

INTERHOSPITAL & INTRAHOSPITAL PATIENT TRANSFER GUIDELINES

It is essential that a systematic approach is taken to the process of patient transfer; starting with the decision to transfer, through the pre-transfer stabilisation, and then the management of the transfer itself.

This will encompass all the stages including skilled evaluation, communication, documentation, monitoring and treatment, handover and return to base.

Decision to transfer

This must be made by a senior doctor, normally a consultant. Documentation of the decision should include name, grade and contact details of the doctor making the decision, and the time and date at which the decision was made. While arranging the destination for the patient, all communication must be documented, including the name, grade and contact details of those making the arrangements both at the referring and receiving centres, the date and time of calls made and details of any advice received.

The transfer must be done by either bleep **6111** or **7647** anaesthetist for general and trauma cases, bleep **6890** PICU anaesthetist for paediatric cases and bleep **6392** obstetric anaesthetist for obstetric cases.

The duty floor consultant anaesthetist **8011** or the consultant on call must be informed prior to transfer.

Stabilisation before transfer

A transfer should not be undertaken until the patient has been resuscitated and stabilised.

It may be necessary to secure the airway with an endotracheal tube with appropriate end tidal carbon dioxide monitoring.

Intravenous access must be in place and basic monitoring instituted (non invasive blood pressure, continuous ECG and pulse oximetry).

For critically ill patients, continuous invasive blood pressure monitoring should be considered; however, treatment should not be delayed while waiting for the transfer.

Temperature monitoring should be considered, especially in paediatric patients.

Accompanying the patient

A critically ill patient should be accompanied by a minimum of two attendants. The precise requirement for accompanying personnel will depend upon the clinical circumstances in each case, a decision to be made by the named consultant of the patient.

A patient's level of critical care needs is often used as a guide to transfer requirements:-

- Level 0: Patients, whose needs can be met through normal ward care, should not usually need to be accompanied by a doctor or nurse.
- Level 1: At risk of their condition deteriorating, or those recently relocated from higher levels of care require a nurse escort.
- Level 2: requiring more detailed observation or intervention including support for a single failing organ system or post operative care and those stepping down from higher levels of care must be escorted by a doctor and a nurse.
- Level 3: Patients requiring advanced respiratory support, or basic respiratory support with together with support of at least two organ systems. This level includes all complex patients requiring support for multi organ failure. These patients must be escorted by anaesthetists and skilled nurses.

All individuals involved in the transport of critically ill patients should be suitably competent, trained and experienced.

Emergency/Trauma ODP (operating department practitioner) can be contacted on bleep **6999**.

Monitoring , drugs and equipment

Patients with level 1, 2 or 3 critical care needs will require monitoring during the transfer. Monitoring needs to be established and secure before the transfer is commenced. This may require the insertion of central venous and arterial lines.

The personnel involved in the transfer should ensure that they have adequate supplies of the necessary drugs. These may include sedatives, analgesics, muscle relaxants and inotropes. Many of these drugs are best prepared beforehand in prefilled syringes. It is also essential to ensure an adequate supply of oxygen cylinders.

As much of the equipment as possible should be mounted at or below the level of the patient. This allows easy access and improves stability of the patient trolley. All equipment should be robust, durable and lightweight. Electrical equipment must be designed to function on battery when not plugged into the mains. Additional batteries should be carried in case of power failure. Portable monitors should have a clear illuminated display and be capable of displaying ECG, arterial oxygen saturation, non invasive blood pressure, two invasive pressures, capnography and temperature. Non invasive blood pressure may rapidly deplete battery power and is unreliable when there is external movement and vibration. Alarms should be visible as well as audible in view of the loud background noise levels.

Adult transfer packs containing airway equipment (ETT/LMA/guedel/facemasks), IV equipment (cannulae, giving sets, fluids) and emergency drugs can be found in:-

- Accident and Emergency resuscitation dept
- General intensive care
- Cardiothoracic intensive care
- Neurointensive care
- Paul Calvert theatre 1.

Paediatric transfer packs containing airway equipment, IV equipment and emergency drugs can be found in:-

- Paediatric intensive care
- Accident and emergency resuscitation dept
- Paul Calvert theatre 1.

Contents of the transfer packs are checked by the individual departments (accident and emergency, general, cardiothoracic and paediatric intensive care units). The trauma ODP (BLEEP **6999**) is responsible for checking the packs in Paul Calvert theatre 1.

Portable ventilators and monitors can be found in:-

- Accident and emergency resuscitation dept
- General intensive care
- Neurointensive care
- Cardiothoracic intensive care
- Paediatric intensive care
- St James theatre 3 (ventilator only)

Documentation and handover

Clear records should be maintained at all stages. This is a legal requirement, and should include details of the patient's condition, reason for transfer, names of referring and accepting consultants, clinical status prior to transfer and details of vital signs, clinical events and therapy given during transport. Inter/Intrahospital transfer sheets are found on the **General Intensive care unit**.

On arrival to the destination, there should be a formal handover between the transfer team and the receiving medical and nursing staff who will assume responsibility for the patient's care.

Handover should include a verbal and written account of the patient's history, vital signs, therapy and significant clinical events, as well as all relevant investigation results.

Special groups: Obstetric Patients

A **Situation- Background- Assessment-Recommendation (SBAR)** sticker must be used to facilitate the transfer/handover of care when antenatal/postnatal women are transferred both within and out of the hospital (SBAR stickers found on delivery suite).

1. All transfers to another hospital must be done via the labour ward co-ordinator (bleep **8149**). The consultant obstetrician and midwifery manager on call must also be informed. For further information please refer to: Transfer of the Obstetric patient, Chapter 13, Maternity Unit Guidelines, St George's Hospital.

Special groups: Paediatric patients

Parents of paediatric patients may request to be present throughout the transfer, permission would be at the discretion of the paediatric anaesthetist. There is an increased risk of hypothermia on transfer, so adequate warming must be undertaken.

References

2. Interhospital Transfer, AAGBI Safety Guideline, February 2009.
3. Guidelines for the Transport of the critically ill adult. 2002. London, The Intensive Care Society.
4. Transfer of the Obstetric patient, Chapter 13, Maternity Unit Guidelines, St George's Hospital
5. Critical Care in the Emergency Department: Patient Transfer. Dunn, Gwinnott et al, Emerg Med J. 2007 Jan; 24(1): 40-44
6. Guidelines and levels of Care for Paediatric Intensive Care Units. Crit Care Med 2004 Vol32, No. 10. Rosenberg and Moss.
7. Paediatric Advanced Life Support, Resuscitation Council (UK) 2010
8. Training and assessment of competency of trainees in the transfer of critically ill patients. Anaesthesia 2004; 59: 1248-9. Spencer et al.
9. Outcome of critically ill patients undergoing interhospital transfer. The Medical Journal of Australia 2001; 174: 122-5
10. Levels of critical care for adult patients. 2002 London, The Intensive Care Society

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