TRUST POLICY AND PROCEDURES FOR PATIENT TRANSFER

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	1	2000-2004	Discharge Leads	Original Policies
	2	Sept 2008	S. Marbrow	Initial review
	2.1	October 2008	S. Marbrow	Amendments following MAC.
	2.2	Oct-Nov 2008	S. Marbrow	Amendments following review
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	2.6	Dec 2009	S. Marbrow	Further amendment
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	2.8	April 2011	S Marbrow	Amendments following changing practice in NICU arrangements and review of IR1's
	2.9	Jan 2012	S Marbrow	Minor amendments
	2.10	October 2014	Lee Doyle	Review and minor amendments
	2.11	June 2017	Jenny Sidle	Amendments following consultation
Intended Recipients: All Trust Staff				

Training and Dissemination: All transferring personnel must have the appropriate knowledge, skills and competence to support the patient's individual physical and psychological needs throughout the transfer period and have undergone an appropriate level of transfer training as directed by their professional role and transfer responsibilities. Dissemination via the Trust Intranet
To be read in conjunction with: Standard Operating Procedure for the Discharge of Adult Patients, Standard Operating Procedure for Outliers, Standard Operating Procedure for the Discharge Lounge, Trust Policy and Procedures for Maintaining the Privacy and Dignity of Patients including Children and Young People, Risk Strategy**,** Trust Policy and Procedures for Resuscitation, DHTFT Infection Prevention and Control Policies, Trust Medicines Code, Transport Booking Guidelines, Trust Patients Property Policy and Safeguarding Policies, Trust Escalation Policy and Full Capacity Plan. Trent Neonatal Network Transport Policy. Admission, Discharge and Transfer Policy for Community Hospitals (DCHS 2011) DTHFT Maternal Transfer- antenatal, intrapartum, postnatal
References Guidelines for the transport of the critically ill adult, Intensive Care Society 3rd Ed 2011. Acutely ill patients in hospital: Recognition and response to acute illness in adults in hospital. CG50 NICE, July 2007. National Dementia Audit 2013, RCN Commitment to Care: Dementia 2013
In consultation with and Date: Director of Patient Experience and Chief Nurse Divisional Nurse Directors**,** Medical Advisory Committee, Joint Professionals Advisory Group, Patient Safety Group, Discharge Leads Steering Group, Infection Control Committee. Quality Review Committee.
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Contact for Review	Lead Nurse – Operations
Executive Lead Signature	Medical Director
Approving Executive Signature	Director of Patient Experience and Chief Nurse

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1 INTRODUCTION

Evidence suggests that the transfer of patients either within, or outside the hospital environment can pose risks to safety which may adversely influence their morbidity and mortality (ICS.3rd edition 2011).

This policy has been developed in response to the potential risks associated with patient transfer and will consider both intra and inter hospital transfers, including transfer:

- from Intensive Care irrespective of whether the transfer is an emergency or elective requirement
- of pregnant, or postpartum women in the community needing to be moved to an acute hospital
- of Pre-term, Neonates, Children and Young People
- of patients with transmissible illnesses
- of patients from the Emergency Department and or Medical/Surgical Admissions Units and wards irrespective of age

It is essential that patient transfers are well coordinated and that they occur in a timely manner so that capacity within the Trust is appropriately managed.
In addition, effective transfer must:

- Ensure all patients, and their property including cash and valuables, are accounted for i.e. their location within the patient journey is known at all times
- Ensure patients receive appropriate care in an appropriate environment in a timely manner and that beds are accessed within an acceptable and appropriate timeframe within the appropriate Division.
- Prevent the avoidable cancellation of elective surgery
- Prevent any avoidable delays of patients requiring emergency admission to Intensive Care.
- Prevent any avoidable delays of patients requiring step down from Intensive Care or HDU beds
- Prevent any avoidable delays of patient transfers from the Emergency Department and or Medical/Surgical Assessment Units.
- Prevent any avoidable delay in transferring patients who develop clinical complications following admission.
- Reduce the number of patients transferred to general wards overnight
- Prevent the avoidable non clinical transfer of critically ill patients
- Utilise the Mid Trent Critical Care Network to act as an effective ICU resource and reduce the number of non-clinical transfers.
- Utilise the Trent Perinatal and Central Newborn Network where appropriate to ensure NICU transfers are appropriate.
- Prevent/minimize the likelihood of cross infection.

This policy presents the evidence based principles required to achieve safe and effective transfer of patients. However, it is beyond the scope of the policy to dictate detailed guidance for the wide range of transfer circumstances seen within individual specialties.

Whilst it is not expected that the described processes are used for every patient movement for example to and from Theatres, fit women going to the Delivery Suite or transfer to the Imaging

and Therapy Departments, the principles described within this policy are good practice and must be borne in mind with any patient leaving the ward to attend/move for such purposes. Staff must communicate any concerns about transferring any patient to/from these departments and provide an escort where indicated.

Patients requiring diagnostic tests e.g. imaging must be transferred to the Imaging Department using the mode of transport jointly agreed with the Imaging Department. This will ensure that the best possible imaging results are obtained and that these are made available in a timely manner to the practitioner who has made the request. Staff must note that imaging undertaken at ward level is less reliable that imaging undertaken in the Imaging Department.

Once the mode of transport has been jointly agreed no staff member should make changes without prior consultation with the Imaging Department.

Once in the department and where practicable and appropriate the escort should remain with the patient. This will greatly reduce patient anxieties and ensure that safe loading principles are addressed safely and that any patient needs can be actioned in a timely manner by staff with the appropriate competencies.

The practitioner completing the imaging request form must ensure the transport section is completed accurately.

Similarly, care should be exercised when determining how an in-patient will transfer to an Outpatient Department. Liaison with the relevant Clinic will avoid sending patients on their beds which, should not be accommodated in clinic spaces.

