Northern Neonatal Transport Service (NNeTS) Guideline

Guideline for NNeTS staff daily routine

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Introduction

This guideline outlines the daily work routine for NNeTS staff. It provides structure to the day shift to ensure that the team is responsive to incoming requests for transfer and outlines the opportunities each day for education and training to optimise staff performance.

The scope and role of the Transport Consultant for the week (TrC) is also outlined.

Guideline scope

This guideline is applicable to all staff (medical and nursing) working with NNeTS (either permanent staff or staff allied to NNeTS). It is available to all NICU (Wd 35) staff for information.

Guideline

NNeTS shift times are currently 0800-2030 hrs and 2030hrs-0800hrs in order to synchronise the medical and nursing shifts, and improve response times around the handover period.

Daily routine/tasking for NNeTS Specialist Nurses

This document outlines the usual routine that should be undertaken by the NNeTS team each day in order to ensure that the team is prepared for transfer activity.

0800: Handover between night and day (nursing) teams, Specialist Nurse Team Lead. Identify:

- Health, wellbeing or newly identified staffing issues
- Any outstanding, urgent or ongoing transfers?
- Any equipment issues from overnight that would impact operational readiness (including actions taken)?

If time allows complete and update daily regional bed state laminates (if no administration support staff available to do this). This can be done after 0930 daily briefing if not time for completion before this. Permanent electronic record use will be established once database has been activated.

0830: attend NICU (Wd35) morning teaching activity

0930: *NNeTS daily briefing* (TrC/Specialist Nurse Team Lead)

- Identify any issues with staffing (health, availability)
- Identify any issues with NNeTS equipment
- Identify any issues with ambulance service
- Identify any safety issues which might affect staff or patients
- Identify any planned work (e.g. repatriations)
- Review of the transport (yellow) sheets from the previous 24 hours (or 72 hours if Monday morning) focussing on:
    - Completeness of documentation
    - Identification of any safety, risk or governance issues (clinical)
    - Minutes of meeting to be captured in communications book

Note: Data will eventually be entered into database (once database is established. A template will be used to record and save this event, one per transport reviewed.

- NCARDRS notification: If the review of a yellow sheet from the previous day highlights a congenital anomaly as one of the features of the clinical presentation, then the TrC should make a NCARDRS notification for the baby. (https://nww.api.encore.nhs.uk/ncardrs/ accessed from a Trust computer; use either neonatal or delivery form, makes no difference)

<u>NNeTS additional daily activity</u>: (to occur ideally after the daily briefing, but flexibly as work allows and need demands)

1. **Formal Equipment Check:**

- Check transport trolleys and kit: replace/restock as required. This **<u>must</u>** be completed once during every shift. If it is possible, the registrar who would be working with the NNeTS team during daytime hours (i.e. the postnatal registrar) should be invited to take part in this check, though their attendance depends on their clinical workload. This is primarily intended to be for their education.

Note: on the first of each month, the four NNeTS kit bags must be stripped and restocked. This is a high priority check as it ensures infrequently used items are in date and allows replacement where they are not. It should be completed either on day or night shift, depending on ongoing workload.

Any missing or unavailable items during restocking should be reported to the SNTL.

2. **Education**

- One activity per day shift (30-60mins), work allowing. TrC, NP or Specialist Nurse Team Lead (SNTL) to lead/deliver. Educational activity for the benefit of the transport nurses +/- TNP on duty. Can include:
    - Skills teaching/practice
    - Drills (using simulation for specific actions e.g. obstructed ET tube)
    - Simulation scenarios of clinical situations that might occur on transport (may include assessment and diagnosis or broader problems than those which lead to use of 'drills')
    - Equipment education (such as a review of set-up/use)

3. **Individual debriefing/case discussions/feedback (as required by staff on duty)**
    - Ad-hoc based on team requirements

4. **Practice support and development:**

Practice support on NICU: if asked to check resus equipment (on NICU or in the delivery suite/NBC) or the in-house trolley, the NNeTS nurse should always take a non-NNeTS staff member with them to teach and develop their skills in managing the equipment.

5. **Small group debriefing/risk management discussion (as first stage of risk management process)**
    - This event will have been organised by SNTL to occur during working hours wherever possible and the TrC notified in advance
    - Will need to be chaired by TrC
    - Summary of learning should be provided to SNTL who will disseminate learning and/or arrange for incident to be taken to fuller risk management if required.

6. **Fielding transfer requests: (through the day)**

The administration support staff will eventually take responsibility for this but in the event of the team being contacted about a transfer (and the administration support staff not being available), the NNeTS nurse should take the initial call details. If it is about an acute transfer of an unwell baby, then the TrC should be informed and involved in the telephone call as soon as possible (daytime hours).

Night shift:

There will be less opportunity for planned teaching during night shifts, but it is still essential that the following activities are complete before any clinical work commences:

- Handover between day and night (nursing) teams (as outlined above)
- Check transport trolleys and kit: replace/restock as required
- Complete and update daily regional bed state laminates (if no administration support staff available to do this). Update the excel spreadsheet with this information (once share drive access secured).

Liaise with Consultant on call for NICU to update them with current and anticipated activity, service capability and also to confirm thresholds for notifying the Consultant of referrals for transport overnight if the Consultant is not on site.

As with daytime working, if asked to check resus equipment (on NICU or in the delivery suite/NBC) then the NNeTS nurse should always take a non-NNeTS staff member with them to teach and develop their skills in managing the equipment.

