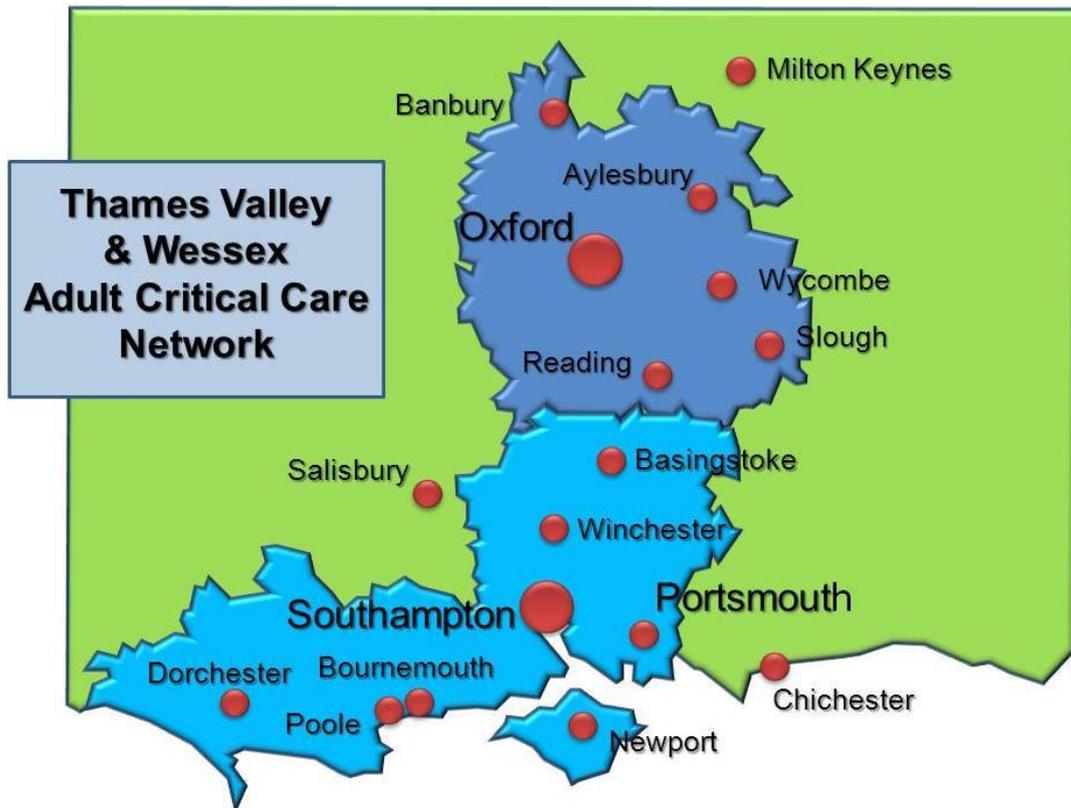


# Thames Valley and Wessex Adult Critical Care Network Transfer Policy



Version	FINAL
Name of responsible (ratifying) committee	Thames Valley & Wessex ODN Oversight Committee
Date Ratified	June 2016
Document Manager(s) (job title)	Carolyn Barrett, TVCCN Transfer Group Chair Chris Beresford, Former TVCCN Transfer Group Deputy Chair Mary Meeks, WCCN Transfer Group Chair Neil Johnson, WCCN Transfer Group Deputy Chair Gill Leaver, Network Lead Nurse Judy Dyos, Former Wessex Lead Nurse Jennie Russell, Former WCCN Transfer Group Chair
Date Issued	June 2016
Review date	June 2018
Electronic Location	<a href="http://networks.nhs.uk/nhs-networks/thames-valley-wessex-adult-critical-care-network/">http://networks.nhs.uk/nhs-networks/thames-valley-wessex-adult-critical-care-network/</a>
Related Prodedural or National Documents	ICS 2011 (3rd edition) Guidelines for the Transport of the Critically ill adult <a href="http://www.ics.ac.uk/">http://www.ics.ac.uk/</a> National Adult Critical Care Specification 2015

