

Thames Valley and Wessex Adult Critical Care Operational Delivery Network Transfer Policy



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1.0 Purpose of this Document

To define the process to be undertaken by referring and receiving hospitals to ensure the safe transfer of critically ill patients (Level 2 & 3) between Critical Care Units within and between hospitals within and outside the Thames Valley & Wessex Critical Care Operational Delivery Network (TV&WODN) for clinical or non-clinical reasons. This includes transfer within this geographic area, whether patients are in NHS or independent healthcare facilities.

Detailed standards for transferring critically ill patients have been published (1997) and updated (2002) and 4th Edition 2019 by the Intensive Care Society and reinforced on other documents. The Thames Valley & Wessex ODN has agreed to adopt and work to these guidelines. These guidelines can be viewed/downloaded from the Intensive Care Society (ICS) Website.

This document is to be used alongside the ICS Guidelines to provide additional, relevant local information and to ensure consistency across the Network with the twin aims of ensuring patient safety and consistent training of all health care professionals involved in transfers.

Each individual unit and professional is responsible for the patient's care and developing local procedures and protocol to implement the policy.

2.0 Organisation within Trusts

Each Trust should have a nominated consultant and senior nurse responsible for intra and interhospital transfer of critically ill patients. They are responsible for ensuring that a process is developed within their Trust to facilitate safe transfers including:

- Establishment and training of transfer teams, in line with STaR and ICS Guidelines
- Availability of equipment compatible with transport modalities, and ICS Guidelines
- Development of Trust Transfer Policy in line with the rest of the Network

3.0 Indications for transfer

3.1 Decision to transfer:

The decision to transfer a Level 3 critically ill patient between hospitals must be made by an ICU consultant. The patient must also be accepted by an ICU consultant at the receiving unit. These will usually be the consultants on call for the critical care units.

Level 1 patients are usually the responsibility of a physician or surgeon and the ICU team may not be adequately resourced to take responsibility for these transfers i.e. primary PCI or leaking AAA. These patients need to be discussed, and agreement reached at a local level. The referring team should demonstrate that the benefit of ICU transfer outweighs the risk caused by potential delay and loss of onsite ICU cover.

Refer to local guidance on the transfer of Level 1 and 2 patients, where available.

Reasons for transfer include

- need for specialist tertiary care
- local capacity exhausted
- repatriation from tertiary centre to district general hospital
- repatriation for geographical reasons

3.2 Clinical and non-clinical transfers:

The decision to transfer a patient must balance risks and benefits. There is a significant risk of deterioration during transfer, and patients and staff are both at risk from accidents.

A transfer for clinical reasons implies the patient requires specialist care not available on site e.g. cardiothoracic surgery, neurosurgery, paediatric critical care, hyperbaric medicine.

A non-clinical transfer occurs when the demand for ICU beds within a trust exceeds the bed capacity of its critical care unit(s). If this is necessary, all critical care units within the Network will complete the following steps before calling other units to accept a critical care patient transfer.

- Ensure that there are no patients on the unit who could be safely transferred to another ward/unit elsewhere in the hospital.
- If the problem in the critical care area is lack of staff, not lack of physical bed spaces, ensure that no patient in the critical care unit is receiving level 3 care when they need only level 2 care. Such a change in level might free up staff to treat an additional level 3 patient.
- Ensure that no other arrangements can be made to safely manage one or more critically ill patients in another area of the hospital (for example, the post-operative recovery room or another critical care unit).
- Ensure that there is no possibility of obtaining additional staff using overtime, through an agency, or by transfer from another critical care unit.
- Ensure that all elective high-risk surgery which requires a post-operative critical care bed is cancelled to reduce pressure on the unit.

When a non-clinical transfer is unavoidable, the referring unit should decide which patient is most suitable for transfer to another unit (i.e. the most stable and least likely to deteriorate). If the new patient is too unstable to undergo transfer, one of the patients already admitted to the unit should be selected. It is important to consider the suitability of the patient for transfer to the receiving hospital: clearly a patient receiving specialist input should not be transferred to a hospital where that specialty is not represented.

Once it has been decided who should be transferred, the agreement of the attending consultant and the family should be sought before the transfer process is initiated.

