The Shrewsbury and Telford Hospital NHS
NHS Trust

SHREWSBURY AND TELFORD NHS TRUST

DRAFT OPERATIONAL POLICY FOR THE TRANSFER OF PATIENTS BETWEEN THE EMERGENCY SITE AND THE PLANNED CARE SITE – CG28

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Contents

1 Policy Statement

Transfer of patients between hospitals is an increasingly common occurrence. Following the reconfiguration of hospital services, if appropriate, patients will be transferred to the planned care site on occasion from the Emergency Site to the Planned Care Site. There is often confusion surrounding the process of transfer of patients between hospitals, for example, what type of ambulance, what equipment to send and who should escort the patient. Careful planning and organization is essential to ensure that patient safety and continuing quality of care remains the primary concern for all healthcare professionals involved, when planning to transfer a patient.

The aim of this policy is to provide guidance to allow Health Care Professionals (HCPs) to assess, identify, plan and implement the safe and appropriate transfer for all patients to ensure patient safety and seamless continuity of care.

2 Overview

Transfers generally fall into one of the following 3 categories:

Group 1 The transfer of Critical / Acutely Ill patients to Other Acute Units

- 1.1 Critical Care Units
- 1.2 Trauma patients from Emergency Department
- 1.3 Acutely Ill Adults from general Wards, between SaTH sites and to Tertiary Centres
- 1.4 Paediatrics and Neonates
- 1.5 Stroke (CVA)
- 1.6 Myocardial infarction

Group 2 The transfer of patients within Shropshire for Specialist Services

- 2.1 Obstetrics
- 2.2 Renal Services
- 2.3 Radiotherapy and Chemotherapy Services
- 2.4 Mental Health Services and sectioned patients using Acute services
- 2.5 ENT/Dental faciomaxillary
- 2.6 Planned Care Site for ongoing recovery and rehabilitation

Group 3 The transfer/discharge of patients to Community Hospitals, Nursing Homes and the Hospice

3 Definitions – please refer to Appendix 8

4 General Duties - please refer to Appendix 8

5 Accountability

The clinical need of the patient for appropriate medical care in the appropriate environment is of paramount importance.

The care and transfer of patients from one hospital to another is the combined responsibility of clinical and managerial staff. Clinical responsibility lies in the direct medical care of patients, and managerial responsibility lies in providing a suitable environment in which appropriate medical care can take place. These responsibilities are not mutually exclusive and clinicians must have an appreciation of organisational and resource issues and managerial staff must allow either their own clinical judgement or that of others, to influence managerial decisions.

Nevertheless, the referring Consultant has primary clinical responsibility for a patient until the patient has been received at the accepting hospital or unit. Authority to make referrals and liaise with the accepting hospital

team may be delegated to junior members of his/her team, subject to the clinical condition and stability of the patient. This particularly applies in the inter-site transfer of emergency patients from Emergency Department. The Consultant however must be assured that the delegated doctor has sufficient experience to make these decisions on his/her behalf. Primary clinical responsibility cannot be transferred to other groups of staff.

6 Transfer Process

In addition to the information in this section please refer to section 8 which gives additional information on the following types of patient:

- Prisoners
- Bariatric patients
- Patients with communicable disease

6.1 GROUP 1 - Transfer of Critical / Acutely Ill Patients to other Acute Units

6.1.1 Critical Care Units

The decision to transfer a patient lies with the on call Critical Care Consultant in discussion with the Consultant in charge of the patient. Responsibility for the transfer may be delegated to the on-call anaesthetic registrar. The Critical care patient should be referred on a Consultant to Consultant basis, and it is the Medical Team's responsibility to ensure the patient has been accepted by a Consultant Team and on call Consultant Anaesthetist from the accepting Hospital. Responsibility for the patient remains with the Referring Consultant until the handover of the patient on the accepting Critical Care Unit.

Transfers are usually in response to:

- Clinical need – transfer to a Tertiary Centre
- A patient on the Planned Care Site requiring critical care input
- Critical Care Bed Management – in liaison with Emergency Bed Service (EBS)

6.1.2 Emergency Department

The decision to admit a patient to another Trust lays with either the Trauma Team leader, who may be a senior ED Consultant, or the lead clinician involved in the management of that patient e.g. ED Consultant/ Consultant Intensivist/Cardiologist/Neurologist. It is the responsibility of the referring doctor to ensure the patient's condition is stabilized and optimized for transfer, good communication with the accepting hospital, that thorough accompanying documentation is provided and the appropriate mode of transport and escort is used.

Transfers are usually in response to:

- Clinical need – transfer to a Tertiary Centre or Specialist service within SaTH
- Critical Care and In-patient bed capacity

Please refer to the following policies/SOPs available on the Intranet:

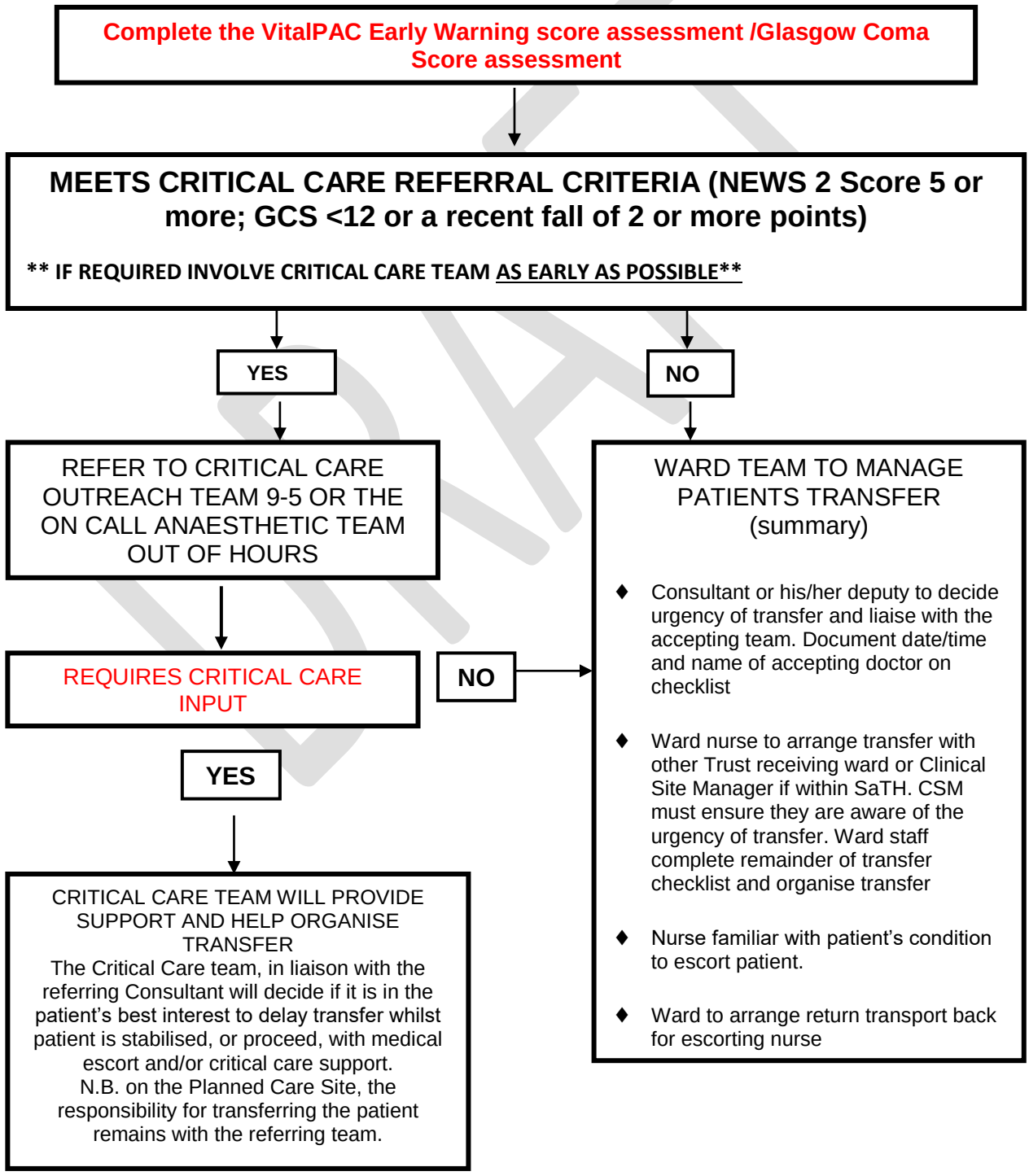
- Transfers from the Emergency Department (2010)
- Head Injury transfer summary RSH only (Emergency Department) (2011)
- SaTH Escalation Plan (2015)