## Contents

<b>Section</b>	<b>Title</b>	<b>ICS Section No:</b>	<b>Page</b>
1.0	Purpose		3
2.0	Organisation within Trusts	6	3
3.0	Indications for transfer	10	3
4.0	Resources to Transfer Patients	8/9	5
5.0	Communication		6
6.0	Mode of Transfer	12/16	7
7.0	Preparation for Transfer	13	7
8.0	Communication with Ambulance Trust		8
9.0	Handing over care of the Patient	17	9
10.0	Documentation	18	9
11.0	Procedures after Transport for Non-Clinical Reasons		9
12.0	Secondary Transfers		10
13.0	Other Key Points		10
14.0	Reference Documents		10
	<b>Appendix</b>	<b>ICS Page No:</b>	
1	SCAS Time Critical Inter-Hospital Transfers Flow Chart		11
2	SWASFT Booking and Inter-Hospital Transfer Procedure		13
3	ICS Competencies	Pages 36-38	17
4	ICS Supplementary equipment for use during transport	Page 39	19
5	ICU Transfer checklist	Page 41	20

## **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 Networks 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 3<sup>rd</sup> Edition 2011 by the Intensive Care Society and reinforced on other documents. The Thames Valley & Wessex Critical Care Networks 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 medical and nursing staff 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 inter-hospital 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 rest of Network

## **3.0 Indications for transfer (ICS section 3, page 20)**

### 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.

Patients not intubated may be the responsibility of a physician or surgeon and ICU may not be able to take responsibility i.e. primary PCI or leaking AAA. This needs to be discussed at a local level.

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 by the use of 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 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 co-morbidity 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.

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.

## 4.0 Resources to Transfer Patient

### 4.1 Equipment (*ICS section 2, page 17*)

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.

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 (ICS section 3, pages 21-22)

The Critical Care Services of 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 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** (ICS section 3, pages 20-21)

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** (ICS section 3, pages 22-23)

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 someone who is 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 has 2 Pre Transfer Checklists

Key points are listed below but please see Appendix 5 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.

The full detailed checklist can be found in Appendix 5

## **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.

1. It is essential that the request for a 'time-critical' emergency inter-hospital transfer is only made for clinically appropriate cases as SCAS will dispatch the next available double manned ambulance (DMA) to effect the transfer ahead of all other emergencies in the community needing an emergency ambulance response, including cardio-respiratory arrest.
2. All decisions for Inter-hospital transfer should be confirmed with the Consultant responsible for the patient's care. The list of diagnoses and circumstances is not exhaustive and is provided to serve as a guide.
3. All requests to ambulance control (EOC) for time critical inter-hospital transfers must be made by someone able to give appropriate clinical information and answer clinical questions asked by SCAS. This should usually be the senior on-site medical clinician responsible for the patient's care.
4. All requests must be made via the dedicated phone line on the attached flow chart (not 999) as these calls will then be identified as time critical transfers to the EOC staff.
5. If there is a need to transfer the patient on a dedicated transfer trolley (e.g. Ferno Trolley for inter-ICU transfers), this must be clearly stated at the time of the transfer request.
6. Requests for 'time critical' inter-hospital transfers cannot be pre-booked – they should be requested at the time needed.
7. It is the responsibility of the referring Acute Trust to ensure that the patient is accompanied by appropriate healthcare professional(s) (HCPs) who are able to undertake any treatment that may be required during the journey; SCAS is unable to guarantee a paramedic crew for such transfers.
8. The patient and the accompanying HCPs must be ready for transfer when SCAS arrive. Where the transfer is delayed more than 15 minutes the SCAS crew may be stood down and the transfer will need to be re-booked. SCAS crews will also be stood down for any inappropriate non-time critical transfer.
9. There is no guarantee that accompanying HCPs will be returned to their base hospital in the event of another emergency call being received by the Ambulance Service. Repatriation may need to be made by taxi.
10. Requests for inter-hospital time critical transfers will be audited by SCAS and feedback provided to the acute trusts and commissioners, particularly where there is discrepancy between the information provided when the request is made and the clinical condition as documented on the SCAS clinical report form.
11. Requests for non-emergency transfer should be made as per locally agreed arrangements with the Hospital's patient transport provider.
12. The final decision about any transfer will rest with the SCAS EOC/Clinical Directorate.

