

**EAST OF ENGLAND**

**CRITICAL CARE OPERATIONAL DELIVERY NETWORK**

**ADULT CRITICAL CARE NETWORK**

**TRANSFER POLICY**

**For Bed availability**

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**Adult Critical Care Network**

**Transfer Policy**

**Documentation Control**

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# Summary:

This policy provides clear information regarding the decision-making process for the transfer of Adult Critical Care patients out of their current bed area to any other place whether in the same hospital or to any other.

The East of England Critical Care Operational Delivery Network transfer policy ensures patients are transferred in a safe and timely manner whilst addressing the associated balance between risk and benefit. Therefore patients will receive the best treatment using the appropriate Critical Care bed capacity across the East of England thus enabling the ability todeliver specialist services, as well as working with organisations to provide the best possible experience and outcome for patients.

**2. Scope**

**2.1** This policy applies to all the trusts within the East of England.

**2.2** This policy applies to the management of all adult critically ill patients who require transfer internally from one department to another within their current hospital or externally from one acute healthcare provider to another by road ambulance. These transfers are either from a critical care / emergency area to another similar area or from critical care / emergency area to standard hospital ward level (this may occur in a repatriation situation). They apply to both inter-hospital and intra-hospital transport since the same level of preparation, supervision and care is required for each.

**2.3** This policy applies to adult critically ill patients, which are defined as requiring a level of care greater than normally provided on a standard hospital ward.

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| --- | --- |
| Level 0 | Patients whose needs can be met through normal ward care in an acute hospital |
| Level 1 | Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team |
| Level 2 | Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care or those ‘stepping down’ from Level 3 care |
| Level 3 | Patients requiring advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure |

(Intensive Care Society 2009, Guidelines for the Provision of Intensive Care Services 2019)

For more detailed information about levels of care please refer to the Intensive Care Society levels of Critical Care for adult patients *(ICS, 2009)*.

**2.4** Patients requiring transfer can be classified under the following broad

areas:

* Intra-hospital transfer
* Inter-hospital Clinical transfer consisting of:
  + Transfer to tertiary centres for a higher level of time-critical specialist care.
  + Transfers to tertiary centres for non-emergency specialist care not available in local hospital.
  + Repatriations ***–*** returning a patient to a tertiary centre nearer to their home for onward care. ***(Please see* East of England Adult Critical Care Repatriation Policy. *EOECCODN/2)***
* Inter-hospital Non-clinical transfer

**2.5** This document should be used in conjunction with the Faculty of Intensive Care Medicine and the Intensive Care Society’s ‘Guidance on: The transfer of the critically ill adult *(3rd edition 2019)*

**3. Policy Aim**

This policy aims to assist East of England organisations and individuals in the decision-making process with regard to the transfer of critical care patients from one care area to another in a safe and effective way for on-going medical treatment. The policy should be used in conjunction with the East of England Adult Critical Care Network Transfer procedure, which outlines a clear and concise description of how to facilitate these transfers with the minimum of risk.

**4. Definitions**

Intra-hospital transfer – Patient is transferred to another hospital

department within the same hospital for relocation to a more appropriate

area (e.g. Accident and Emergency to Critical Care), or for procedural or

diagnostic purposes (e.g. Critical Care to CT scanner)

Clinical Inter-hospital transfer – Patient is transferred to another hospital when the patient needs specialist care not available locally. This can be broken down further depending on the urgency of the transfer. These will be either immediate or urgent and comes with applicable timescales. Please refer to the the EoE Transfer Procedure for clarification.

Non-clinical Inter-hospital transfer – Patient is transferred to another hospital when demand exceeds local critical care capacity. This is classed as a critical incident and the necessary organisational paperwork should be raised such as Datix incident report.

Repatriation – Refers to a patient returning to their local hospital either due to speciality care completed or returning to their local hospital to complete in-patient care, either critical care or to ward level. This will also include non-urgent clinical transfers.

Local Hospital – The local hospital is determined by the address of the

General Practitioner at which the patient is registered.

East of England – This includes the counties of Norfolk, Suffolk,

Cambridgeshire, Essex, Hertfordshire and Bedfordshire.

**5. Network Arrangements**

**5.1** The East of England Critical Care Operational Delivery Network (ODN) transfer arrangements and issues are discussed and actions monitored at a transfer forum, which meets a number of times each year. The Chair of this group is the ODN nominated lead for transfers across the region.

**5.2** Critical care networks should liaise with local NHS Ambulance Provider Trusts to ensure the availability of suitable ambulances for critical care transfer and compatibility of mounting systems and transfer trolleys

**5.3** Standardised equipment lists and standardised transfer bags offer practical and safety advantages and should be considered by all networks / trusts.

**5.4** Please refer to the network repatriation policy when patients are stepping down from specialist care; repatriation should occur within 48 hours of being identified as suitable for repariation.