This policy does not replace the existing Standard Operating Procedure for the Discharge of Adult Patients where patients are being discharged to the care of a general practitioner or, in case of Maternity patients transferred to the care of a community Midwife.

Nothing must prevent good communication between practitioners.

The policy is supported by a number of appendices in support of safe transfers

The fundamental principle for any transfer is "Do no harm"

2 PURPOSE AND OUTCOMES

This policy describes the process for managing the risks associated with the transfer of patients and includes:

- A description of the transfer requirements, which are specific to each client group.
- Guidance on patients not suitable for transfer- see Box 1 (5.1) on page 11
- The standard documentation to be used to support the handover of patient information
- The electronic handover processes to be used for intra hospital transfers
- The documentation to be used for all inter hospital critical care transfers
- The process and exceptions for transfer out of hours.
- Guidance on infection control measures
- The process for escalation and transfer of patients out of ICU and medical HDU beds
- The determination of the absolute need for transfer following an informed and individual clinical assessment.

- The need for effective assessment of the patients' physiological and psychological

needs prior to transfer by the most appropriate health care professional(s) responsible for their care.

- Adequate and optimal preparation of the patient prior to transfer.
- Assurance that transfer is timely and that the patient is escorted by an appropriate health care professional(s) or, a member of the Facilities Team with the knowledge, skills and clinical competence required to support the patient's individual physiological and psychological needs and,
- Recognition that all staff have joint responsibility in decision making about transfers.

3 DEFINITIONS USED

Transfer	The movement of a patient from their base ward/ department to another area/department either within or outside of the Trust
Transfer Team	An individual(s) responsible for the clinical care during the transfer period. They may or may not be assisted by portering staff.
Inter-hospital Transfer	The transfer of a patient externally between different hospital trusts or units.
Intra-hospital Transfer	The transfer of a patient internally within the hospital site I.e. transfer of patients from the Emergency Department who require admission, transfer of patients from one area to another or patients transferring from higher level care to other wards within the Trust.
Critical Care Transfer	The elective or emergency transfer of an adult, child or young person either internally or externally to the Trust into a higher level of care facility for either specialised care or when local critical care beds capacity has been reached.
Level 0 transfer	Patients whose care needs can be met through normal ward care in an acute hospital
Level 1 transfer	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 transfer	Patients who require more detailed observations including support for a single organ system or post-operative care and those "stepping down" from higher levels of care.
Level 3 transfer	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 multiple organ failure
Non Clinical Transfer	The transfer of an adult, child or young person that occurs for non-clinical reasons e.g. as a result of bed capacity issues, where patients are transferred due to the lack of beds within the current location.

In-utero	An infant who is unborn. (Transfer of the pregnant mother may have implications for the safety and health of the mother and baby.)
Ex-utero	An infant who is born. (Any infant requiring intensive or special care will require initial resuscitation and stabilisation prior to transfer.)
Premature infant	An infant born less than 37 weeks of completed gestation
Seasonal Plan	A plan agreed by the local health community to manage patients and beds during periods when the service is under pressure.
Trust Escalation Policy	Document that identifies actions and arrangements to be taken to effectively manage bed capacity to accommodate emergency admissions.
Full Capacity Plan	A plan to share risk across the Trust when there is a surge in non-elective demand.
Registered Practitioner	All staff who have professional registration.
Patient Flow Team	A group of staff responsible for the co-ordination of beds and patient movement throughout the Trust.

4 KEY RESPONSIBILITIES / DUTIES

4.1 Director of Patient Experience and Chief Nurse

Accountable to the Trust Board for ensuring compliance with this policy.

4.2 Lead Nurse- Operations

Responsible for the development, co-ordination, distribution and review of the policy.

4.3 Medical Team

Responsible for ensuring risk assessments are completed, making direct doctor-to-doctor referrals, and for ensuring patients are regularly reviewed throughout their stay irrespective of whether the patient is on a base ward, or outlied / cohorted to another area of the Trust. This includes the need to review resuscitation status.

4.4 Managers/Clinical Leads/ Matrons/ Midwives/Senior Sisters/ Therapy Leads/ Facilities Manager

Accountable and responsible for ensuring their own practice complies with the policy and for ensuring the policy is implemented and complied with within their areas of responsibility.

Responsible for ensuring non-compliance with the policy is raised by completion of IR1s and remedial action is taken to improve compliance, reporting through to the Divisional Clinical Governance Group via their representatives.

4.5 Patient Flow Team

Have responsibility throughout the Trust for the management and co-ordination of beds and

patient flow. This includes discussions where patients need to be repatriated to the Trust and supporting the step down of patients from critical care and HDU beds.

4.6 Individual employees

Have responsibility for ensuring:-

- The patient's safety, privacy and dignity are maintained during transfer.
- If a nurse escort is required, this is identified when booking portering, and is made available to support the transfer.
- Portering staff must raise the question of whether an escort is required on arrival at the transferring ward/department, and report any discrepancies to line management immediately.
- All staff are responsible for ensuring that their own practice complies with this policy and for encouraging others to do so.
- An alert organism tag (available on ICM and Lorenzo) is checked when the patient is admitted/transferred.
- Isolation precautions in place are checked prior to transfer.
- Where an infection control risk is identified the receiving healthcare facility and/ or Infection Control Team is informed of the patient's infection status prior to transfer / discharge.
- The Infection Control Team / Patient Flow Team are contacted if there is difficulty allocating a side room when patients need transferring for infection control reasons.
- The patient transfer handover process uses the ISBAR principles (Individual/Situation/Background/Assessment/Recommend) and the e-ISBAR transfer form is completed by the sending ward/department prior to patient transfer.
- Patients transferring to DCHS beds are accompanied by a copy of the drug card and medical record and a verbal handover is provided to the receiving hospital prior to transfer.
- Any concerns regarding the transfer of any patient are reported through the hospital Datix system.
- The Patient Flow Team is kept informed of patients needing repatriation to the Trust from other health care Trusts.
- Any property including cash and valuables is transferred with the patient. This may mean liaison with the Cashiers office.