Prior to any transfer, the ICS and the TV&WODN advocate a risk assessment that includes assessment of the following factors:

- Clinical History: Are there any specific risks related to the underlying condition and / or comorbidity which the patient might encounter during transfer?
- Current Clinical Condition: Is the patient stable and / or what is the trend? Use a recognised track and trigger scoring system (e.g. MEWS) and if possible, allow sufficient time for more than one observation.
- Other information available from additional monitoring (e.g. oxygen saturation) and / or specific investigations (e.g. lactate, blood glucose, base deficit, arterial pH).
- The anticipated length of the journey, mode of transport and any specific transport related issues.
- The number and skills of staff required for a transfer can also be guided by the risk assessment

An example of a risk assessment can be found in Guidance On: The Transfer of The Critically Ill Adult, ICS, May 2019

A receiving unit should always accept an appropriate patient unless the unit is full or has only one bed available for an emergency admission. A request for transfer should not be refused simply because it will disrupt planned high-risk elective surgical activity (i.e. beds should not be ring-fenced for pre-booked elective surgical patients – but every possible effort should be made to allow elective surgery to proceed if it has been previously cancelled. This should involve clinical judgement and consultant to consultant discussion between units).

If the referring unit cannot identify a receiving unit within its own Transfer Group or elsewhere in the Network using the above criteria, the referring unit should either call back the nearest unit with one free critical care bed or consider transferring the patient outside both Transfer Group and Network. This decision will depend on whether there is a relative shortage of ICU beds locally or whether the problem is more widespread.

3.3 Repatriations

Repatriations from tertiary centres must be given priority over elective admissions. These patients may well require transfer out of hours and should not be classed as an out of hours discharge for reporting purposes. It is recommended By the ICS and the TV&WODN that patients are repatriated with in 48hrs.

4.0 Resources to Transfer Patient

4.1 Equipment

Specific transfer equipment should be identified within each Trust and kept in a state of permanent readiness. It must be fully maintained and fit for purpose. All battery powered equipment must be kept on charge and back-up battery provision must be carried with the equipment.

Ideally transfer equipment should be standardised across the Network, however it is acknowledged that individual hospital and ambulance trusts will have their own standard suppliers and individual requirements.

The transfer bag should be routinely replenished, checked, sealed, and certified. The date of expiry of the earliest perishable item should be recorded on the outside of the bag. Following this it should not be necessary to open it prior to use.

A transfer checklist will be attached to each bag. Monitoring, ventilation, and other equipment should be identified using the inventory numbers where possible. The list must be checked before transferring a patient to ensure that everything needed is taken. A further check should be undertaken after the transfer to ensure that all equipment has been returned.

Use of the Network standardised transfer bag is recommended. It is also strongly recommended that a dedicated transfer trolley is used.

Dedicated syringe pumps and a portable ventilator suitable for transferring critically ill patients should be available to the transfer team. Ideally this equipment should be secured to a purpose-built gurney designed to be secured in an ambulance. If this is not available, other means of securing equipment safely in an ambulance should be used.

Supplementary equipment may be required for specific transfers, a suggested list of equipment is available in the Guidance On: The Transfer of The Critically Ill Adult, ICS, May 2019

The weight of the patient must be taken into consideration. The relevant Ambulance Service must be made aware of any patient weighing more than 20 stones or 130kg. Very heavy patients (weighing more than 28 stones – 180kg) exceed the capacity of a standard stretcher and will require special arrangements. This may involve the use of a specialist ambulance which may incur additional time delay.

4.2 Personnel

The critical care unit at the referring hospital will usually be responsible for providing the medical and nursing staff (ODA as required). The source of staff may vary in different hospitals, but all staff should have been trained and deemed competent to local unit and Network standards.

All members of the team should be familiar with the environment they will be working in, the equipment to be used and how it is packed before undertaking any patient transfers.

4.3 Indemnity Insurance

The ICS guidelines identify that members of The Intensive Care Society and Association of Anaesthetists of Great Britain and Ireland have negotiated insurance for their members involved in the transport of critically ill patients.

It is also the responsibility of the NHS Trusts to hold adequate insurance for staff that are trained and expected to transfer the Critical Ill patient as part of their job.

Ambulance Trusts also hold a responsibility to ensure their staff and vehicles are adequately insured for this role.