**5.5** The ODN standardised documentation and process must be used for inter-hospital transfer. The transferring unit has the responsibility to scan and email a copy of the transfer form to [mandy.baker6@nhs.net](mailto:mandy.baker6@nhs.net) at earliest opportunity. Further transfer forms can be obtained from mandy.baker6@nhs.net

* **5.6** All hospitals must have local intra-hospital transfer documentation. The ODN can provide examples of appropriate documentation, which units may adapt, and implement locally. This should include a core data set for audit purposes.

**6. Operational Arrangements**

**6.1 Hospital Arrangements**

**6.1.1** Each Trust should have a nominated lead Consultant for transfer of the

critically ill with responsibility for guidelines, training and equipment

provision and escalation of issues through the Trust Critical Care Delivery Group, governance meetings and ODN transfer forum.

**6.1.2** In the case of non-clinical transfers, the national Directory of Services(DOS) should be used to identify the nearest available critical care bed [**www.directoryofservices.nhs.uk**](http://www.directoryofservices.nhs.uk)

**6.1.3** All acute hospitals must have systems and resources in place to resuscitate, stabilise and transport critically ill patients when required. Plans should encompass all areas where critically ill patients may require transfer.

**6.1.4** Trusts should ensure that there is a training programme for those

expected to perform transfer duties or arrange for staff to have access

to a course delivered by another provider. Training should

encompass theory and the practical aspects of transfers (including simulation if possible) and include a range of competencies appropriate to their role should be completed. Staff should be competent in the use of monitoring & equipment required during a transfer. Opportunities should be available for staff to gain experience in a supernumerary capacity. Staff without the appropriate training and competence should not undertake unsupervised transfers.

**6.1.5**  Pre-departure check lists should be used to help to ensure that all

necessary preparations have been completed. The Transfer Procedure Document provides more detail and examples.

**6.1.6** All patients requiring transfer with a tracheostomy MUST have a

complete tracheostomy safety box and spare inner cannulas; enough to manage any patient who may have an alternative tracheostomy tube type than is stocked by the receiving hospital. Spares are to be left with the receiving hospital if required.

**6.1.7** Blood required en-route or on arrival should be ordered early, carried correctly and destination documented fully to enable traceability. (See EoE Transfer Procedure)

**6.1.8** Equipment must be serviced, maintained and checked prior to use in such a way as to reduce the risks of failure during transfer.

**6.2 Decision Making – For Inter-hospital transfers**

**6.2.1** The decision to transfer a patient between hospitals is potentially hazardous and must be made at consultant level.

**6.2.2** The decision to transfer and to accept a patient must be made by appropriate consultants in both the referring and receiving hospitals.

**6.2.3** The referring hospital Critical Care consultant contacts the receiving hospital to accept the patient. All referrals should aim to be consultant to consultant where possible. In exceptional cases or where there are clear patient pathways, then a representative may act on behalf of the consultant.

**6.2.4** Transfer for immediate lifesaving interventions must not be delayed by lack of availability of a critical care bed.

**6.2.5**  It is normally expected that the referring critical care consultant would have personally assessed the patient prior to arranging transfer. Document in the clinical notes that the patient is to be transferred to which hospital and that the receiving hospital has accepted the transfer.

The accepting critical care unit will notify the appropriate ward based team**.**

**6.2.6** Clinical transfers for non-emergency specialist interventions such as renal or non-emergency neurological conditions, should not be delayed more than necessary. Specialist units should admit patients in order of clinical need, then order of referral and not by geographical area. Patient outcomes deteriorate with long waiting times, it delays rehabilitation and gives a poor patient experience. Patient outcomes may be affected in a similar way when specialist units are unable to repatriate their patients in a timely manner.

**6.2.7** Occasionally, an emergency department consultant, physician or surgeon may make the referral. This may be necessary when time-critical specialised interventions are required from a tertiary centre but the assistance of senior help from critical care should be sought as soon as possible and for management of the transfer. Unnecessary delays in transfer can adversely affect outcomes for patients.

**6.2.8** All transfers will be made to the nearest suitable unit.

**6.2.9** Ambulance transportation will be organised by the transferring hospital, providing the necessary escort arrangements, together with all necessary documentation.

**6.2.10** The Directory of Services (DOS) should be maintained.

**For Non-Clinical Transfers**

**6.2.11** The decision to transfer should be undertaken after all alternatives

have been explored.

**6.2.12** It may not always be appropriate for the referring hospital to transfer

their new patient, e.g. due to clinical instability. The patient for

transfer should be stable with acceptable physiological parameters

prior to commencing the journey. The referring consultant has the

responsibility as to which patient is to be transferred.

**6.2.13** Non-clinical transfers must not occur because critical care capacity is reduced through the delayed discharge of Level 1 patients in the Critical Care Unit to wards. Trusts must monitor such delays and make all efforts to eliminate them. Transfers for capacity reasons should occur only as a last resort.

**6.2.14** The critical care consultant will decide which patient to transfer. This

must be discussed with the receiving critical care unit consultant. Any

contentious issues will be discussed retrospectively in the East of

England Critical Care Transfer Forum Group, and learning shared within

the network.