The nurse responsible for organising the transfer must complete the 'Inter-hospital transfer form – acutely ill Adults (Appendix 1). One copy is to be sent with the patient, one to be kept in the health records.

6.1.3 Acutely Ill Adults from General Wards, between SaTH sites and Tertiary Centres

The decision to transfer a patient to another site lies with the Consultant responsible for that particular patient. The acutely ill patient should be referred on a Consultant to Consultant basis where possible and is the referring team's responsibility to ensure that the patient has been accepted by a doctor from the accepting Hospital. The decision to accept a patient must be made by a senior member of the team, and the referring doctor should note the date/time/name of doctor accepting the referral in the patient's notes and on the Transfer form.

Responsibility for the patient's 'fitness to transfer' is with the referring Consultant and the patient remains their responsibility until handover by an escort /ambulance staff / patient arrival on the receiving ward. It is imperative that the patient continues to be monitored up to, and during the transfer, and the transfer delayed if the patient's condition deteriorates. The use of an Early Warning scoring system will aid assessment up to and during transfer.



NB: Patients may be referred to critical care Consultant, even if they do not trigger the ViEWS Score at the discretion of the referring consultant e.g. patients at high risk of significant deterioration.

Transfers from the Emergency site to the Planned Care site will all be patients that are either not for 'escalation of treatment' or who are stable following 72 hours on the Emergency site. There will be no critical care involvement in the transfer of any of these patients.

The decision to transfer any patient from the Planned Care site for critical care on the Acute Care site will be made directly between the consultant responsible for the patient (or the on call consultant of that speciality) and the critical care consultant on duty. This decision and discussion will not be able to be delegated to registrars. Decisions about the timing of transfer (for those accepted) and who accompanies these patients will be for the critical care consultant to make in conjunction with the referring consultant who will need to be aware of the patient's clinical condition.

Transfers of this group of patients are usually in response to;

- Clinical need – transfer to a Tertiary Centre or to the Acute Care site at XXXX
- Acutely Ill patients should not be transferred for bed capacity reasons and more stable / recovering patients should be selected if necessary.
- Where the non-admitted patient in the Urgent Treatment Centre (UTC) deteriorates, the UTC should call 999 and manage the patient along with the arrest team until the ambulance arrives. The ambulance would at this point transfer the patient to the most appropriate acute facility

Patients transferred from the General Wards included in this section:

- Non-intubated neurosurgical patients to tertiary centres.
- See Transfer of patients with serious head injury and other emergency neurosurgical conditions (2007)
- Acute cardiac patients to tertiary centres for emergency procedures.
- Respiratory patients, including those with Chest Drains.
- Any patient where acute deterioration during transfer may occur – examples include haemorrhage, sepsis and suspected perforated viscous. See specialty specific protocols for details e.g. Colorectal transfer policy for emergencies (2010).

Responsibility of the ward team – all adult wards (including CCU)

- A summary of the patient's condition should be clearly written in the medical notes or in a letter addressed to the receiving consultant. It is the medical team's responsibility to ensure copies of all relevant test results accompany the patient. Doctors may have to give advance warning to X-ray department to download relevant scans or x-rays from PACs to hard copy or CD-rom. Note: at present, some other tertiary hospitals can view CT scans on PACs for referral purposes, but will still require a hard copy or CD Rom for transfer. (See point 4.6, page 13)
- The nurse responsible for organising the transfer must complete the 'Inter-hospital transfer' form for Acutely Ill Adults (Appendix 1) including checking the name of the accepting doctor.
- A nurse escort should be sent with ward patients transferred in this (1.3) category (those patients thought to need a medical escort will usually fall into the criteria for referral to Critical Care Outreach). Not all emergency 'Transfer of Take' patients from UTC/ED will require escorts. The decision not to send a nurse escort should be made on clinical judgment and the reasons documented on the form.

The nurse co-ordinating / organising transfer will:

- Book ambulance
- Identify nurse to escort the patient
- Inform relatives
- Inform Clinical Site Manager of the need and urgency of transfer
- Contact receiving ward to handover, and to inform of expected time of arrival
- Identify and prepare equipment required for transfer or get a fresh fully charged device from the Equipment Library
- Liaise with pharmacy to arrange non-stock/discharge medication where appropriate
- Photocopy relevant section of notes identified by the medical team, and nursing records
- Ensure all property is packed up and sent with patient. Refer to valuables policy for further information
- Arrange return journey for nurse escort. (e.g. Taxi, train) The Escort should not rely on the Ambulance for the return journey as delays may be incurred in returning to SaTH
- Communication with the accepting team is imperative if the transfer is delayed. It is the responsibility of ward staff and Clinical site managers to keep the relevant parties informed of any significant delay and to ensure the accepting hospital and team is still in a position to safely accept the patient when the transfer occurs

6.1.4 Paediatric and neonate inter-hospital transfers

- Please refer to Paediatric and Neonatal policies located on the Intranet by typing 'transfer' into the keyword search:
  http://intranet/document_library/DocumentLibrarySearchForm.asp

    - Transfer of a Child or Young person within SaTH SOP
    - Transfer of Children
    - Transfer of Children from a PICU to the Children's Ward
    - Transfer of Children to PICU
    - Newborn Care
    - Transfer of infants from the Neonatal Unit to the Paediatric Ward
    - Transport arrangements for Neonates within SaTH
    - Transport arrangements for the movement of a sick newborn into hospital from home or a Midwife Led Unit

6.1.5 Stroke (CVA)

Patients who are known to have had a stroke or whose stroke was confirmed by the Ambulance Service should be taken directly to the Acute Stroke Unit on the Acute Care site at XXXX. However patients may self present with stroke like symptoms or suspected stroke at the UCC on the Planned Care Site. If stroke is confirmed the patient is transferred via emergency transport to the Acute Stroke Unit. A pathway is in place to support and guide staff in managing stroke patients presenting at the Planned Care Site.