## **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](http://www.swast.nhs.uk/Downloads/SWASFT%20downloads/swasft_bookinginterhospital.pdf)

Details can be seen in Appendix 2.

It is essential that the request via 999 for a 'time-critical' emergency inter-hospital transfer is only made for clinically appropriate cases.

It should be noted that SWASFT do not undertake non clinical transfers due to bed states, as this is not part of their contracted activity, and as such will not be able to resource such transfers.

### **9.0 Handing over Care of the Patient and Documentation (ICS section 3, page 26)**

**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.

### **10.0 Documentation (ICS section 3, page 26)**

Clear documentation is essential at all times 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 South Central Critical Care Networks Inter Hospital Transfer Form

Routine information on the transfer and identification of any adverse events will be fed back to the Thames Valley & Wessex Adult Critical Care Network.

### **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 on a daily basis 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 transfers will be subject to audit

## **14.0 Reference Documents**

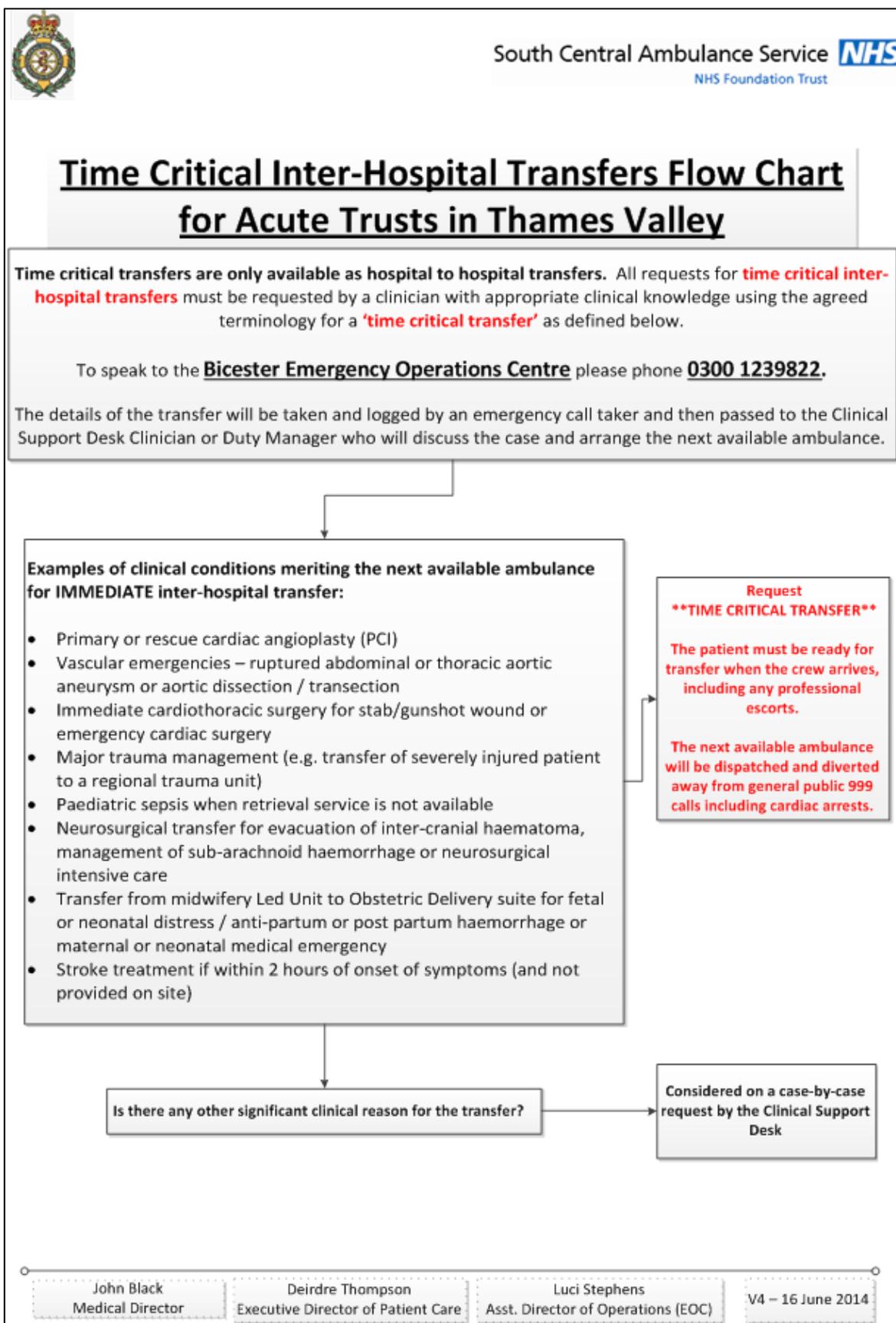
Guidelines of the Transport of the Critically Ill Adult, Intensive Care Society, Standards and Guidelines, 2011, 3<sup>rd</sup> Edition.

