PAEDIATRIC EVENT REPORTING TRIGGER LIST

PAEDIATRICS INCLUDING EMERGENCY DEPARTMENT

Examples of incidents

This list contains examples and is not exhaustive. If you have any doubts, discuss with the Sister, Matron, Associate Director of Nursing for Paediatrics (ADN), Service Manager or with the Governance Team.
Once the incident has been put onto Datix, the Governance Team or Matron will allocate a handler, who will receive a notification email. The handler will coordinate and investigate the incident accordingly. The Patient Safety & Governance Nurse will oversee the incidents and give advice as required.
Completion of Datix is a reporting tool that aids learning and refection, it does not lead to disciplinary action, except where acts and omissions are malicious, criminal or constitute gross or repeated professional misconduct, or knowing failures to follow Trust Policies and procedures.

Clinical

• Theatre List Delayed/ Changed without adequate notice • Clinic cancelled/ delayed over 30 minutes • Unplanned return to theatre • X-Rays not available on line • Delay in receiving results • Poor documentation • Breach of patient confidentiality • Patient not labelled/ labelled incorrectly • Missing patient record • Self/ Parental discharge against medical advice if medical and/ or safeguarding concerns identified • Difficulty in contacting doctor to attend ward / ED	• Consent issues • Treatment policy/ procedure not followed within appropriate time constraints • Blood product/transfusion issue • Blood Loss - unexpected • Patient self harm on Trust premises • Patient feeding issues • Unplanned extubation • Extravasation injury • Falls/Slips/Faints/Injury – patients, staff and visitors • Symptomatic Hypoglycaemia on inpatients • Death – unexpected or expected • MRSA (including surface swab)

Drug

• Drug documentation error • Delay in delivering drugs to patient • Prescribed drugs not available • Controlled drugs issue • Drug overdose/ omission	• Drug error due to pump set up • FP10 issue • PCA issue • Prescription/ dispensing/ administration error

Service/Other

• Staffing level/skill mix concerns **(Red Flag)** • Communication issues – staff/ patient/ parent/ external • Hazardous patient environment • Equipment issues – defective/ failed/ availability • Mismanagement of sharps and sharps injuries	• Breach of security – actual/ potential • Abusive/ aggressive behaviour • Patient missing/ absconded • Ambulance transport issues • Child protection procedure not followed • Actual or highly suggestive of NAI • Any other 'near miss' • Ward closure

Agreed by PNQGC
December 2017
Review June 2022

PAEDIATRIC EVENT REPORTING TRIGGER LIST
Neonatal Intensive Care Unit and Transitional Care

Examples of incidents

This list contains examples and is not exhaustive. If you have any doubts, discuss with the Sister, Matron, Associate Director of Nursing for Paediatrics (ADN), Service Manager or with the Governance Team.
Once the incident has been put onto Datix, the Governance Team or Matron will allocate a handler, who will receive a notification email. The handler will coordinate and investigate the incident accordingly. The Patient Safety & Governance Nurse will oversee the incidents and give advice as required.
Completion of Datix is a reporting tool that aids learning and refection, it does not lead to disciplinary action, except where acts and omissions are malicious, criminal or constitute gross or repeated professional misconduct, or knowing failures to follow Trust Policies and procedures.

Clinical

• Actual Complaint • X-Rays not available on line • Samples not received in lab • Abnormal delay/wrong results reported from lab • No hospital number documented on drug chart • Handover sheet left unattended • Patient not labelled/labelled incorrectly • Missing patient record • Failure to get written consent as per guideline • Hypothermia on admission to NICU • Neonatal death • NGT misplaced/not in place • Lines/ETT misplaced and not dealt with	• Unexpected admission to NNU >35 weeks (inc HIE) • Delay in performing procedure without reason and with impact on patient care • Failure to follow blood product/transfusion safety checklist • Blood Loss - unexpected • Wrong EBM given • Accidental missed feed • Unplanned extubation • Falls/Slips/Faints/Injury –staff and visitors • Injury or harm eg extravasation, arterial line complications • MRSA (surface swab)

Drug

• Significant drug documentation error • Antibiotics not given within 1 hour of prescription • Prescribed drugs not available • Controlled drugs issue • Drug overdose/omission without reason	• Infusion error • FP10s discrepancy on CD check • Prescription/ dispensing/ administration error

Service/Other

• Staffing level/skill mix concerns **(Red Flag)** • Unit over capacity • Communication issues – staff/patient/parent/external • Nursery room temp above 28 degrees • Nursery room temp below 18 degree	• Equipment issues – defective/failed/availability • Needle stick injury • Breach of security – actual/potential • Abusive/aggressive behaviour • Significant network transfer issue • Safeguarding policy not followed

Agreed by PNQGC
December 2017
Review June 2022