6.1.6 Myocardial Infarction

Patients with confirmed MI are usually taken straight by the Ambulance Service to the Cardiac Centre – University Hospital of North Staffordshire or New Cross, Wolverhampton. However symptomatic or critically ill patients presenting to ED may have a myocardial infarction confirmed in the Emergency Department on the Emergency Site. In such an instance staff should follow the pathway described above for critically ill patients in section 6.1.3.

6.2 GROUP 2 - transfer of patients within Shropshire for Specialist services

6.2.1 Obstetrics

The structure of Obstetric services within Shropshire of one Consultant led unit on the Emergency Site with GP/Midwifery led units at other sites around the County make it likely that transfers are an important episode of some women's care.

The transfer of obstetric patients in labour, or post partum with their baby is highly specialised and the appropriate protocol should be consulted and can be found on the Intranet:
http://intranet/document_library/DocumentLibrarySearchResults.asp -

- Transfer of a woman in the antenatal, intrapartum and postnatal period
- Maternal Transfers from Wrekin MLU to Consultant Unit
- Consultant postnatal transfer to MLUs
- Staffing arrangements for MLUs during transfer of mother or baby

6.2.2 Renal Services

Renal services within Shropshire are structured with a main Renal Unit on the Emergency Site and satellite dialysis unit on the Planned Care Site. At the present time only patients considered 'low risk' are dialysed on the Planned Care Site reducing the likelihood for need to transfer.

Should transfer of an Acutely Ill Adult be necessary, the General conditions of section 1.3 apply in liaison with a Consultant Nephrologist and senior Renal Unit staff. If an in patient stay is required, a bed will also need to be arranged on the Nephrology ward on the Acute Care site.

6.2.3 Radiotherapy and Chemotherapy Services

Transfers to the Oncology / Haematology Ward 23 are usually arranged directly with the Consultant Oncologist / Haematologist and the senior nurses on duty.

6.2.4 Mental Health Services – including transfer of sectioned patients

On transferring the patient in any of the circumstances below, it is essential that all Mental Health documentation goes with the patient. It is also essential that the forms are accurately completed (e.g. spelling of name must be the same on all documents). Any errors can invalidate the Section and the patient can be deemed to be held illegally.

- If the patient has been transferred from a Mental Health establishment (e.g. Redwood Centre) on a Section 17, all legal responsibilities remain with that establishment and no further documentation is required on arrival or when transferring back
- If the patient has been transferred from a Mental Health establishment on a Section19 (form 24), the lower half of the form must be completed on the patient's arrival. On transferring from the Trust, the top section of a second form 24 must be completed. If this is not done the receiving hospital may refuse to accept the patient.
- If the patient has been sectioned whilst a patient of the Trust, a transfer to a Mental Health establishment will require the top section of a Section19 (form 24) to be completed and sent with the patient. Again, if this form is not completed, the receiving hospital can refuse to accept the patient.

Patient Services on either site can be contacted during office hours for assistance. Out of hours all of the relevant forms can be found in the control room where the clinical site managers are based.

6.2.5 ENT / Dental Faciomaxillary

Patients who are known to have had an ENT / Max Fax injury or whose need was confirmed by the Ambulance Service should be directed or taken to the Acute Care site at XXXX where the Emergency Head & Neck service will review and treat. However patients may self-present with Head & Neck conditions at the UCC on the

Planned Care Site. If a need to escalate treatment is confirmed the patient is transferred via WMAS to the Emergency site. A pathway is in place to support and guide staff in managing Head & Neck patients presenting at the Planned Care Site.

6.2.6 Planned Care site transfers for ongoing recovery and rehabilitation

To enable the Emergency site to maintain sufficient emergency admission capacity there will be a daily need to transfer patients from the Emergency care site to the Planned Care site.
Patients will be identified by their clinical team and referred to the appropriate specialist medical / surgical team on the Planned Care site for the remainder of their treatment.

Decisions to transfer must be pragmatic and where possible account for imminent discharge the following day and / or were that patient will be going post discharge. The decision to provide an escort must be made on an individual basis but it is envisaged that in the majority of cases the transport team will be appropriate.
The nurse responsible for organising the transfer must complete the non-acutely ill patient intra hospital, Community and Hospice transfer / discharge form (Appendix 2).

The non-emergency hospital transport service are contracted to transfer approximately 17 patients per day from the Emergency site to the Planned Care site.

Suitable candidates for transfer once clinically identified will include:

- Patients who are stable following up to 72 hours of treatment on the Emergency site but still require ongoing treatment, rehabilitation and care needs established prior to their discharge.
- Patients who are able to continue their recovery closer to their usual place of residence
- Patients who are not for escalation of treatment and are reaching the end of their life

Patients who are not for escalation of treatment must have had the appropriate clinically led discussion with themselves and family present. The result of these discussions should be documented and in the event of cardiac arrest a Do Not Resuscitate instruction has been consented. Please refer to Shropshire and Telford & Wrekin End of Life Plan documentation.

Evidence from a recent clinical audit (2016) has demonstrated that up to 68% of the medical patient population would be appropriately transferred to the Planned Care site for their ongoing recovery following their acute phase of treatment.

6.3 GROUP 3 - Transfers/discharge to Community Hospitals / Nursing Homes / Hospice

6.3.1 Community Hospitals

These are Community Rehabilitation Units for patients who are medically stable. The units do not have medical staff on site. Care of the Elderly Physicians are usually responsible for deciding when patients are appropriate for transfer to Community Hospitals at Bridgnorth, Ludlow, Whitchurch and Welshpool.

Transferring patients is usually part of the discharge process which should be planned as early as possible by referral to the Community Liaison Nurse for each Community Hospital

The nurse responsible for organising the transfer must complete the non-acutely ill patient intra hospital, Community and Hospice transfer / discharge form (Appendix 2).

NB: Patients to Bridgnorth Community Hospital require a medical checklist (medical information for patients transferring to Community Hospitals) to be completed by a doctor. A nurse escort is not routinely required. The nurse co-ordinating / organising transfer will:

- Book ambulance (48 hours notice), inform ambulance staff at time of booking if any additional equipment needs to be sent with the patient e.g. zimmer frame, wheelchairs, etc. Alternative transport for this equipment may need to be arranged.
- Inform Relatives
- Inform ward pharmacist of transfer details. TTOs are required.
- Contact receiving ward to handover, and to inform of expected time of arrival. The ward must be notified of any infection control issues.
- Prepare and book out notes and x-rays to send with patient. An up to date, legible drug chart is essential.
- Ensure all property is packed up and sent with patient. Refer to valuables policy for further information.
- A resume of the patient's condition should be clearly written in the medical notes or in a letter addressed to the receiving ward / GP.
- See SaTH Discharge Policy (2008) for more information about multi-disciplinary discharge planning

NB: If the patient is transferred with a 'Not for Cardio-pulmonary Resuscitation order' the ambulance crew must be informed via a letter from the consultant / designated deputy that clearly states this.

