not clean the equipment or remove any disposables such as ventilator tubing or infusion lines etc. The trolley/equipment should be "quarantined" and not used until the equipment has been examined by Medical Physics and the all clear has been given that the trolley is safe to use.

4.3 Exceptions requiring reporting to NUH in addition to UHL

4.3.1 Serious Incidents which require review in line with PSIRF framework

4.3.2 Any NUH staff related injury should also be reported via NUH. This will also need to be established as to whether or not this is a RIDDOR reportable incident and appropriate steps taken.

4.3.3 Incidents or concerns regarding fitness to practice relating to NUH staff competence who are not working 100% for the transport services e.g. drug error, will be shared with NUH. Any issues will also be picked up at the monthly catch up meetings with the relevant matrons.

4.3.4 Any incident relating to the 'trolley chasis system' will be duplicated at NUH to enable Clinical engineering to have some oversight.

4.3.5 Any incident which relates to a child that has died will be shared with the relevant child death review/ CDOP to ensure lessons learned.

5 Approval Process

All SOPs must be written/reviewed by the appropriate lead. SOPs which involve more than 1 service must be taken to the relevant groups for approval and comment before being ratified by the senior team at CoMET and CenTre.

6 Dissemination and Implementation

Approved SOPs will be placed onto the CoMET website, NHS futures and the EOLAS app for access by all staff. It is the responsibility of the senior management or the SOP Author/s to disseminate the SOP changes to relevant staff groups.

7 Review and Monitoring Criteria

All SOPs must be reviewed every 2 years. Any changes in practice which require amendments to SOPs will be undertaken jointly by the CoMET and CenTre senior team and ratified through both UHL CMG and NUH Divisional Boards.

[2] NHS Improvement (2021) **Never Events List 2018** Available at: 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk) (Accessed 28 December 2023)