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***

# Appendix 1: SCAS Time Critical Inter-Hospital Transfers Flow Chart





## Time Critical Inter-Hospital Transfers Flow Chart for Acute Trusts in Hampshire

**Time critical transfers are only available as hospital to hospital transfers.** All requests for **time critical inter-hospital transfers** must be requested by a clinician with appropriate clinical knowledge using the agreed terminology for a **'time critical transfer'** as defined below.

To speak to the **Otterbourne Emergency Operations Centre** please phone **0300 1239806**.

The details of the transfer will be taken and logged by an emergency call taker and then passed to the Clinical Support Desk Clinician or Duty Manager who will discuss the case and arrange the next available ambulance.

### Examples of clinical conditions meriting the next available ambulance for IMMEDIATE inter-hospital transfer:

- Primary or rescue cardiac angioplasty (PCI)
- Vascular emergencies – ruptured abdominal or thoracic aortic aneurysm or aortic dissection / transection
- Immediate cardiothoracic surgery for stab/gunshot wound or emergency cardiac surgery
- Major trauma management (e.g. transfer of severely injured patient to a regional trauma unit)
- Paediatric sepsis when retrieval service is not available
- Neurosurgical transfer for evacuation of inter-cranial haematoma, management of sub-arachnoid haemorrhage or neurosurgical intensive care
- Transfer from midwifery Led Unit to Obstetric Delivery suite for fetal or neonatal distress / anti-partum or post partum haemorrhage or maternal or neonatal medical emergency
- Stroke treatment if within 2 hours of onset of symptoms (and not provided on site)

### Request **\*\*TIME CRITICAL TRANSFER\*\***

The patient must be ready for transfer when the crew arrives, including any professional escorts.

The next available ambulance will be dispatched and diverted away from general public 999 calls, including cardiac arrests.

Is there any other significant clinical reason for the transfer?

Considered on a case-by-case request by the Clinical Support Desk

John Black  
Medical Director

Deirdre Thompson  
Executive Director of Patient Care

Luci Stephens  
Asst. Director of Operations (EOC)

V4 – 16 June 2014



## Booking an Inter-hospital Transfer

In addition to providing an emergency ambulance response to over 3,000 incidents a day across the South West, the Trust provides an inter-hospital transfer service. The number of transfers requested by each Acute Trust varies significantly from just 250 to 1,500 per annum. With over 6,000 inter-hospital transfers being requested every year, it is vital that health care professionals work with us to ensure that patients in the community, as well as those in hospital, receive the most clinically appropriate response.