Patients discharged into the community with hospital acquired or communicable diseases must have a SC & TW PCT Inter-Healthcare Infection Control Transfer Form completed

6.3.2 Nursing Homes

Nursing Home patients are discharged and referred back under the care of their GP. The nurse responsible for organising the transfer must complete the non-acutely ill patient intra hospital, community and Hospice transfer / discharge form. (Appendix 2). It should be started at the time the patient is put on the waiting list or at the decision to transfer. A nurse escort is not routinely required. The nurse co-ordinating / organising transfer will:

- Book ambulance (48 Hours notice). Inform ambulance staff at time of booking if any additional equipment needs to be sent with the patient e.g. zimmer frame, wheelchairs. Alternative transport for this equipment may need to be arranged
- Inform Relatives
- Ensure a discharge summary is completed, obtain TTOs from Pharmacy and ensure they are given to the Patient at discharge
- Contact Nursing Home to handover, and to inform of expected time of arrival
- Ensure all relevant contact information, including liaison with social services, and other relevant documents should be photocopied and sent with the transfer information.
- Ensure all property is packed up and sent with patient. Refer to valuables policy for further information.

NB: If the patient is transferred with a 'Not for Cardio-pulmonary Resuscitation order' the ambulance crew must be informed via a letter from the consultant / designated deputy that clearly states this.

6.3.3 Transfers to the Hospice

The decision for transfer is made following either referral from the palliative care team within Shrewsbury and Telford Hospitals Trust or by the consultant responsible for the patient, independent of direct intervention of the palliative care team. The hospice will inform the ward direct of the transfer date. Transfer is to be arranged for 2pm arrival at the hospice. Consultation with hospice staff is needed if transfer is to take place prior to this time. The nurse responsible for organising the transfer will:

- Complete the non-acutely ill Patient intra hospital, Community and Hospice transfer / discharge form (Appendix 2).
- A hospice check list is required to be completed and sent on the front of the patient notes (Appendix 3).
- Book ambulance (ideally giving 48 hours notice)
- Order oxygen if necessary
- Inform ambulance staff at time of booking if any additional equipment needs to be sent with the patient e.g. syringe driver, Zimmer frame, wheelchairs. Alternative transport for this equipment and its return will need to be arranged
- Inform relatives – one may accompany the patient; inform ambulance at time of booking - directions to the hospice and map should be given, (available from Palliative Care Team)
- A nurse escort is not routinely required, unless it is thought warranted by patient's condition.
- Book out notes and x-rays with appropriate department and send with patient
- Nursing care plans and documentation should be up to date and provide all information regarding nursing care. Any special / specific information should be documented on the transfer checklist
- An up to date drug chart is essential
- TTOs <u>are</u> required to be sent with the patient
- A resume of the patient's condition should be clearly written in the medical notes or in a letter addressed to the receiving ward / consultant / GP
- In the event of any significant deterioration in the patient's condition, a medical / nursing decision should be made regarding suitability of transfer, following full discussion with the relatives and patient if possible
- Ensure all property is packed up and sent with patient. Refer to valuables policy for further information
- The hospice should be telephoned when the patient has left the Hospital, as well as any relative that has requested

NB: If the patient is transferred with a 'Not for Cardio-pulmonary Resuscitation order' the ambulance crew must be informed via a letter from the consultant / designated deputy that clearly states this.

7 Other Related Issues: General Information for all transfers

7.1 West Midlands Ambulance Service and Non-Emergency Ambulance Service

Shrewsbury and Telford Hospital NHS Trust uses 2 different ambulance services dependent on the service required. It is the responsibility of the referring hospital to ensure the most appropriate service is used. Advice can be obtained from the Transport Liaison Manager and the Eligibility Criteria for Hospital Transport Policy

Clinical responsibility for the patient stays with the referring hospital until the patient reaches the receiving hospital; it is not delegated to the ambulance service.

7.1.1. West Midlands Ambulance Service - Emergency Department and Urgent Care Centres

West Midlands Ambulances should be used to transfer:

- Women in labour
- Critical Care patients
- Unstable acutely ill adults – this includes unstable cardiology and neuro surgical transfers to tertiary centres (NB patient will require an escort if unstable)

Types:
i. 999 – Emergency for public
ii. Doctor's immediate – Emergency for inter-hospital transfer. Will arrive within 8 minutes therefore patient must be ready.
iii. Urgent, within one hour
iv. Urgent, within 2 hours

NB Transfers that can wait >4 hours are considered stable and a high dependency patient first crew should be considered.

- Staffed by a Paramedic crew, but will nearly always require nurse and/or doctor escort. Paramedics are not trained in the use of infusion devices or chest drains and will require an escort.
- Vehicle carries one stretcher case patient with the capability of carrying up to two escorts.
- Vehicle carries a full range of equipment including:
    - Cardiac Monitor / Defibrillator
    - Oxygen – piped and portable
    - Sphygmomanometer
    - Drugs and fluids: all drugs recommended by Resuscitation Council for immediate resuscitation and treatment
    - Intubation, Infusion and Cannulation equipment
    - Suction
    - Various splint types
    - Various Dressing – including burns
    - Maternity equipment

7.1.2. Non-Emergency High Dependency Crews
Non-Emergency High Dependency Ambulances may be used to transfer:

- Unstable acutely ill adults provided that an escort accompanies the patient.
- Inter hospital transfers of stable acutely ill adults who require some supervision and low levels of intervention, with or without an escort – these accounts for the majority of the Emergency Site to Planned Care Site transfers.
- Staffed by Extended Technician crews. Unstable patients will require an escort, but stable patients, including those with infusion devices and chest drains which ONLY require supervision, may be sent unescorted. Technicians with extended skills are trained in performing observations but cannot give drugs themselves.
- Vehicle carries 1 stretcher case patient with the capability of carrying up to two escorts.
- Vehicle carries a full range of equipment including:
    - Cardiac Monitor / Defibrillator
    - Oxygen – piped and portable
    - Sphygmomanometer
    - Suction
    - Various splint types
    - High Dependency crews do not carry drugs, which must be provided by the referring hospital in sufficient quantities to last the journey.

7.1.3 Non-Emergency Transport Service - mainly for patients in Group 2 & 3
Technician crew are first aid trained only, able to perform simple observations, and simple fluid management.

Sitting Case 1 — Single staffed vehicle for the transportation of able-bodied patients requiring no medical intervention.
Vehicle carries no equipment other than Bag Valve Mask (BVM) and first aid equipment.

Sitting Case 2 — Double staffed vehicle for the transportation of infirm patients both wheelchair and stretcher type but still requiring no medical intervention

Vehicle carries no equipment other than Ambu-Bag, Mask and first aid equipment.

Stretcher — Double staffed vehicle for the transportation of patients requiring some medical treatment en-route i.e. oxygen and IV fluid management.
Vehicle carries piped oxygen and suction and basic first aid equipment only.

7.2 Management of Equipment

Preparation and selection of any equipment (in addition to that available in the ambulance) is important to maintain patient safety. The Critical Care Transfer trolley is maintained by site specific allocated staff and used for Critical care and ventilated patients.

The battery life of all electrical equipment varies depending on its use and amount of charge. The team responsible for transfers must be aware of battery lives for particular equipment and the implications of losing power en route. Hence equipment on each trolley should always be kept on continuous charge. If there are any doubts a backup unit could be obtained from each site's own Equipment Library service.