4.7 Infection Prevention and Control Team

- Will advise on the infection control precautions required.
- Will liaise with the receiving infection prevention control team where applicable.

4.8 Transfer Lead

A senior healthcare professional responsible for the co-ordination and communication of the transfer and for ensuring that appropriate documentation is completed and sent with the patient liaising with the Patient Flow Team where appropriate.

4.9 Discharge and Integrated Care Team

Will support ward teams in patient assessment re suitability of transferring to a different care

setting or commencing or increasing an existing package of care.

4.10 Discharge Leads Steering Group

This forum will monitor compliance with the policy, highlighting good practice and identifying and monitoring remedial actions against non-compliance.

5 MANAGING THE RISKS ASSOCIATED WITH THE TRANSFER OF ALL PATIENTS

5.1 Principles of Safe Transfer for Adult Patients

These principles **MUST** be adhered to for all adult patient transfers:

- The decision to transfer a patient must be made as early as practicable during the day.
- An individual assessment must inform the decision for patient transfer prior to the transfer taking place. The health care professional responsible for the patients care at the time must ensure that the transfer is required and that the benefits of transfer outweigh the associated risks.
- The assessment must take cognisance of any advanced care planning and/or preferences the patient has made and that the patient's ongoing care is delivered in line with the End of Life Care Strategy.
- The assessment must include determination of whether an escort is required.
- Patients identified for transfer must have an expected date of discharge. Attempts should be made not to transfer patients who have high levels of social care needs which have not be addressed and, who consequently do not have a discharge plan.

As a general guide the following patients are not suitable for transfer from:

Box 1.

Division	Description of patients
Any area	**CAUTION should be exercised during "out of hours" times (7pm-8am) for patients who have dementia, confusion or delirium. Moving people with dementia between wards and units in the hospital can be very distressing and, if the move is needed, every effort should be made to ensure this is carried out during the day to avoid further distress and confusion. Carers and relatives must be kept informed** **CAUTION: Do not transfer after night sedation has been administered unless clinical status determines transfer need and this has been agreed with the patient's consultant** **Consider treatments in progress and the appropriateness of moving the patient. Patients should not transfer within 30 minutes of commencing a blood transfusion.**
Medicine/DME	Patients with major cardiac implications, chest pain, self-poisoning or patients undergoing dialysis. Caution should be exercised during "out of hours" times for those patients who are high risk of falling,

Surgery	Patients currently undergoing pain control management. Major vascular or bowel surgery and patients within 3 days of abdominal postoperative major surgery.
Cancer	Patients undergoing chemotherapy, or receiving active symptom control management. Those patients receiving care via the End of Life Pathway and have identified their preferred place of death.
Specialist Services	Rape victims and / or late abortions

- Effective communication is crucial and must occur between referring and receiving personnel to ensure that the transfer is appropriate and safe.
- All essential therapeutic interventions/monitoring must be continued throughout the transfer period and extreme care must be taken to prevent disruption.
- All heath related records and the relevant Transfer documentation must be completed and available throughout the transfer period. Only Trust approved documentation should be used.
- All patients being transferred must have a documented plan of care.
- All patient intra-hospital transfers must be recorded on the electronic e-whiteboards which will update Lorenzo (PAS system)
- Where, the care of a patient is moving from one Consultant to another this must be changed on Lorenzo (PAS system).
- Where patients are transferring to another hospital and the records are accompanying the patient, this must be recorded on the Lorenzo (PAS System). This does not apply to patients attending Imaging, going to Theatre and their return, or Therapeutic Departments for diagnostic or treatment sessions.
- It is essential that clear, comprehensive information regarding the transfer is communicated to the patient and their family/carers at the earliest opportunity.
- A verbal handover must occur on all transfer occasions with particular reference to any critical health issues/changes and any on-going diagnostics that need to be addressed. An e- ISBAR handover sheet supports this process and is to be completed by the sending ward on the electronic whiteboard (Appendix 1 SOP).
- The Patient Flow Team will monitor all patients requiring step down from intensive care /HDU beds as directed by the patient's clinical team and facilitate timely patient transfer to prevent any mixed sex breaches (Appendix 2 Process for Escalation and SSA breaches).
- Staff within Intensive Care must follow the critical care full capacity plan which details actions to be taken when intensive care capacity has been reached (Appendix 3).
- Patients transferring with a NEWs score of 5 or above for two consecutive hours should have a documented clinical management plan which has been discussed with the parent team prior to transfer..
- Staff within the Medical Assessment Unit and Emergency Department will follow their local protocol for the allocation of patients and the time category classification to be used.
- There is a ward 'buddy' system for medical patients outlied into other wards /Divisions to ensure that senior specialty reviews occur daily for all patients. The effectiveness of this plan will be monitored through the Operations Centre.
- At times of increased activity patients will be outlied into the identified 'Buddy wards' as part of the agreed Seasonal Plan.
- At times of extreme activity patients may be transferred to another ward location to release bed capacity. Non clinical transfers outside the seasonal plan must be agreed at Executive level.
- Medical and Nursing staff must pro-actively identify and prioritise suitable patients to be outlied should the need arise. This must be documented in the Health Record and reviewed prior to any transfer taking place.
- The Patient Flow Team will provide a daily list of all patients outlying onto other wards.