5.0 Communication

The initial referral should be Consultant to Consultant. Information to be included is:

- Reason for transfer
- Patient Name, Age, Sex
- Medical History
- Details of clinical current condition
- Details of current therapy
- Changes in therapy to be undertaken for transfer
- Infection risk
- State of family communication
- Time frame of transfer
- Mode of transfer
- Contact details for referring team

It is important that the responsible service (e.g. surgery, respiratory, etc.) and not just the ICU team, hand over to their colleagues in the receiving hospital.

A mobile phone should be taken on the transfer to allow communication with both referring and receiving units, as necessary. A mobile phone compatible with medical equipment is ideal.

Bed availability must be confirmed with the receiving unit prior to the transfer.

6.0 Mode of Transfer

Road ambulances should be first choice of transfer used within the Network (for journeys of up to 3 hours) and may be used for longer transfers of stable patients.

Air ambulances may be considered for long distance transfer of stable patients. There are specific issues relating to the transfer of patients by air which should be considered on a case by case basis. The decision should be taken by the referring consultant in close liaison with the ambulance service.

Arrangements for transfer to and from the aircraft at either end of the flight should be carefully considered e.g. distance, need for ambulance, need for extra crew to lift in and out of aircraft

Consideration should be given to any relative contraindications to flying the patient e.g. intra-cranial air or raised intracranial pressure.

7.0 Preparation for Transfer

The consultant responsible and the transfer team should all be satisfied that the patient is in the optimal condition possible prior to movement.

For information on categorisation of urgency, refer to the relevant Critical Care Ambulance Request Procedures

The person making the request to the ambulance service must be involved in the care of the patient, has clinical credibility and be able to answer questions about the patient and their needs.

7.1 The ICS recommends Pre-Transfer Checklists

Key points are listed below but please see Appendix 1 for full checklists

Checklist 1 Is the patient stable for transfer?

- Airway
- Ventilation
- Circulation
- Neurology
- Trauma
- Metabolic
- Monitoring

Checklist 2 Are you ready for departure?

- Patient
- Staff
- Equipment
- Organisation
- Departure

The decision to go is made when the two checklists are complete.

8.0 Communication with Ambulance Trust

8.1 Hospital Guidance on South Central Ambulance Service (SCAS) Protocol for Emergency Inter-Hospital Transfer

Refer to SCAS guidance on time-critical and other transfers, including details of appropriate telephone numbers.

<https://www.scas.nhs.uk/our-services/>

8.2 Hospital Guidance on South Western Ambulance NHS Foundation Trust (SWASFT) Protocol for Emergency Inter-Hospital Transfer Decision

Full details for SWASFT Procedures for booking an Inter-hospital transfer can be found at the following link:

http://www.swast.nhs.uk/Downloads/SWASFT%20downloads/swasft_bookinginterhospital.pdf

9.0 Handing over Care of the Patient and Documentation

The responsibility for the patient does not pass to the receiving team until the patient has arrived at the receiving unit and been handed over.

The decision to transfer should be recorded in the patient's notes, documentation should include the name of the clinician making the decision, their grade and contact details, and reasons for the transfer and the date and time at which the decision was made, and a copy of the risk assessment.

10.0 Documentation

Clear documentation is always essential to record the patient's condition before, during and after the transfer. This should include:

- Transfer letter/Discharge Summary
- Copies of patient notes (electronic where available)
- X-rays, Laboratory results
- Blood products
- Patient ID Bracelet
- Completion of TV&WODN Inter Hospital Transfer Form

Routine information on the transfer and identification of any adverse events will be fed back to the TV&WODN.

11.0 Procedures after Transfer for non-clinical reasons

Any non-clinical transfer is a critical incident, and should be reported as such, both within the referring trust, and onward to the network, via the transfer link. Non-clinical transfers between units in the same trust are equally reportable as those between trusts.

After transfer of a patient for capacity reasons the referring unit should contact the receiving unit daily to check on the progress of the patient and inform on possible bed availability for repatriation.

Patients who have been transferred for non-clinical reasons should be repatriated as soon as they are sufficiently stable and a bed becomes available unless the receiving hospital is not under particular pressure and chooses to continue to look after the patient. Repatriation should take precedence over elective surgery which may need to be cancelled.

A patient who has been transferred once for non-clinical reasons should only be transferred again to allow repatriation.

12.0 Secondary Transfers from DGH to Specialty Units

There may be occasions where a clinically indicated secondary transfer is required from Emergency or Critical Care departments. The transfer requirements remain the same, but the referral pathway may differ.