As a rough guide, current Trust Infusion Devices: Battery life, from fully charged

For large volumes of infusion;

- Signature (Oncology and Children's), 4 Hours
- Carfusion GP 6 Hours

Syringe Drivers:

- PCA (P5000) 4 Hours
- Carefusion CC 6 Hours
- CMC McKinley (Palliative Care) 30 minutes
  (from low battery alarm sounds)

- The PCA Syringe Drivers (P5000) will last approximately 4 hours on 'middle' infusion rates (i.e. not full blast) provided that the device has been charged for at least 16 hours.
- The Patient Monitors used will also last approximately 4 hours but frequent (i.e. more than every 15 minutes cycle time) use of the non-invasive Blood Pressure cuff will deplete the battery life much quicker
- The Alaris Signature Infusion Pump will sound the 'low battery' alarm 30 minutes before the battery runs out. The escorting nurse must know the 'half-life' of any drug being infused and the implications of the patient not receiving it if the infusion stops.
  NOTE: If the **Signature** is not charred at this point, the device will reach a critical voltage and will no longer charge the battery. It will continue to sound the alarm and the user will be unable to silence the device.
- The escorting nurse must have successfully completed and be up to date with respect to Infusion Device training. Hence be familiar with using the devices and able to troubleshoot any problems.

  When the trolley leaves the Trust the Equipment Record Book must be duly completed. Please refer to appendix 5 & 6 for further guidance.

7.3 Drugs en route

- Intensive Care, Emergency Department, Neonates and Paediatrics each have a transfer pack of drugs, which they carry, en-route for acute transfers.
- General ward nurse escorts should not need to carry any extra drugs to administer en route, but may need extra IV fluids when using High Dependency crews. It is the referring hospital's responsibility to ensure that any infusion devices have sufficient volumes to last several hours beyond the expected length of the journey.
- Drugs should not be carried except as part of a transfer pack.

7.4 Discharge Medication (TTOs)

Where patients are transferred between units receiving pharmacy services from SaTH it is not necessary to organise TTOs prior to transfer. Patients being transferred between hospitals should take their tablets with them to avoid unnecessary duplication. Pharmacy must be made aware of the transfer either through the ward pharmacist/technician or by phoning the dispensary. The dispensary may request the drug chart to ensure non-stock drugs are available on transfer.

For transfers to other NHS trusts, Community or private hospitals and the Hospice, TTOs will be required depending on the patient's drug therapy. TTOs must be ready before transport arrives as the transport is unable to wait whilst drugs are obtained.

7.5 Transporting blood / blood products

Blood Bank must be informed if blood is being moved off site. Within the Trust, blood that has already been cross matched for the patient should be transported with the patient to avoid wastage. Blood Bank will box up the blood in external transport bags with chill packs. Blood can remain in these bags for 3 hours after which it must either be used or returned to a designated Blood Fridge. On arrival at the other site, it is important unused blood is placed in a designated fridge as soon as possible. E.g. Theatres or Blood bank

Depending on the urgency, and specific requirements of the patient e.g. unusual antibodies, other Trusts may or may not use blood crosshatched in another Trust. Blood bank will liaise with the accepting Hospital's Blood bank and advise.

7.6 Notes and X-rays

Notes should not routinely be transferred to hospitals outside Shrewsbury and Telford Hospitals Trust. The relevant sections should be photocopied and sent with the patient wherever possible

Relevant x-rays and scans will be downloaded from PACS and sent as Hard copy or CD Rom but they will need as much notice as possible to do this. University Hospital of North Staffs (Stoke) The Queen Elizabeth Hospital (QE), Birmingham Children's Hospital and Walton Hospital, Liverpool have the the facility to have PACS images transmitted to their respective sites for initial assessment. Those patients accepted for transfer will still require hard copy or CD-Rom.

8 Additional information for special groups of patients

This section provides additional information for specific patient groups in addition to the information in section 6.

8.1 Not for Cardio-pulmonary resuscitation orders

If a patient is transferred with a 'Not for Cardio-pulmonary Resuscitation order' the ambulance crew must have a 'Do not attempt cardiopulmonary resuscitation' transfer form (appendix 5).

8.2 Inter–hospital transfer of prisoners

Any ward or unit that needs to transfer a prisoner patient to another hospital must inform the Clinical Site manager who will co-ordinate with the Prison Authorities. Their assessment of risk during a transfer may be viewed very differently than the risks in hospital. When booking the transport, the booking officer must be told the patient is a prisoner so that they are booked to travel alone. i.e. not 'doubled up' with another patient going in the same direction at the same time.

- For a guarded prisoner the security of the transfer conditions and appropriate escort must be agreed in advance with the prison authority, usually an accompanying prison officer.
- For any transfer of a high security prisoner the police need to be consulted in advance of a transfer in addition to the prison authority

8.3 Inter-hospital transfer of Bariatric patients

Any ward or unit that needs to transfer a bariatric patient to another hospital must inform the ambulance booking service the weight of the patient and the type of transport required. This will help them to determine whether they require more than one crew for the transfer or if they require any other specialist equipment.

- Patient First crews can take patients up to 42 stone (267Kg) if they are notified in advance.
- The referring ward must perform a Manual Handling Assessment which should be given to the crew. Ward staff and equipment must be used to help transfer the patient onto the Ambulance trolley.
- The receiving hospital should also be informed so that they can make suitable arrangements for the patient.

8.4 Transfer of patients with a communicable disease Duty 6 Health Act 2006

Healthcare professionals have a duty under the Health Act 2006 to provide information when a patient moves from the care of one healthcare body to another. This will apply to any patients' known or suspected to have MRSA, ESBL producing Ecoli, TB, group A streptococci, clostridium difficile, norovirus, diarrhoea, shingles, influenza and other communicable conditions.

Any ward or unit that needs to transfer a patient with a known communicable disease must inform the ambulance booking service of the specific alert conditions and the type of precautions required.

The receiving unit/ward/hospital/nursing or residential home and the SaTH infection control team must be informed so that they can ensure that there are suitable facilities for isolating the patient.

Patients discharged into the community with hospital acquired or communicable diseases must have a SC & TW Community Trust Inter-Healthcare Infection Control Transfer Form completed

9 Process for transfer Out of Hours (Between the hours of 22.00 – 08.00)

Out of hours transfers should only occur through patient choice or in an emergency situation and under the direction of the Clinical Site Manager.

Where possible all agencies (including GPs and District Nurses), relatives and carers should be contacted during working hours to inform them of out of hours transfer plans. If this is not possible, then this should be completed as soon as normal hours resume. It is the responsibility of the transferring nurse to ensure this occurs.

A risk assessment regarding patient transfer should be conducted by the clinician in charge of the care that is physically located in the area from where the transfer is being made. In practice this will mean the nurse in charge of the ward, department, or the nurse allocated to look after the patient on that particularly shift.

The assessment should include:

- Acuity of care
- Instability of condition
- Behavioural risks and concerns

No patient with cognitive impairment or learning difficulties should be transferred out of hours unless it is an emergency.

A copy of all healthcare records, investigations and relevant completed transfer forms must accompany the patient and medications, personal belongings and other items must be recorded and transferred with the patient.

A correctly completed patient wristband must be securely in place before transfer.

All out of hours transfers for reasons other than emergency specialist / critical care transfers should be recorded on Datix as a clinical incident.

10 Training

There is no mandatory training associated with this guidance. If staff have queries about its operation, they should contact their line manager in the first instance – this may need a review due to increase in transfers.

11 Review

This document will be reviewed in 6 months of approval date, or sooner if required. In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the policy without the document having to return to the ratifying committee

12 Equality Impact Assessment (EQIA)

This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group.