It is currently most likely that night shifts will involve ad-hoc involvement in care of babies on NICU if not out on transfer. If 2 NNeTS nurses are on shift overnight then one should liaise with ITU (red) and one with HDU/SCBU (blue/green) areas to assist. As staffing on NICU improves the non-transport time for NNeTS team members will increasingly involve service development and governance activities.

Postnatal registrar

The postnatal registrar is the current ‘first port of call’ for providing medical staff on transfer during the day. They need to ensure that at some point in the morning (best timed with the end of the NNeTS briefing) they liaise with the NNeTS nurses on shift and *complete a joint, transport equipment check with them* at that time. The aim of this joint check is to ensure that the medical staff doing transport are familiar with the kit that they have to use and offers opportunity for them to ask questions if required before equipment issues arise in the field. This check is separate from, and does not replace, the functional and restocking check done by the NNeTS during their shift.

Transport Consultant (TrC) Role

The current allocated hours for the weekly transport consultant is 7PA/week (i.e. 28 hours total, or 5 hours 36 minutes per day over a normal 5 day working week). An alternative way to accomplish the role would be to work 0830-1530hrs for 4 days per week.

Work pattern is at the professional discretion of the TrC for the week, but it should be communicated clearly to the SNTL and the red consultant for that week to avoid any confusion about availability.

The 28 hours are flexible within reason, such that a longer than expected day may be offset later in the week. In the early stages of evolution of the service, while there is still significant demand on the NNeTS nurses to fill spaces in the NICU working, it *may* be optimal that the TrC is available 5 days a week where possible.

The role of the transport consultant will evolve over time as the team completes recruitment and the nurse practitioners come on line, though this is anticipated within months-years, not weeks.

Outlined above is the first iteration of a proposed working day for the transport team above, though clinical need may impact the educational aspects until there has been suitable improvement of the staffing on NICU to reduce the ad-hoc daily secondment of NNeTS staff into the NICU establishment.

It should be noted that out of the specified hours for TrC presence, the oversight for NNeTS process falls under the on-call consultant. When there is no TrC for a week for any reason, the red consultant should take the lead in negotiation with their colleagues in-house that week. In these circumstances the 'daily routine' timings may vary to accommodate the ward round.

Currently, the TrC role has three key facets:

a) Logistics

- Responsibility for taking telephone calls regarding acutely unwell babies requiring transfer, giving advice and organising the transfer (in liaison with the red consultant)
- Providing advice for NNeTS teams during transports

b) Teaching/training

- Each day (workload allowing) there should be some education provided for the team. This might well be led by the TrC but equally the SNTL or a nurse practitioner might do some training on a piece of equipment, or the whole team (TNP plus nurses) might be engaged in simulation or drills. Case reviews or discussions about a particular clinical topic would also be an alternative. As TrC is for the week, this can be planned on the Monday for the week ahead with the team.
- Daytime supervision and teaching *on transfer*s: as the Transport Nurse Practitioners (TNPs) move through their training there will be a degree of 'on the road' apprenticeship to their learning. For the majority of these episodes, an experienced neonatal HST or one of the research

fellows doing regular transfers should be well placed to support this learning.

Similarly there will be a 1-2 month period each 6m as trainees rotate through the NICU during which some upskilling of middle grades is required to continue the acute transport delivery for the foreseeable future.

The TrC should be prepared to make a case-by-case assessment as to whether it is possible, beneficial and/or in the best interests of the patient for them to go on a transfer. If the TrC does go, this should be as an addition to the normal team complement (Nurse +1) and with the principal aim of supporting learning.

c) Governance

- There should be a daily review of transports from the previous 24 hours led by the TrC. There will be an excel template for recording this review available on the shared drive and each review should have a saved file to accompany it. The yellow sheet data will be put into a separate transport database but it is not the TrC's responsibility to do so. The daily review should highlight any problems which have occurred and if needed (either as part of a 'theme' of problems, or a significant individual event) this should then be notified to the SNTL who will schedule a formal meeting with the staff involved on the transfer and possibly further inclusion for formal case review as part of risk management.

A note on consultant service delivery:

NNeTS cannot provide a dedicated, consultant *delivered* service 24/7. As outlined above, the role of the TrC week is one which is best served with the TrC resident in the building providing liaison, advice, education and support to the NNeTS staff.

However, if there is an acute transfer situation arising that would potentially benefit from a consultant presence during the transfer, the TrC should consider this at the time and make a decision about going out on transfer or not. This unusual occurrence might arise, for example, due to the acuity of the transfer in combination with another factor(s) such as a very junior, recently-rotated registrar.

For the foreseeable future the bulk of service *delivery* for ITU transfers will remain with medical staff at tier 2/research fellow level.

NNeTS meetings

Formal transport risk management meetings occur every other month, chaired by either the NNeTS Transport Consultant Lead or Specialist Nuse Team

Leader, and learning/outcomes will be disseminated to a wider audience following these via minutes.

Any complaints or serious incidents relating to NNeTS will be investigated by NNeTS Transport Consultant Lead and SNTL, then discussed formally in risk management with an independent observer present (in the first instance one of the other NICU consultants independent of the incident, and ideally an external observer to sign off on the process).

Outcomes will be shared the regional Northern Neonatal Network meetings.

Monitoring

This document is intended to cover the period April 2017 to September 2017 and will be reviewed in light of ongoing evolution of the NNeTS service and NICU staffing.