### Step 1 - Determine if the transfer requires an NHS or private ambulance response

South Western Ambulance Service NHS Foundation Trust is contracted to provide the following types of inter-hospital transfers:

Type	Acceptance Criteria
Emergency transfer to a higher level of care	Transfers where all of the following criteria are met: <ul style="list-style-type: none"> <li>■ Patient is being transferred to a higher level of care;</li> <li>■ Patient is being transferred for an intervention/treatment that requires their arrival within the next 4 hours;</li> <li>■ Clinical observations or interventions are required en-route.</li> </ul>
Transfer from a Trauma Unit to a Major Trauma Centre	Patients who are being transferred from a Trauma Unit (TU) to a Major Trauma Centre (MTC).
Mental health	Transfers where any of the following criteria are met: <ul style="list-style-type: none"> <li>■ Transport to the nearest clinically appropriate mental health facility or agreed place of safety for patients "sectioned" under the Mental Health Act (this covers section 135 &amp; 136).</li> <li>■ Transport to the nearest clinically appropriate mental health facility or an agreed place of safety for "voluntary sectioned" patients where a double crewed ambulance or patient support vehicle is required and the patient must arrive within the next 4 hours. This includes transfers from Emergency Departments;</li> <li>■ Mental Health Patients being conveyed urgently to an acute hospital for immediate treatment (within 4 hours) where a double crewed ambulance or pathway support vehicle is required.</li> </ul>
Palliative care	Transfers where all of the following criteria are met: <ul style="list-style-type: none"> <li>■ Requires urgent (within 4 hours) transfer to or from a hospice.</li> <li>■ Clinical condition necessitates the use of an emergency ambulance with Paramedic crew.</li> <li>■ Journey is for NHS funded treatment or care commissioned by an NHS organisation.</li> </ul>

Patients who require a Paramedic crew but do not fulfil all of the emergency transfer criteria, should be transported by a private ambulance service. This service can normally be booked by discussing the case with your site manager - follow local procedures. Patients who do not require a Paramedic or Technician level crew should be booked with the local private Patient Transport Service (PTS) provider according to local procedures.





## Step 2 - Decide how urgently you require a response

Use the table below to decide on the response that is clinically most appropriate:

Category	Response	Telephone Number
<b>Time critical</b>	Immediate Paramedic assistance required, which cannot be provided by hospital clinicians e.g. cardiac arrest at hospital without ED/Cardiac Arrest team.  Time critical transfer where an ambulance arriving on blue lights within 30 minutes would not clinically be fast enough. Patient must be ready to travel within 8 minutes of the call.	999
<b>Immediate</b>	Immediate transfer where an ambulance arriving within 1 hour would not clinically be fast enough. Patient must be ready to travel within 30 minutes of the call.	
<b>Urgent</b>	Urgent transfer requiring a response within 1, 2 or 4 hours.	<b>Dorset</b> 0845 757 3302  <b>Cornwall, Devon and Somerset</b> 0845 602 0455  <b>Avon, Gloucester and Wiltshire</b> 0845 1206342

Last year, hospitals requested over 1,500 blue light 8 minute ambulance responses. It is important to consider that when a hospital requests such an immediate response, it may result in an ambulance driving past an acutely unwell patient in the community. In an Acute Trust with an Emergency Department and Resuscitation Team, the clinical need for a Paramedic to arrive within 8 minutes should arise only in exceptional circumstances.

If a time critical (8 min) or immediate (30 min) transfer has been requested, but the patient will not be ready travel promptly on arrival of the ambulance, you may be asked to call 999 again when the patient is ready to travel. The ambulance service will not put staff or the public at an unnecessary risk by responding with blue lights and sirens to patients who are not ready to travel.





### Step 3 - Dial the appropriate number

Dialling the appropriate number helps us to prioritise calls to patients in a time critical condition.

#### **PLEASE ONLY CALL 999 IN A CLINICAL EMERGENCY.**

It is important that wherever possible, the telephone call is made by a health care professional, as the triage process requires a range of clinical information. In exceptional cases where this is not possible, it is vital that the non-clinician making the call is aware of the clinical information that will be required.