13 Monitoring Compliance

Incidents of non compliance will be reported via the Trust incident reporting system, and by Community colleagues via the Purple card reporting system. Incidents and actions arising will be investigated and discussed at Clinical Governance meetings and forwarded to the Transport Manager for information. Incidents of non compliance with this policy will be forwarded to the Transport Manager for discussion, action and resolution.

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Duties	To be addressed through the monitoring below			
Definition of all patient groups	Audit of transfer covering the areas listed	Clinical Audit Department	Minimum of annually	HEC
Transfer requirements which are specific to each patient group				
Documentation to accompany the patient when being transferred				
Process for transfer out of hours				

14 Supporting Documents

- Transfers from the Emergency Department (2010)
- Head Injury transfer summary RSH only (Emergency Department) (2011)
- Colorectal transfer policy for emergencies (2016)
- Head Injury – accepting and referring Paediatric Neurotrauma (2015)
- The transfer of patients to Paediatric Intensive Care Units (PICU) (2015)
- Transfer of Patients from Paediatric Intensive Care Unit (PICU) to the Children's Ward – Ward 19 (2015)
- Transfer (by Ambulance) of a Woman in the Antenatal, Intrapartum and Postnatal Period (2016)
- Consultant Postnatal Ward Transfers to MLUs
- SaTH Discharge SOP (2016)

15 References

The Health Act (Hygiene Code) 2006,

Department of Health. (2007). *Procedure for the transfer of prisoners to and from hospital under section 47 and 48 of the Mental Health Act (1983). Version 4*. London: Department of Health. Available at: www.dh.gov.uk

Department of Health. (2010). *Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care*. London: Department of Health. Available at: www.dh.gov.uk

Royal Pharmaceutical Society of Great Britain, the Guild of Hospital Pharmacists, The Pharmaceutical Services Negotiating Committee, the Primary Care Pharmacists' Association. (2006). *Moving patients, Moving medicines, Moving safely: Guidance on Discharge and Transfer Planning*. London. Available at: www.rpsgb.org.uk

Association of Anaesthetists of Great Britain and Ireland. (2009) *Safety Guideline. Interhospital Transfer*. Available at: www.aagbi.org

Royal College of Nursing, (2008). *Improving the Safe Transfer of Care. A quality Improvement Initiative. Final Report*. Available at: www.rcn.org.uk

Department of Health. (2003). *Medical Stability and 'Safe to Transfer'*. Department of Health. Available at: www.dh.gov.uk

16 Appendices

Appendix 1	Inter-Hospital Transfer Form – The Acutely Ill Adult
Appendix 2	Non acutely ill patient intra hospital, Community & Hospice transfer / discharge form
Appendix 3	Hospice checklist
Appendix 4	Quick reference guide: patient escort
Appendix 5	Flowchart for loans of medical devices to patients
Appendix 6	Loan Agreement of Medical Equipment / Device Form
Appendix 7	DNAR transfer form
Appendix 8	Definitions and General Duties

Appendix 1 Inter-Hospital Transfer Form – The Acutely Ill Adult

The Shrewsbury and Telford Hospital NHS

NHS Trust

Patient Label or Name,	Unit number
Home address	Consultant
	Date of Birth

DATE OF ADMISSION…….

REFERRING DOCTOR……

ACCEPTING DOCTOR……

DATE & TIME REFERRAL ACCEPTED

……

PRIOR TO TRANSFER, DOCUMENT PATIENT VITAL SIGNS IN THE APPROPRIATE BOX

Date	3	2	1	0	1	2	3
CONSCIOUS LEVEL (Tick)				ALERT	DROWSY/ Responds to voice	CONFUSED/Responds to pain	UNRESPONSIVE
RESP RATE/MIN	<8			9-16	17-22	23-29	>30
HR/MIN	<40	41-50		51-100	101-110	111-129	>129
BP SYSTOLIC	<80	81-90	91-100	101-199		>200	
URINE over last 4hrs in mls				>120	<120	< 40	<20

Add together the score awarded for each observation to give TOTAL

Time			
Score			

Score of 1	Inform senior nurse. Re-perform observations prior to Transfer
Score 1 - 3	Inform Medical Team. Consider critical care opinion and/or delaying transfer
Score 4 or more	Do not transfer patient until score is less than 4 unless there is an overriding clinical urgency, in which case critical care should be contacted and a medical escort required

I HAVE ASSESSED THE PATIENT AS ABOVE AND DECLARE THEM FIT TO TRANSFER

SIGNED ……

DESIGNATION……DATE/ TIME……

WARD/DEPT/ TELEPHONE NUMBER……

atent cannula(e)		Notes / Photocopy		Doctor Escort	
IV Fluids (inc. spare bags)		Hard Copy X-rays/ scans		Nurse Escort No Escort required	
Infusion Device (specify type and Reference number)		Medication/ TTOs		Check Return Transport for Escort	
		Other		Notify accepting Dept	

Diagnosis including Reason for transfer

Procedures/Operations/Abnormal or Outstanding Investigation results

Respiratory including Oxygen Therapy and SaO2 or Blood Gas Results

Cardiovascular including recent stability of HR / BP and IV infusions

Neurological including current/ fluctuating levels of consciousness / pain

Nutrition and Hydration including restrictions / supplements

Elimination including urine output, level of assistance required

Mobility and Hygiene including Waterlow score and assistance required

Wound Care including Grade of any pressure ulcer

Psychological including understanding of reason for transfer and knowledge of illness / prognosis

NEXT OF KIN / CONTACT NAME AND TELEPHONE NUMBER

……..

Aware of transfer and reason for it Yes / No

Appendix 2 Transfer of Care Summary (non acutely ill)

Transfer of Care Summary (non acutely ill)
(Between Acute Trusts, Nursing/Residential Homes, District Nurses etc)

Transferred From: Site, ward _____

Date of Admission: _____

Date of Transfer: _____

Name _____

Unit Nº _____ Consultant/GP _____

NHS No: _____ D.O.B: _____

1. Admitted From

Address: _____

_____

_____

Lives Alone: ☐ Y ☐ N

Next of Kin: _____

Relationship: _____

Tel No 1: _____

Tel No 2: _____

2. Transferred to ☐ Same address as 'Admitted from'

Address: _____

_____

_____

GP/practice: _____

Tel No: _____

Religion: _____

Known to: ☐ Proactive care team

☐ District Nursing Team

3. Relevant Medical Information

Reason for admission (include working diagnosis, procedures and Rx dates): _____

_____

_____

_____

Other ***current*** clinical conditions/relevant PMH: _____

_____

_____

_____

Follow up arrangements: ☐ None ☐ OPA, Date/Time: _____ Clinic/Site: _____

☐ Other (details): _____

4. Resuscitation Status
(at referring hospital/Nursing home etc)

☐ For full cardio-pulmonary resuscitation

☐ Not for cardio-pulmonary resuscitation

☐ Advanced Directive in force (enclose with this form)

5. Allergies N☐e/None Known

☐ Y (State):

6. Is the patient an infection risk? ☐ N

☐ Y (state):

Current Infection 1: Site Organism: _____

Current Infection 2: Site: Organism: _____

PMH of Infection Site: Organism: _____

Site Organism: _____

Provide details of any exposure within the last 2 weeks to patients with diarrhoea or vomiting: _____

_____

Is the patient aware of their diagnosis/risk of infection? ☐ Y ☐ N

7. Does the patient have diarrhoea illness? ☐ N

If patient has diarrhoea illness, please indicate bowel history for the last week based on Bristol stool chart

