

Risk Management Referral and Strategy

Definition

Risk Management is concerned with identifying and generating information about risk and potential risk in order to put into place systems which will minimise events of activities that could expose the patients, staff, others and network property to risk.

Philosophy of Risk Management

Risk Management assists all members of the transport team, cot bureau and the network to control and reduce the risk within the transport service. It has a positive approach to the protection of the baby, staff, public and the network

Responsibility

The Transport Team will have a Transport Risk Management Group with a membership that reflects the multidisciplinary team involved in the delivery of the transport service that includes:

- Clinical Lead for the Neonatal Transport Service
- Transport Lead Nurse
- Risk Management Transport Sister x 2 (Chairpersons)
- Perinatal Cot Bureau co-ordinator
- Greater Manchester Ambulance Service Risk Management co-ordinator
- Representatives from the Greater Manchester Clinical Managed Network for neonates
- Transport Nurses and ANNP's
- A Technician
- Clinical Fellow
- Neonatal Consultants
- Representative from the Clinical Governance Forum

The Clinical Lead and the Risk Management Transport Sisters have the responsibility for the co-ordination of risk management within the Neonatal Transport Service. There will be clear lines of communication between the co-ordinators through the Network wide members of the Transport Service. There will be Risk Management meetings held on the NNMU at St Mary's Hospital every 3 months, the group will

- Encourage an environment of open and honest incident reporting from all
- Manage the incident reporting system – investigate and discuss risks
- Co-ordinate the implementation of recommendations for change
- To monitor the frequency and severity of clinical risk incidents
- Influence guidelines/practice standards formation
- Ensure that issues are effectively disseminated to ensure all are able to make changes to reduce and evaluate

Learning from experiences

Risk Management should not be viewed as negative, but it empowers clinicians to utilise their skills and expertise in order to maintain a safe and secure environment for the baby and for the staff.

The Transport Service promotes a culture of learning and enquiry in which all members of the team are encouraged to reflect upon their practice and that of others. The service will ensure that those involved in adverse incidents are offered support and advice. This will be available in the form of peer support which for medical staff is the Consultant or senior colleague, and for nursing staff the Lead Nurse, the ambulance service staff will receive support from their Operations Manager, and the Clerical staff from their Line Manager.

A robust system will be in place to facilitate the reporting of unusual cases, adverse incidents and near misses within the transport service. The Transport Risk Management Group will participate in the review of such cases. This will provide evidence that action has been taken, where appropriate.

TRANSPORT INCIDENT TRIGGER LIST

- Ph <7.0 on arrival at accepting unit
- Temperature <36°C on arrival at accepting unit
- Blood sugar <2.0 mmol on arrival at accepting unit
- Extubation during transfer
- Poorly secured vascular lines resulting in loss of fluid/blood during transfer
- Any significant intervention or resuscitation during transfer
- Iatrogenic injury
- Medication/infusion related incidents
- Death of patient during transfer (from time of first contact up to 2 hours post transfer)
- Communication issues: referring, accepting unit and/or ambulance
- Documentation issues
- Equipment/Ambulance failure
- Road traffic accident
- Personal injury
- Health and Safety issues
- Transfer delays
- Transport team staffing problems
- Staff illness during transfer
- Complaints

References

Department of Health (1998) A 1st Class Service, Quality in the NHS, London, NHS Executive

Department of Health and the National Patient Safety Agency (2001) Doing Less Harm, London, NHS Executive

NHS Litigation Authority (2002) Clinical Risk Management Standards, London