- Every effort must be made to include patients in the decision to transfer.
- Practitioners must refer to the National Early Warning System to assist in the determination of suitability for transfer of adult patients.
- Unless clinical circumstances dictate, all patients must be adequately stabilised prior to the transfer taking place and where this is not achievable a further clinical assessment must be made as to appropriateness and need for transfer.
- Where possible, transferring patients during protected mealtimes will be avoided.
- Nursing/Midwifery staff must raise any concerns regarding patient transfer to the Patient Flow Team. Such concerns must be documented at the earliest opportunity in the patient's health record and an Incident Report Form completed.
- Multiple moves/transfers of the same patient during increased escalation times must be avoided unless determined by the patient's clinical condition and agreed with the patient's consultant.
- Any level 2 or 3 patients being transferred externally to another health facility for further or ongoing care (inter hospital transfers) must be recorded using the Mid Trent Critical Care Network Transfer Form. Similarly, Neonates and babies transferred within the Trent Perinatal and Newborn Network should adhere to communication standards set by the network.
- The senior health care professional responsible for the patients care will act as Transfer Lead and therefore co-ordinate the transfer arrangements once the decision to transfer has been made. For Neonates and small babies this will be via the Centre Transport Team.
- A discharge//transfer MDT, to include mental health staff, should be arranged for patients with complex physical care needs prior to transferring to a mental health facility.

5.2 Transferring Patients Out of Hours

Transfers must be avoided wherever possible between 22.00 hours and 07.00 hours. The exceptions would be where a patient is moving to a specialty bed from an assessment area, is acutely ill requiring transfer to a higher level of care facility or where women within Maternity Services are moved to manage labour and or complications of labour. (See Division specific Guidelines – IP/06:04/Hb5) In addition, it is recognised that the Emergency Department is a 24 hour facility and that patients who have attended the Emergency Department and who require admission, will need to move into inpatient beds at any time. As such, there is no expectation that the Emergency Department or assessment units will complete IR1's when transferring the patients throughout the 24 hour period.

Patient transfers to DCHS /LRCH beds should arrive at their transfer destination no later than 2200hours.

For patients transferring to private nursing home beds transfers should take place as early as possible as some providers will decline transfer after 1800hours.

5.3 Managing Infection Control

On admission/transfer all patients' medical notes must be checked, additionally ICM/ Lorenzo should be checked for any patient alert organism tags. Liaison with the Infection Prevention and Control Team must be undertaken prior to transfer where the transfer involves patients with transmissible illnesses. The allocation of single rooms to patients with suspected / confirmed infections must be a priority and take precedence over bed management / capacity issues.

Patients must not be transferred to wards where Infection control restrictions are in place unless it has been sanctioned by the Infection Prevention and Control Team. Out of hours

advice can be obtained from the Consultant Microbiologist.

Whenever possible patients must not be transferred to other wards unless they require specialist care that can only be provided on that particular ward, or they are moving to another ward because isolation facilities are available. If the transfer is not medically urgent, consideration should be given to postponing the transfer until they are deemed to be non-infectious.

The appropriate personal protective equipment must be available to support a safe transfer.
Visits to other departments must be kept to a minimum. If the patient needs an investigation (i.e. endoscopic procedure, x-ray, CT scan) or has an appointment within outpatients, the Medical Team must decide whether the investigation / appointment is clinically urgent or if it can be safely postponed. If the investigation / appointment is necessary, it is the responsibility of the nurse looking after the patient to ensure that the receiving department is aware of the patient's infection status in order that they can ensure that the appropriate precautions are in place.

5.4 Escorting Personnel

Part of the assessment of suitability for transfer, whether internally or externally, is the decision about the need for an escort. "Levels of Care" a categorisation applicable to an adult patient being transferred is shown in the definitions and should be decided by the Transfer Lead.

For transfers within the hospital where an escort is required it must be provided/ organised as determined by the base ward/department. Guidance on the requirement for and selection of an appropriate escort is shown in Appendix 4.

Staff are reminded of their duty of care for patients waiting for hospital transport. Patients should not be left in an unattended area during this time.

Patients transferring from Intensive Care to a ward must wherever possible be retrieved by a trained member of staff from the receiving ward. However, in exceptional circumstances, it may be undertaken by Intensive Care staff to prevent avoidable delay.

It is crucial that transfer personnel possess the skills, experience and competence to provide safe and effective care to each individual patient outside of their base ward/department and that the patient receives care equal to that they would receive should transfer not have taken place.

For patient transfers that require escorting personnel, basic airway equipment as an absolute minimum must accompany the transfer.

Portering staff have a specific role in the transferring of patients - they provide the means of moving the patient from one area to another. This enables the Trust to maximise nursing resources and provide nurse escorts based on clinical need.

The porters role does not extend to dealing with patient observations or re-establishing any therapeutic treatment in progress e.g. Oxygen therapy. Receiving staff are responsible for disconnecting the cylinder piping, re-establishing the oxygen therapy and ensuring levels are set at the prescribed volume once the patient has reached their destination.

If an incident occurs during the transfer of a patient help should be summoned immediately. For example if:-

- **A cardiac or respiratory arrest** occurs summon help via the nearest telephone and return to the patient and commence CPR.
- **The patient becomes aggressive** do not attempt to restrain the patient, retreat to a safe place and summon security staff

5.5 Training

All transferring personnel must have the appropriate knowledge, skills and competence to support the patient's individual physical and psychological needs throughout the transfer period and have undergone an appropriate level of transfer training as directed by their professional role and transfer responsibilities. In addition all transferring personal must have a sound knowledge of infection control.

All senior registered practitioners must be encouraged by their Divisions to attend an AIM/ALERT course and be assessed as competent.

The Patient Flow Team will coordinate the importance of timely transfers to appropriate beds. Patients transferred to an inappropriate bed as assessed against clinical need, will be monitored through Datix incident reporting.

All bank and locum staff must have a structured local induction which must include being informed of local policies/procedures/protocols specifically about patient safety including movement and handling needs to ensure patient safety.

All critically ill patients requiring emergency transfer from a ward to Intensive Care must be accompanied as a minimum, by either an Intensive Care Nurse, a member of the Critical Care Outreach Team or a Night Nurse Practitioner (Hospital Out of Hours Team) and, depending on the patient's physiological status, may also require the support of an appropriately trained doctor.. The ward nurse should provide a handover prior to this or accompany the patient.

5.6 Preparation for Transfer

All patients must undergo a clinical assessment prior to transfer to ascertain their suitability.