_____

_____

_____

Does the patient require isolation? ☐ Y ☐ N

If the patient requires isolation the receiving area must be notified in advance

8. Social Care Arrangements: ☐ None required

☐ Social Worker	Name: _____
	Tel No: _____
☐ District Nurse	Start Date: _____
☐ Care Agency	Start Date: _____
☐ Intermediate Care	Start Date: _____
☐ Meals on Wheels	Start Date: _____
☐ Dietician	Start Date: _____
☐ Physio/OT	Start Date: _____

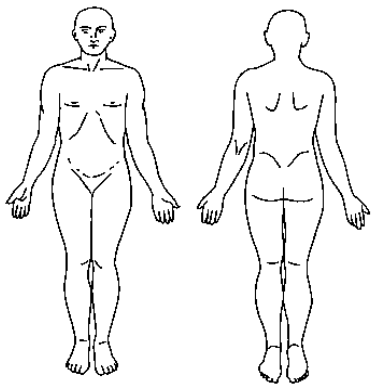
9. Hospital Outreach/Macmillan Referrals: ☐ None required

☐ Urgent (1-2 days) ☐ Non Urgent (within 5 working days).

Symptom Control

☐ Mild Pain	☐ Nausea	☐ Nausea
☐ Moderate Pain	☐ Vomiting	☐ Anxiety
☐ Severe Pain	☐ Diarrhoea	☐ Confusion
	☐ Constipation	
☐ For GSF register	☐ Anorexia	☐ Breathlessness
☐ DS 1500 complete	☐ Dysphagia	☐ Dyspnoea

10. Skin Integrity Chart and invasive items (Please annotate any break in skin integrity or bruise on the body map)



Wound Number	Type of Wound / Invasive item (inc grade if pressure sore)	Current Treatment	Date of Last dressing/item change (if applicable)

Waterlow Score	

Invasive Items– (indicate on body chart)

Type (eg Catheter/PEG etc)	Date Inserted	Comments

11. Assessment of Patient Needs at Transfer

Learning Needs/Understanding	Mobility	Sensory	Continence	Dietary
☐ Normal related function	☐ Normal related function	☐ Normal related function	☐ Fully Continent	☐ Normal Function
☐ Totally dependant on others ☐ Reduced ability to understand information ☐ Impaired Social Functioning **Mental State** ☐ Confused ☐ Confused at Times ☐ Unable to co-operate ☐ Lethargic	**Requires help to** ☐ Stand ☐ Transfer in Chair ☐ Walk ☐ Transfer into bed ☐ Turn in bed/PAC **Aids required** ☐ Walking.____ _____ ☐ Nursing ____ _____	**Speech** ☐ Dysphasia ☐ Other (specify) _____ _____ **Hearing** ☐ Impaired (specify) ____ _____ **Eyesight** ☐ Blind ☐ Partial Sight (specify) _ _____	**Faecal** ☐ Incontinence ☐ Stoma **Urinary** ☐ Incontinence ☐ Self Catheterises ☐ Indwelling Catheter ☐ Urostomy ☐ On dialysis **Bowels last opened**	**Requires help with** ☐ Feeding ☐ Drinking **Medical Diet** ☐ PEG ☐ NGT ☐ _____ **Enteral Feed** ☐ Dietician prescription

12. Transfer Checklist (or use with all patients for which this form is appropriate)

Check Wristband (remove if for direct discharge)	☐ Y ☐ Removed	Valuables	☐ Y ☐ None

Pts own medication or TTOs for 5 days (if discharge)	☐ Y ☐ N/A	Dressings for 48 hours	☐ Y ☐ N ☐ N/A
E script summary/copy of MAR chart completed and sent with patient	☐ Y ☐ N ☐ N/A	Transport booked	☐ Y ☐ N/A
Time last regular medication given		Inform transport if pt bariatric	☐ Y ☐ N/A
Inform Pt of Transfer	☐ Y	Discharge Leaflets/Information	☐ Y ☐ N ☐ N/A
Inform NOK of transfer	☐ Y ☐ N ☐ N/A	Receiving Centre informed of Infection	☐ Y ☐ N ☐ N/A
Case Notes and X Rays (if for transfer between SaTH, Shropshire or Powys Community Hospitals)	☐ Y ☐ N ☐ N/A	Acute Trust: Fax copy of this form to CCC if pt has an Active Sema Care Plan	☐ Y ☐ N/A **(01743 354347)**

13. Signature ☐ **Pt seen by Dr who has requested transfer** ☐ **Nurse co-ordinated transfer** ☐ **Emergency transfer**

Signature of Nurse Transferring Pt:		**Print Name/Title:**	
Telephone Number for Enquiries:		**Date:**	

Appendix 3 Hospice checklist

Severn Hospice

Shrewsbury & Telford Hospital NHS Trust

PATIENT CHECKLIST FOR HOSPICE TRANSFER.

PLEASE COMPLETE PRIOR TO TRANSFER OF A PATIENT TO THE HOSPICE.

Patient details **Ward** ……

……

……

……

……

	YES	NO	N/A	NURSE SIGNATURE
Is the patient aware of transfer plans to the hospice?				
Have you informed the patient's relatives of transfer plans?				
Is there a completed discharge letter? (Can you ensure this is as up to date as possible)				
Has the hospice been phoned to hand over the patient?				
Are the medical and nursing notes with the patient on leaving the ward?				
Are TTO's completed?				
Have appropriate services been informed of this transfer? (i.e. GP, Macmillan Nurse)				
Are there any outpatient appointments that need to be passed on to the hospice?				