**6.2.15** If a critical care transfer is required for non-clinical reasons, the capacity management system (CMS) should be utilised to ascertain local bed availability within the network or wider areas. Critical Care consultant to Critical Care consultant discussions must be held. Empty beds should not be protected for internal use if no admissions booked.

**6.2.16** The patient should be transferred to the nearest possible hospital, within the network if possible.

**6.2.17** Non-clinical transfers should be recorded as a critical incident.

**7 RISK ASSESSMENTS / MINIMISING RISK**

**7.1 STAFF TO ACCOMPANY PATIENT**

**7.1.1** All level 3, critically ill patients should normally be accompanied by two suitably trained, experienced and professionally competent attendants during transfer, one of which should be a medical practitioner from an anaesthetic or critical care background. Both attendants should be appropriately trained and up to date in the management of critically ill patients during transfer and in the use of the necessary equipment as in 6.1.4. In such cases, it should not be necessary to request a paramedic staffed ambulance to facilitate the transfer. Variations from this may occur for less dependent patients. A risk assessment needs to be completed to support decision-making, see an example of a risk assessment in *Appendix 1.*

**7.1.2** The Critical Care consultant arranging the transfer, in partnership with the senior nurse shift co-ordinator, should determine the seniority of the escorting staff. The decision will be based on the risk assessment in 6.1.1 along with any other related risk factors such as potential for requiring additional intervention during the transfer, duration and mode of transfer.

**7.1.3** Ideally the escorting staff should have been directly involved with the care of the patient and be able to provide the required handover of patient and clinical information.

**7.1.4** Reliance on the Ambulance service to provide the transfer capable clinical staff is not acceptable. It is the transferring Consultants responsibility to ensure adequate continuity of care to the patient with suitably trained staff to manage the patient condition and the medical equipment being sent alongside the patient. For level 0 & 1 patient transfers, it may be appropriate to not have to send a transfer team along with the patient. An Ambulance crew may be acceptable providers of this care and should be decided at a senior clinical level.

**7.1.5** It is the responsibility of the transferring department to ensure the means of return of their staff and equipment, which does not rely on the ambulance crew providing this.

**7.2 THE PATIENT**

**7.2.1** The Consultant responsible for Critical Care must assess the level of anticipated risk for each individual transfer. A risk assessment should be completed to determine the suitability of the patient for transfer taking into consideration current condition, nature of any underlying illness, co-morbidities, level of dependency, risk of deterioration during transfer together with risks related to movement/transfer.

**7.2.2** Transfers will take place once the patient’s condition is considered as stable as possible within a given situation and the benefits outweighing the risks of the transfer. Where this refers to non-clinical transfers, the safety of all the patients within a given area of care must be considered.

**Please now follow the East of England Adult Critical Care Network Transfer procedure document for detail on how to prepare and perform an intra and inter hospital transfer of any Emergency Critical Care patient.**

***APPENDIX 1***

East of England Critical Care ODN

**Risk assessment prior to transfer**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Low Risk** | **Medium Risk** | **High Risk** |
| * Nurse or clinical practitioner with appropriate competencies | * Critical Care Nurse, accompanied by Doctor if potential to deteriorate in transit, may need escalation of care. * Paramedic support for intubation may be deemed appropriate if risk at lower end of scale | * Anaesthetist with Critical Care Competency and advanced airway competencies * Nurse with appropriate critical care skills |
| **NEWS2 1 - 4** | **NEWS2 5 - 6** | **NEWS2 7 or more \*** |
| **Airway**  **Breathing**  **Circulation**  **Disability**  **Exposure**  **Add Other Considerations** | Maintaining airway  Adequate blood gases for patient – FiO2 <0.4  Stable no inotropic or vasoactive support  GCS 14+  Normothermic | Maintaining airway  Blood gases for patient – FiO2 >0.4 and <0.6  Stable, low dose inotropes or vasopressor support < 0.2mg/kg/min  GCS 9-13 consider elective intubation  Mild Hypo / Hyperthermia | Intubated  Ventilated - FiO2 ≥0.6 / Base deficit worse than -8 mmol/l  CVS instability, significant inotrope / vasoactive support > 0.2mg/kg/min  GCS <8 or sedated  Moderate Hypo / Hyperthermia  Major Trauma Eg. Multiple injuries, unstable C spine, chest injuries, significant head injuries, abdominal or pelvic injury |
| **NEWS2 Score:** (tick level of risk) | □ | □ | □ |
| Print name: Sign: Designation: Grade: Bleep/contact no: Date: / / Time: | | | |

* A high risk score may also be achieved by scoring 3 in one parameter as it refers to extreme variation in a single physiological parameter.

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| --- |
| **Additional Comments:** |

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| --- |
| **Please note:**   * Largely subjective decision * This chart is for guidance * Not exclusive, if there are other factors not highlighted in this risk assessment, please add them in as a consideration in the risk assessment process |