All senior registered practitioners must be able to identify whether a patient is potentially too ill to transfer and use the NEWS to guide this judgment. Where any clinical staff are concerned that the patient is too ill to transfer, contact with the patient's Consultant and/or their team must be made immediately. Any concerns must be clearly documented in the patient's record with concerns escalated to line management.

Consideration must also be given to risks associated with any infection control issues or

infection control measures in place on the proposed receiving ward.

Consideration must also be given to current treatments in progress in determining the suitability of patients for transfer. In particular, where patients are undergoing blood transfusion it is recommended that such patients do not transfer within 30 minutes of a blood transfusion commencing. See Box 1 page 11 for clinical suitability for transfer.

All patients must be informed of the transfer and the reason why. Similarly, relatives/carers/person with parental responsibility must be informed of the transfer preferably before the transfer takes place.

Where transfers are from Intensive Care, staff must work within the timeframes and level of urgency directed by the Critical Care Full Capacity Plan (Appendix 2) and Dignity Policy. This will be overseen and monitored by the Patient Flow Team.

Once the appropriate mode of transport and the transfer time frame has been determined, the Transfer Lead must ensure effective communication and collaboration between the transferring department and those responsible for providing the mode of transport/transport vehicle. (Ambulance Control, Porters etc.) Where inter hospital transfers are required full negotiation with the appropriate Ambulance Service must ensue.

Care must be taken prior to transfer to secure invasive cannula, drains, catheters etc. to prevent displacement.

Privacy and dignity must be maintained throughout the transfer period. Care must be taken by transferring personnel to ensure that the patient is appropriately clothed prior to the transfer taking place. Existing Patient's Property procedures must be adhered to and all property, including the patient's medicines, should accompany the patient.

Where health care professionals are undertaking inter-hospital ambulance transfers, high visibility clothing must be worn. This must comply with BS EN 47:1994 High Visibility Warning Clothing and consist of a clean yellow long sleeved jacket with retro reflective material bands surrounding the circumference. Any health care professional failing to comply will not be insured against accidental injury outside of the ambulance. High visibility clothing is stored in Intensive Care.

The importance of good communication between transferring staff and receiving staff cannot be under-estimated in terms of minimizing risk. This refers to both verbal communication and the need to ensure all documentation relating to the patient transfers is legible and contemporaneous and, is filed in the patient's healthcare record

Where any member of staff has a concern about the safety of the transfer and or their role within the transfer, they must report this to their line manager/supervisor immediately. Completion of an IRI must be considered where any member of staff is expected to function outside of their role and responsibilities.

5.7 Transfer Equipment

All equipment/monitoring required to support the safe and effective transfer of the individual patient must be decided by the Transfer Team prior to transfer taking place. It must have been checked beforehand to ensure it is fully functional and that battery requirements will support the transfer time period. The Transfer Team are also responsible for checking or delegating the checking and decontamination of all transfer equipment on return. For level 2 & 3 transfers the transfer trolley agreed by the Mid Trent Critical Care Network should be utilised to avoid loose equipment being placed on the patient. In general, to avoid injury to the patient no loose

equipment should be transferred on the bed frame. Wherever possible, the equipment should be secured to the bed frame.

Where oxygen is required an assessment, by a registered health professional, must take place as to the predicted amount required and spare oxygen cylinders must accompany the transfer where it is deemed necessary.

The need for any 'special' transfer equipment that is required is usually accessed from those providing the transfer vehicle and this must be communicated prior to them arriving on the ward/department.

All transfer equipment must also be appropriately packaged and secured safely to facilitate safe and effective transfer. It should be easily observed by transfer personnel and secured effectively to prevent accidental displacement which may result in injury to the patient or members of the Transfer Team.

Protective clothing (gloves, aprons) are not required for generally transporting patients to other wards/departments. Staff carrying out any transfer must be given clear instructions, e.g. that the wheelchair or trolley used for the transfer must be cleaned and disinfected after use.

For patient transfers that require escorting personnel, basic airway equipment as an absolute minimum must accompany the transfer.

Therapeutic treatments in progress for example intravenous infusions, oxygen therapy must not be discontinued. It is the responsibility of a Registered Practitioner to assess the person's need and take appropriate action to ensure the regime continues during transfer. Portering staff must not discontinue or re- commence therapeutic treatments.

5.8 Patient Medication

Medicines must be transferred in accordance with the Trust Policy and Procedures for Medicines

Where patients are transferring to a new ward or another hospital, the transferring practitioner must check the medicines for appropriateness and completeness.

Where indicated, all patient specific medications must accompany the patient. Practitioners must remember that some medicines may be required to be stored in fridges and or in controlled drug cupboards normally.

The receiving ward must check and confirm that all necessary prescription items have been transferred and are then stored and recorded appropriately.

Registered staff are responsible for reconciling medicines on transfer and accountable for ensuring this reconciliation is completed in accordance with the Trust Medicine Code.

A green bag can be used to transport medication

- Emergency drug boxes are available in each ward area
- Drugs pertaining to individual patients can be transported as necessary
- The Registered Nurse/Midwife in the Transfer Team is responsible for the medications during the transfer
- Controlled medication must be in a secured bag, held by the nurse/midwife within the

Transfer Team and documented in accordance with the Controlled Drug Policy and Procedures when used during the transfer.

- Prescriptions must be available for all medications/fluids administered during the transfer in order that a transparent audit trail is available.

5.9 Documentation to support Patient Transfer

Accurate documentation will be recorded pre and post transfer, and where appropriate during the transfer for specialised care, and must be recorded using the appropriate transfer form.

The e-ISBAR Transfer form should be completed on the e-whiteboard by the sending ward. This will be filed in the e-patient record once the patient has been received and accepted.

Additionally the Mid Trent Critical Care Network Transfer Form (adults) or the communication sheets from CenTre Transport Service (neonates) should be completed where indicated.