### Step 4 - Provide the patient's details

Your call will be answered by an Emergency Medical Advisor in our Clinical Hub (Control Centre), who will ask a number of questions to help determine the most appropriate response for the patient. Every day we have to co-ordinate the most appropriate response to over 3,000 calls; we depend on the information you provide to ensure that we prioritise each case correctly.

Please ensure that the healthcare professional making the call is able to discuss the following:

- The answers to steps 1 and 2;
- Current patient location;
- Receiving hospital and department;
- Whether a Paramedic is specifically required;
- Details of any escort that will be provided;
- Patient's current condition, including if they are sedated or anaesthetised;
- If a helicopter transfer is being requested, the weight of the patient + escort + equipment is also required

It is also important that you clearly state if the patient:

- Is potentially infectious, including diarrhoea and vomiting;
- Has a DNAR or Advanced Decision to Refuse Treatment (Living Will);
- Is a compulsory admission under the Mental Health Act;
- Is over 28 stone/177kg (bariatric stretcher required)
- Is connected to a medical device which must be transported with them e.g. syringe driver;

All inter-hospital transfer requests are reviewed by the Clinical Hub Duty Manager, to ensure that the service sends an appropriate level of response. If further information is required, or it appears that the call may not fall within the emergency ambulance contract,





you may receive a call from the Senior Clinical Advisor. The Senior Clinical Advisor is a senior Paramedic (ranging from the equivalent level of Matron to Deputy Director of Nursing), who will provide the final decision on any request.

## Step 5 - Final preparations for the transfer

### Mental health

In the case of patients who are under a mental health Section, the mental health professional responsible for the patient must travel with the patient, or with agreement of the ambulance crew, follow behind with the appropriate paperwork.

### Medical devices

With the exception of patient controlled analgesia and end of life infusion pumps, Paramedics are not able to transfer patients with a syringe driver or infusion pump running. The driver must either be disconnected (if clinically appropriate), or an escort who is competent in the use of the device must accompany the patient.

All ambulances provide a minimum of two standard 230v power sockets, which may be used to power equipment. All critical medical devices provided for the transfer must also have fully charged battery back up, in case of a power failure.

### Escorts

If an escort is being provided it is important that the individual is:

- Confident and competent to undertake the transfer including the use of all medical devices and equipment required;
- Has sufficient experience in undertaking transfers;
- Fulfils any applicable professional or employing organisation's requirements;
- Appropriately dressed including good footwear and a high visibility jacket.

The Trust is not responsible for arranging the return of any escorts provided for the transfer. Where possible we will facilitate the escort to travel back in the ambulance, but cannot commit to returning them directly to the original hospital. Once the ambulance has left the receiving hospitals it will potential be required to attend further emergency calls, which may delay the escorts return.



### Appendix 3 ICS Competencies

5a. Core competencies required of all staff ( levels required appropriate to role)	
Knowledge	of Local / Network / National transport guidelines Understands the principles of safe transfer of patients Knowledge of ambulance / transfer environment and associated health and safety issues and relevant legislation Knowledge of Advanced Life Support guidelines
Skills	Use of oxygen, respiratory therapies and portable ventilator Use of basic monitoring (ECG, NIBP, Pulse oximetry) Use of transport equipment, Competent to carry out advanced life support
Attitudes and Behaviour	Evidence of good team working Evidence that plans for and prevents problems during transfer Understands the benefit of pre-transfer check lists and uses these in clinical practice. Understands the need for good communication with referring & receiving institutions & teams and evidence of this in practice. Completes all required documentation including clinical notes / observations charts / audit forms. Seeks support from senior / more experience colleagues appropriately

