Thames Valley & Wessex
Critical Care Network

Thames Valley & Wessex Adult Critical Care Operational Delivery Network

Core Principles for Infection Prevention & Control hospital transfers and repatriations

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Document Purpose:	Reduce unnecessary delays to patient transfer whilst ensuring appropriate IPC precautions, placement and prioritisation are in place to facilitate safe patient transfer		
Version:	FINAL	**Date:**	1st September 2025

Revision History

Version	Date	Summary of Changes
0.1	24/06/25	Direct copy of original document from the South West, with one updated link and updates to agreement and principles, to reflect the different geography, reviewed by NW
FINAL for approval	15/07/25	Sent to NHSE Spec Comm SMT for final approval
FINAL	01/09/2025	Approved by NHSE South East Spec Comm Senior Management Team

1. Agreement

This guidance has been shared and approved by Infection Prevention and Control (IP&C) Teams of the Trusts within Thames Valley and Wessex, NHS England South East Infection Prevention and Control and the Thames Valley and Wessex Critical Care Network.

2. Principles

Critical care patients may need to be transferred between organisations, within the Thames Valley & Wessex Critical Care Network for purposes of escalation, repatriation, and mutual aid. Unnecessary delays to patient transfer, due to the requirement for a single room and/or use of single rooms within receiving hospital/unit may delay the care of the transferred patient, as well as other patients across the network. Clinical risk assessment should consider the risk of delayed transfer, as well as the risk of possible infection. Referrals or repatriations should not be refused because of colonisation/ infection. Appropriate IPC precautions, placement and prioritisation should be in place to facilitate safe patient transfer.

IPC precautions should follow the specific guidance as outlined in the National Infection Prevention and Control Manual and the A-Z of pathogens NHS-England-IPC-A-to-Z-pathogen-resource. The hierarchy of controls should be used to formulate a risk assessment, elimination, substitution, engineering controls, administrative controls, and personal protective equipment (PPE) respectively.

3. Pre-Transfer Communication

A detailed, effective handover between referring and receiving organisations is key to safe patient care. If there is a particular IPC element to the transfer, e.g. the patient is infected or colonised with a multidrug

resistant organism (MDRO) and/or transmissible organism, then IPC teams may be required to be involved from the referring and receiving organisation.

If the patient is in an area where there is a suspicion or confirmed outbreak/cluster of an organism, which requires IPC precautions, the IPC teams must be involved from both the referring and receiving organisations.

If there is an IPC element that may delay transfer, this must be discussed with the IPC teams.

4. Screening swab results

Screening swabs should be taken as per national guidance and local policy. Receiving organisations should accept results as documentary evidence. All results, positive or negative, should be provided by the referring organisation. There may be exceptional situations when additional screening may be requested by the receiving IPC team. An example of this may be in an outbreak situation. The table below sets out the screening requirements as stated in the national guidance.

To inform a risk assessment, the following screens should be completed as per national guidance and local policy. If the screens have not been completed as described in the table below, then isolating a patient in the receiving organisation may be necessary until the tests results have been received and reviewed.

Organism	Screening criteria	Swabs Required
MRSA Implementation of modified admission MRSA screening guidance for NHS (2014) MRSA screening guidance(publishing.service.gov.uk)	All patients admitted to critical care (classified as a high-risk units/location). The frequency of (repeat) screening should be determined locally and made explicit in local guidance – the majority of TVWCCN hospitals require swabs on admission.	Nose, groin/perineum and 'other' sites where appropriate (e.g. wounds, indwelling devices, throat, etc).
CPE Framework of actions to contain carbapenemase-producing Enterobacterales (2022). Actions to contain carbapenemase- producing Enterobacterales (publishing.service.gov.uk)	Current guidance advises that anyone who has been an inpatient within the past 12 months requires CPE screening, therefore anyone transferred between critical care units will require a CPE swab. Specifically: All patients in the last 12 months, if they have: Been previously identified as CPE positive. Been an inpatient in any hospital, in the UK or abroad. Had multiple hospital treatments, for example are dialysis dependent. Had known epidemiological link to a known carrier of CPE.	A rectal swab, making sure faecal material and/or discolouration is visible on the swab (a stool specimen if a rectal swab is not feasible or acceptable) a wound swab and or a urine sample (if catheterised)
Covid 19: Full guidance available. COVID-19: testing from 1 April 2024 - GOV.UK (www.gov.uk)	Symptomatic adults and children admitted for care or developing symptoms within hospitals where having COVID-19 will change clinical management, for example to inform treatment	PCR and LFD at local discretion

***C. auris*:** Guidance for the laboratory investigation, management and infection prevention and control for cases of Candidozyma auris. Candidozyma auris (formerly Candida auris): guidance for acute healthcare settings - GOV.UK	All Patients coming from other affected hospitals/units in the UK and abroad.	Groin and axilla (the most persistently positive in Trusts that have conducted screening).

5. Use of Single Rooms

Routine isolation of patients in single rooms when transferred from one organisation to another may not be required if:

- the above screens are negative
- screens have been taken within an appropriate timescale for transfer (according to receiving organisations local policy, e.g. 72 hours)
- the patient is not known to be previously or currently infected or colonised with an MDRO

If this is not the case, the transfer should not be delayed, and the patient should be isolated on arrival until a risk assessment has occurred. If no isolation room is available, patients must be individually assessed for infection risk, if possible, before transfer or promptly on arrival. This assessment should influence placement decisions in accordance with clinical/care need(s). (National Infection Prevention and Control Manual)

Where test results indicate the need for continued IPC precautions, the receiving IPC team will advise on the requirements for isolation, cohort nursing or hierarchies of control. Where the IPC results described above have been appropriately obtained and a detailed handover has occurred to the referring organisation, re-testing to facilitate release from a single room in a receiving hospital may not be required.

Patients with known immunodeficiency may require single room placement for protective isolation.

6. Possible Risk Assessment Considerations

Acute trusts will need to make their own risk assessment based on regional prevalence, patient mix, and linkages with other care providers. (UKHSA 2022). Other considerations include:

- Whether the patient was previously or currently infected or colonised with an MDRO or significant organism (for example Candidozyma auris, C. difficile, viral respiratory illness such as Covid-19)
- Whether the patient is a known 'contact' of any of the following: MRSA, CPE, Candidozyma auris
- There have been occurrences or outbreaks/periods if increased incidence of MDRO or other significant organisms in the past. e.g. 3 months (CPE, GRE, C. difficile, Candidozyma auris)

7. Reporting any delays in transfers relating to IPC issues

Please report any delays in transfers relating to IPC issues to: england.tv-w-criticalcarenetwork@nhs.net