The exceptions to the above, will be where patients are attending theatres where pre theatre checking mechanisms are in place and where patients are temporarily transferred to diagnostic or therapeutic departments or the Labour Ward. However, robust and timely communications with such departments are still required to ensure a safe transfer and on-going clinical treatments are maintained.

5.10 Documentation to Accompany Level 0 and 1 Intra Hospital Transfers

Staff must use the e-ISBAR as described in this policy

It is essential that the receiving ward/department have contemporaneous information about the patient and their condition. Therefore, all relevant and available documentation must also accompany the patient when they are transferred. The accompanying health records must include diagnostic results and nursing records.

All relevant documentation must accompany the patient and be packaged and secured effectively to prevent accidental misplacement.

5.11 Documentation to Accompany Inter Hospital Transfer Level 2 and 3 (adults)

For all level 2 and 3 patients undergoing inter-hospital transfers to another hospital the Mid Trent Critical Care Network Transfer Form must be completed and remain with the patient during transfer and act as an accurate clinical record of the Transfer period. A copy must be filed in the Patients Health Record. This form is available from either the Emergency Department or Intensive Care.

All relevant and available information must accompany the patient and be packaged and secured effectively to prevent accidental misplacement.

5.12 The Process for Managing the Risks Associated with the Transfer of Neonates, Babies, Children and Young People within or outside the hospital

Ideally all neonates, babies, children and young people will be cared for at the Children's Hospital or in the Neonatal Intensive Care Unit in the Maternity Unit within the Trust.

However, some children or young people may require specialised care which is not available within the Children's Hospital or the Maternity Unit

The main principle in transferring is to promote the safe and effective transfer of the neonate, child or young person, all referrals/decisions to transfer must be led by a Paediatric Consultant or Senior Clinician.

Neonates

Refer to the Network Transport Stabilisation guideline https://derby.koha-ptfs.co.uk/cgi-bin/koha/opac-detail.pl?biblionumber=817&query_desc=kw%2Cwrdl%3A%20transfer%20neonates

This guideline standardises procedures in preparing babies for transfer. It details the responsibilities of neonatal units and transport teams at the time of transfer, with the aim of promoting seamless transfer of care between units. The tasks that need attending-to in preparing a baby for transport are detailed. Some tasks are the responsibility of the referring team, others the responsibility of the transport team and these are highlighted as such. Other tasks may need to be done, but may be performed by either the referring or transport team.

For all other Paediatric transfers including intra hospital neonate transfers:

Please refer to the Full Paediatric Guideline https://derby.koha-ptfs.co.uk/cgi-bin/koha/opac-detail.pl?biblionumber=1994&query_desc=kw%2Cwrdl%3A%20transfer

5.13 Transport Arrangements

A Registered Practitioner must determine the mode of transport required for the transfer and any escort requirements (Appendix 4)

Where Ambulance Transport is required, it must be arranged as per current Transport Booking Guidelines.

Where a child or young person is attending a diagnostic procedure they may walk to the relevant department at the discretion of the nurse in charge.

Occasionally the parents (or person with parental responsibility) may use their own transport for the transfer. The decision and rationale must be recorded in both the health and nursing record.

Where applicable, the person's property should accompany them.

5.14 Post Transfer- <u>all patients</u>

All patients must be welcomed to the ward/department within 15 minutes of arrival

Following transfer all patients must be seen and appropriate observations taken by a registered nurse/midwife immediately or, at the latest, within 30 minutes of arrival. This includes checking and noting the resuscitation status of the patient by physically checking whether or not there is a completed DNAR form located at the front of the Health Record.

The receiving staff should ensure that the Patients Property Policy and Procedures have been adhered to and instigate necessary action where there are discrepancies.

Where key information is missing from the e-ISBAR transfer form an assessment of the patient must be undertaken immediately in order to minimise any risk to patient safety.

Whilst patients may have transferred with bed rails in situ, an assessment must be undertaken within 15 minutes of the patient's arrival on the receiving ward/department to determine whether their ongoing use is required.

Any concerns identified by receiving staff concerning the transfer must be raised with the referring practitioner immediately. Where concerns are related to the safety and appropriateness of the transfer this must be documented using the IR1 form. In addition, any clinical problems that are encountered in the transfer must be escalated to the patient's Consultant immediately.

Any concerns raised by the patient must be addressed immediately by a registered nurse/midwife.

All staff on the receiving ward must be advised of patient transfers at the next available "hand over"

E Whiteboard—
TRANSFER– "e-SBAR!"

Using the "Transfer!" **referral icon and completing the attached transfer information form** will help timely and accurate communication with the receiving ward to support safe and effective care

RED icon:

Who is responsible for initiating the icon (red border) ?

The transfer icon with a red border will be automatically switched on when the patient is admitted to MAU

What should it be used for and when?

To indicate to the nurse caring for the patient that the transfer form needs to be completed

AMBER icon:

Who is responsible for changing the icon to amber?

A member of the MAU nursing team to indicate the transfer form has been fully completed.

What should it be used for and when?

To indicate that the transfer form has been completed and the receiving ward will need to be contacted

GREEN icon:

Who is responsible for changing the icon to green?

The MAU team when the receiving ward has been notified that the transfer information is available to read and the patient transfer is imminent

What should it be used for and when?