An example of this is for secondary trauma transfers where the relevant local secondary trauma transfer tool provides details of the pathways for transfers including relevant contact details, clinical indications for secondary transfers and important factors to note when making these decisions.

Another example is the guidance produced by neurosurgical units for referring urgent and emergency neurosurgical patients.

All decisions to transfer will be made at Consultant level.

13.0 Other Key Points

- On the job training opportunities should be made available by each Trust. It is the responsibility of each unit to release staff for training and ensure that the appropriate competencies are completed. Training should be aligned with STaR and ICS principles
- If relatives request to accompany the patient, this must be agreed with the transferring team and the ambulance crew.

- Critical incident reporting should follow individual Trust procedures; in addition, the Network transfer link for the Trust should be informed in order that the incident is discussed at the appropriate Network forum.
- Data will be collected on standard Network Transfer forms for later collation and interpretation.
- There should be a form of debriefing following a transfer if required.
- All transfer incidents should be reported and investigated. Incidents should also be shared at Unit and Network level for joint learning.

14.0 Reference Documents

- Guidance On: The Transfer of The Critically Ill Adult, ICS, May 2019
- Comprehensive Critical Care, A Review of Adult Critical Care Services, Dept of Health, 2000
- Quality Critical Care: Beyond 'Comprehensive Critical Care', a report by the Critical Care Stakeholder Forum, 2005.
- Adult Life Support Group (2006) Safe Transfer and Retrieval (STaR) Manual – The Practical Approach
- Guidelines for the Provision of Intensive Care Services, 2nd Edition, ICS, June 2019.

15.0 Appendix Appendix 1

Pretransfer check list 1

Is your patient stable for transport?

Airway

- Airway safe or secured by intubation
- Tracheal tube position confirmed on chest X-ray

Ventilation

- Adequate spontaneous respiration **or** transport ventilator securely connected to portable oxygen supply and adequate ventilation confirmed
- Adequate gas exchange confirmed by arterial blood gas
- Sedated and paralysed as appropriate

Circulation

- Heart rate, BP optimised
- Tissue & organ perfusion adequate
- Any obvious blood loss controlled
- Circulating blood volume restored.
- Haemoglobin adequate
- Minimum of two routes of venous access
- Arterial line and central venous access if appropriate

Neurology

- Seizures controlled; metabolic causes excluded
- Raised intracranial pressure appropriately managed

Trauma

- Cervical spine protected
- Pneumothoraces drained
- Intra-thoracic & intra-abdominal bleeding controlled
- Intra-abdominal injuries adequately investigated and appropriately managed
- Long bone / pelvic fractures stabilised

Metabolic

- Blood glucose > 4 mmol/l
- Potassium < 6 mmol/l
- Ionised Calcium > 1 mmol/l
- Acid – base balance acceptable
- Temperature maintained

Monitoring

- ECG
- Blood pressure
- Oxygen saturation
- End tidal carbon dioxide
- Temperature

Pretransfer check list 2.

Are you ready for departure?

Patient

- Stable on transport trolley
- Appropriately monitored
- All infusions running and lines adequately secured and labelled
- Adequately sedated and paralysed
- Adequately secured to trolley
- Adequately wrapped to prevent heat loss

Staff

- Transfer Risk assessment completed
- Staff adequately trained and experienced
- Received appropriate handover
- Adequately clothed and insured

Equipment

- Appropriately equipped ambulance
- Appropriate equipment and drugs
- Pre-drawn up medication syringes appropriately labelled and capped.
- Batteries checked (spare batteries available)

- Sufficient oxygen supplies for anticipated journey.
- Portable phone charged and available
- Money for emergencies

Organisation

- Case notes, X-rays, results, blood collected
- Transfer documentation prepared
- Location of bed and receiving doctor known
- Receiving unit advised of departure time and estimated time of arrival
- Telephone numbers of referring and receiving units available
- Relatives informed and discussion documented
- Return travel arrangements in place
- Ambulance crew briefed
- Police escort arranged if appropriate

Departure

- Patient trolley secured
- Electrical equipment plugged into ambulance power supply where available
- Ventilator transferred to ambulance oxygen supply, adequate ventilation and oxygenation confirmed
- Test for secure connection of transfer ventilator to the ambulance oxygen supply
- All equipment safely mounted or stowed
- Staff seated and wearing seat belts

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