5b. Additional competencies which may be required by medical staff to undertake level 2 / 3 transfer, depending on the clinical condition of the patient and the outcome of pre transfer risk assessment. Note: not all competencies will be required in every case. In many cases the parent team should have the competencies required.	
Knowledge	Knowledge of physiology of critical illness Knowledge of pharmacology of drugs including sedatives / muscle relaxants / inotropes and vasopressors Knowledge of the physiological effects of the transfer process and acceleration / deceleration forces in the critically ill
Skills	Use of a structured approach for assessment of critically ill patient prior to transfer Ability to interpret blood gases, and other clinically relevant investigations. Ability to identify potential needs of patient prior to and during transfer. Ability to respond to changes in the patient' s condition during transfer including ability to undertake the following procedures if required <ul style="list-style-type: none"> <li>• Basic / advanced respiratory support</li> <li>• Bag mask ventilation</li> <li>• Intubation</li> <li>• Emergency needle decompression / chest drainage</li> <li>• Resuscitation / optimisation of haemodynamic status including appropriate use of fluids / inotropes / vasopressors</li> <li>• Management of dysrhythmias including cardiac arrest.</li> <li>• Ability to care for arterial lines / central lines and other indwelling catheters and to use / access appropriately.</li> </ul>
Attitudes and Behaviour	Ability to assume leadership role during transfer Ability to provides clear and precise structured handover to receiving unit

5c. Additional competencies required for second attendant accompanying level 2/ 3 patient	
Knowledge	<p>Knowledge of the physiology of critical illness</p> <p>Knowledge of the administration of drugs likely to be required during transfer (includes sedatives / muscle relaxants / inotropes and vasopressors)</p> <p>Knowledge of the potential problems associated with movement acceleration / deceleration forces</p>
Skills	<p>Ability to carry out appropriate nursing observations and nursing care in the transport environment.</p> <p>Ability to assist with:</p> <ul style="list-style-type: none"> <li>• Airway support - including intubation</li> <li>• Respiratory support - including <ul style="list-style-type: none"> <li>o oxygen therapy devices</li> <li>o basic ventilator operation</li> </ul> </li> <li>• cardiovascular resuscitation</li> <li>• Fluid management including the preparation of infusions</li> <li>• The use of sedative drugs, and the use of syringe pumps</li> </ul>
Attitudes and Behaviour	Ability to provide clear and precise structured handover to receiving unit

## **Appendix 4**

### **ICS Supplementary equipment for use during transport**

#### **Airway**

- Guedel airways (assorted sizes)
- Laryngeal masks (assorted sizes)
- Tracheal tubes (assorted sizes)
- Laryngoscopes (spare bulbs and battery)
- Intubating stylet / Bougie
- Lubricating gel
- Magill's forceps
- Tape for securing tracheal tube
- Sterile scissors
- Stethoscope

#### **Ventilation**

- Self inflating bag & mask with oxygen reservoir and tubing
- Spare Bodock seals (for oxygen cylinders)
- Chest drain (Seldinger type)
- Heimlich flutter valve
- Airway filters / HME.

#### **Suction**

- Yankauer sucker
- Suction catheters (or closed tracheal suction system)
- Nasogastric tubes (assorted sizes) & drainage bag.

#### **Circulation**

- Syringes (assorted sizes)
- Needles (assorted sizes)
- Alcohol & Chlorhexidine skin prep.
- IV cannulae (assorted sizes)
- Arterial cannulae
- Central venous cannulae
- Intravenous fluids
- Infusion sets / extensions
- 3 way taps
- Dressings
- Tape
- Minor instrument / cut down set

## **Appendix 5**

### **Pre transfer checklist 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 ventilation established on transport ventilator
- 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

## **ICS Pre transfer 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
- 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
- All equipment safely mounted or stowed
- Staff seated and wearing seat belts

**Version Control:**

<b>Version</b>	<b>Date</b>	<b>Details</b>	<b>Author(s)</b>	<b>Comments</b>
1	23.07.2015	Draft	KP/NJ/MM/CBa/CBe	Final Draft after consultation with Transfer groups & Ambulance Providers
2	18.05.2016	Draft	KP	Updated Issue and Review date
3	26.05.2016	Draft	GL	Change to author details & minor grammatical amends.
Final	09.06.2016	Final		
<b>Review Date:</b>				