To indicate that the patient is ready to transfer

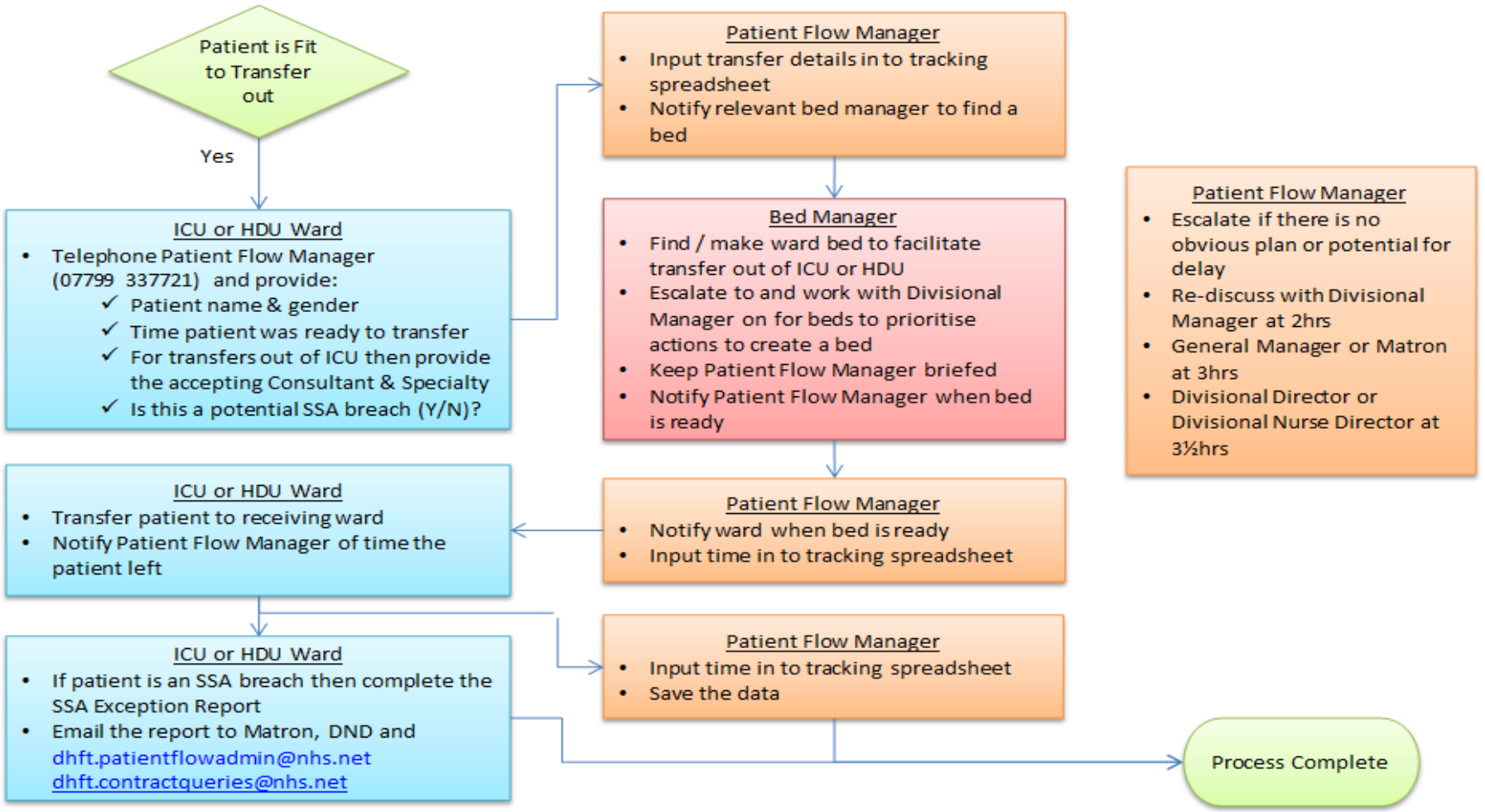
Completing the icon

Who is responsible for completing the plan?

The receiving ward once the patient has been placed into a bed and the information has been read and accepted. The plan will then switch off the front screen and sit in the background

Appendix 1

Process for Escalation and Transfer of Patients out of ICU & Medical HDU Beds to Avoid Single Sex Accommodation Breaches



Appendix 3

Critical Care Full Capacity Plan Escalation

ICU Status	Trigger	Action	Comments
Green	Able to accommodate all planned & unplanned ICU/HDU activity without increasing ICU bed base outside of established bed capacity i.e. 16 beds No requirement for non-clinical transfers to accommodate unplanned activity levels No delay ≥ 4hours for patient admission to ICU/HDU once decision to admit has been made No alert within Mid Trent Critical Care Network that ICU/HDU capacity is an issue elsewhere	Continue to utilise established ICU/HDU bed compliment flexibly Ensure planned activity is subject to effective 'elective booking policy' Facilitate transfer of patient to the ward area ≤ 4 hrs. post decision to transfer is made N.B. > 24hour delay is reported a CQUIN delay. > 4 hour delay post decision that patient is medically fit for transfer will be considered potential 'single sex breach' and may be subject to financial penalty. Facilitate transfer of patient to the ward areas no later than 17.00 hrs. Any patient transfer between 22.00 –	Awareness of potential inpatients requiring critical care admission via liaison with Critical Care Outreach Awareness of Trust OPEL status which may impact on ability to transfer level 1 patients to the wards and SDU Awareness of any critical care repatriation requests from inside or external to MTCCN Awareness of Mid Trent Critical Care Network capacity status

		07.00 should be documented as a critical incident Intensivist in-charge to make decisions with regards to patient admissions and transfers and liaises closely with ICU Coordinator In liaison with ICU Senior Sister, ICU Coordinator communicate with Flow Team / HOOH to ensure appropriate and timely transfers to the wards occur **Nurse Staffing** ICU currently has the capacity for 11 level 3 and 5 level 2 beds. It is staffed to match patient dependency with ratio 1:1 for level 3 and 1:2 for level 2. To fully staff funded beds on ICU = 15 staff on each shift 24/7	Awareness of previously cancelled ICU / HDU elective admissions Senior Clinical Staff to assess and evaluate degree of clinical risk depending on the throughout the escalation process

		1. ICU Senior Sister OR ICU Coordinator in their absence to assess RN staffing to patient dependency which also requires the immediate ability to be able to admit an emergency patient **Number of RN's excluding ICU Coordinator = patient dependency +1** **2**. Where current ICU staffing can enable supporting deficits in other areas within the Trust, the staffing levels should remain ICU RN's = Dependency +1 and should not be reduced to <10	
Amber	a) Established (16) bed ICU/HDU capacity is full b) Unable to safely staff established ICU bed capacity so no emergency bed available	**In addition to above** Where possible ICU/HDU bed base is increased incrementally to total of 20 beds subject to availability of safe staffing levels Planned surgical activity MAY require prioritisation re: urgent/cancer with view to cancellation Ensure any cancellation of elective surgery is documented and the patient rebooked at soon as is feasibly possible	**As above**

	c) Unable to transfer appropriate patients to the inpatient wards due to unavailability of ward beds	Consider non-clinical transfers once elective activity has been cancelled **3.** Where a staffing deficit occurs, ICU Senior Sister OR ICU Coordinator should communicate this to Lead Nurse / General Manager, liaise with SDU, send text to ICU staff and consider use of audit / informatics nurse / professional development nurses and then appropriate use of Flexible staffing via bank. **4**. Where staffing deficit remains, the Senior Sister or ICU coordinator in their absence should immediately escalate this to Divisional Nurse Director to consider agency request. **5**.Lead Nurse, ICU Senior Sister or ICU Coordinator in their absence will continue to explore feasibility to increase staffing levels above established capacity to meet patient dependency **6**.Lead Nurse/ General Manager liaise with Manager	

		on for Surgical Beds / Flow and if necessary attend daily bed meetings to communicate priority status for ICU transfers vs ward bed availability	
Red	ICU/HDU bed base requirement is increased to 20 beds	**In addition to above** Consider expanding ICU/HDU bed capacity temporarily into theatre recovery until ICU/HDU capacity becomes available Planned ICU / HDU surgical activity WILL be reduced or cancelled Liaise with MTCCN to arrange for non-clinical transfers to occur **7**. Lead Nurse will explore feasibility of supporting patient in recovery with staff from CCOT/ Recovery/ ICU staff until capacity on ICU/HDU becomes available **8.** Lead Nurse / General Manager to liaise with Flow to prioritise urgent patient transfer to the wards	**As above**
Black	a) Emergency admission requirement for ICU bed capacity of 20 beds has been reached with no patients clinically	**In addition to above** Consider ICU/HDU expansion into SDU OR theatre	Awareness of Trust OPEL status which may impact on ability to transfer level 1

	fit for transfer to the wards b) Emergency admission requirement for ICU bed capacity of 20 beds has been breached	recovery **9.** Consideration will be given to temporarily halt the Care Outreach Service in order to support ICU/HDU activity and the associated organisational risk of removing this from the escalation response for the deteriorating patient **10**. Staff from 'other' areas with ICU/HDU experience will be relocated in order to support ICU/HDU	patients to the wards and SDU Awareness of Mid Trent Critical Care Network capacity status
Black **Sustained** **Surge i.e. pandemic**	c) ICU/HDU resource overwhelmed at times of unexpected and sustained surge in emergency admissions e.g. Pandemic influenza	**In addition to above** Refer to Adult Critical Care Pandemic Plan (2016)	

Appendix 4

ESCORT GUIDELINES ADULT PATIENTS

	AIRWAY/BREATHING	CIRCULATION	NEUR	MIS
DOCTOR accompanied by an appropriately registered practitioner	• Intubated & mechanically ventilated patients	• Resuscitation • Active shock Managemen t	• GCS < 8 risk of airway problem	• Potential need for drug intervention requiring medical administration
DOCTOR / REGISTERED NURSE OR MIDWIFE dependent on patient assessment	• Potential risk of compromised airway • Tracheostomy with potential for airway obstruction. • Self-ventilating Intubated patients i.e. breathing spontaneously • 02 Therapy **and** difficulty breathing	• Post Cardiac Arrest • Acute haemorrhage	• Cervical spine unstable • Unstable spinal injury	

REGISTERED NURSE or MIDWIFE ***** or assistant practitioners, senior student nurse/theatre practitioner post airway / recovery placement	• Respiratory depression • Post anesthesia***** • Ongoing regional anesthesia*****	• Acute M.I. • Potential cardiac arrhythmias resulting in cardiac compromise • Post investigation e.g. arterial puncture • Unstable angina • Thrombolytic therapy	• GCS 8-12	• Acute mental illness • In labour-***Must be registered Midwife or Doctor*** • Potential need for drug intervention requiring nurse / midwife administration
REGISTERED NURSE / MIDWIFE	• < 1 hour post sedation/sedating analgesia • Chest drain in situ	• Blood Transfusions	• Patients with stable spinal injury / condition	• Dying patients • Distressed patients • Learning disability • Transfer to theatre
CTA / STUDENT / HCA / NA/PORTER (Staff must refer to directorate specific tasks for non-qualified staff)	• Oxygen therapy and **no** difficulty in breathing ***Oxygen therapy must be initiated, disconnected and re-connected by health professional***	• Stable chest pain Normal ECG • Volumetric infusion pump/syringe driver	• GCS 12 - 14 • Patients in Acute confusional state with / without relative / carer`	• Clinically stable children < 14yrs not accompanied by guardian • Aggressive/unco-operative patients • PEG / NG feeds
STA / PORTER	• No airway/breathing problem or potential problem	• IV maintenance fluids only (to be switched off by a qualified nurse)	• GCS 15 • Patients in non acute confusional state with / without	• Clinically stable children accompanied by guardian

- **All critically ill patients requiring emergency transfer to I/C must be accompanied as a minimum by either an I/C nurse, a member of the Critical Care Outreach Team or, a NNP out of hours**
- **It is the responsibility of a registered practitioner to assess the patients need for an escort**
- **Careful consideration needs to be given to the escorting staff member's competence/experience**
- **Ensure clothing/linen is positioned to maintain patient dignity**

IR1 to be completed when patient assessment indicates need for escort but staffing resources makes this unachievable