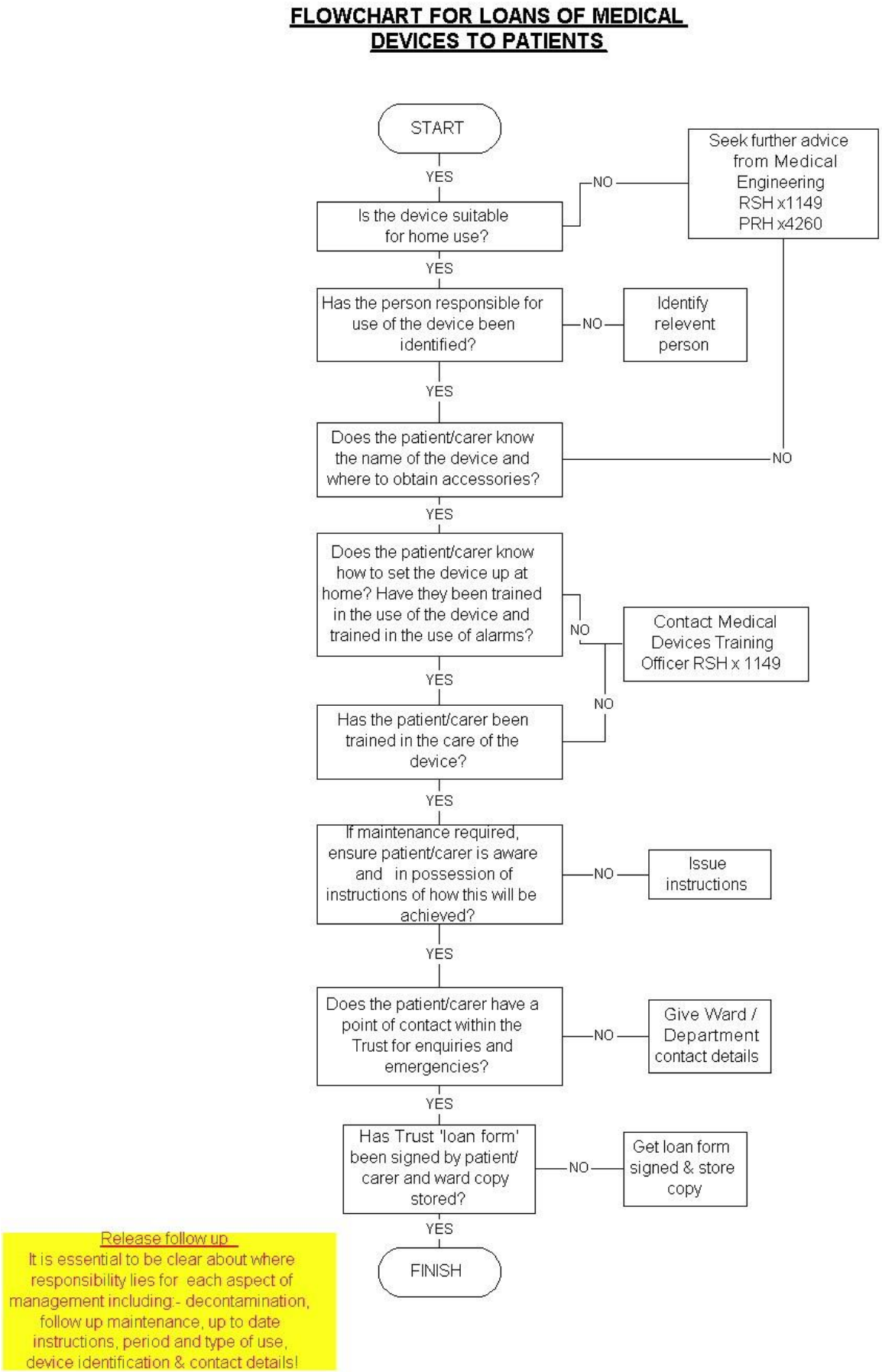
Nurses signature ……
Designation ……
Contact No ……
Date ……

Thank you for taking the time to this form. Please attach this form to the front of the patients notes and send it with the patient. Palliative care team 200

Appendix 4 Quick Reference Guide: Patient escort

	My Patient:	Escort Required
	• Is Post Sedation • Is Post Anaesthetic • Has been administered a Controlled Drug (eg Morphine, Diamorphine) prior to transfer • Has received Dextrose/Insulin prior to transfer	Registered Practitioner (Nurse or Doctor)
	• Has a fluctuating level of consciousness • Is semi- conscious or unconscious • Of uncertain mental state (eg possible head injury, hypoxia, toxicity) • *Disorientated, confused, anxious*	Critical care assessment and possibly anaesthetic Escort if patient is for ACTIVE treatment Registered Nurse escort may also be required *Consider non-Registered practitioner or relative if patient is for palliative care only*
	Requires on-going treatment/monitoring during transfer • Eg: Regular Observations: B/P, P,R BSugar, • IV Infusions: Fluids and Drugs • Chest Drain • Cardiac Monitor NB: If unprescribed or acute interventions anticipated - Medical Practitioner required	Registered Practitioner (Nurse and/or Doctor) West Mids AmbParamedics cannot escort patients with infusions and chest drains and nurse is required. However Patient First High Dependence Crews will supervise a stable patient with chest drain and/or infusion device without an escort
	• Has Potential airway problems • Patient's condition could deteriorate (eg CardioVascular instability) • New Tracheostomy • *Is Ventilated* NB: If unprescribed or acute interventions anticipated - Medical Practitioner is required	Critical care assessment required Medical Practitioner & Registered Nurse *Anaesthetist & Registered Nurse*
	• Requires a detailed clinical handover • Has comprehension and/or language difficulties • Requires assistance to transfer between bed/trolley etc	Registered Practitioner Consider non registered Escort. D/W Ambulance service whether relative escort would be helpful Consider non registered Escort who has had manual handling Training

Appendix 5 – Flowchart for loans of medical devices to patients



The Shrewsbury and Telford Hospital NHS
NHS Trust

Appendix 6 - Loan Agreement of Medical Equipment / Device Form

Equipment Number Asset Reference:_____

Equipment Type / Description:_____

Model Number: _____ Serial Number: _____

Department:_____ Estimated Period of Loan:_____

Hospital Contact Telephone Number:_____ Extension Number:_____

Patient / Client Name:_____ Telephone No:_____
Address:_____
_____ Post Code: _____

I acknowledge receipt of the above equipment on loan in a clean condition with responsibility for any loss or damage to the equipment for which a charge may be made.
I will inform you of any change to my details e.g. address and return the equipment any requested schedule maintenance or if no longer required.
I have been trained in the use of equipment and have received written instructions for its use and cleaning.
I understand that the Trust will not be liable for any costs, claims, damage or injury resulting from the misuse of the equipment.
All equipment should be made socially clean before being returned i.e. wiped with a damp cloth using soapy water.

Signature:_____ Date:_____

Equipment Issued By: _____ Staff Grade: _____

Staff Signature: _____ Date: _____

Please Ensure the Equipment Is Returned On or Before: _____

Returned On: _____ Accepted By: _____

Additional Comments: _____

FILE IN WARD/DEPARTMENT MEDICAL DEVICE FOLDER

Appendix 7 Do not attempt cardiopulmonary resuscitation transfer form

DNAR TRANSFER FORM 3

The Shrewsbury and Telford Hospital NHS
NHS Trust

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

TRANSFER FORM

Please Note

This form should be used **only** when a patient is being transferred from The Shrewsbury & Telford Hospital NHS Trust to another destination. A **Do Not Attempt Cardiopulmonary Resuscitation Decision Form (Adults aged 16 and over or Children less than 16 years of age (as appropriate))** must have been completed and endorsed by the Doctor responsible for the patient's care **before** this form is completed.

Please ☑ both boxes

☐ A Do Not Attempt Cardiopulmonary Resuscitation decision is currently in place for this patient.

☐ A Do Not Attempt Cardiopulmonary Resuscitation Decision Form (DNAR16+ Form 1 **or** DNAR<16 Form 2 (as appropriate)) has been completed and endorsed by the Doctor responsible for the patient's care. This is retained in the patient's medical notes.

Name _____

Address _____

Date of birth _____

NHS or hospital number _____

Transfer from (please state):

Transfer to (please state):

Form completed by:

Name (PRINT) _____ **Position** _____ **GMC / NMC No.** _____

Signature _____ **Date** _____ **Time** _____

*** This form should be completed by a doctor or the nurse in charge of the ward / department ***

Consultant responsible for patient care whilst at The Shrewsbury & Telford Hospital:

Name (PRINT) _____ **Position** _____

NB:

If the patient is conscious during transfer and competently revokes an earlier DNAR Decision, CPR should be performed. You may wish to contact the responsible Consultant for advice.

- **If the patient dies during transit, the patient should be returned to the Emergency Department (ED) in order that death may be certified and their body taken to the mortuary.**
- **Emergency Department staff will inform the discharging ward of the death and arrange for relatives to be informed as soon as possible.**

SaTHDNARTransfer.3(May 2009)

Appendix 8 – Definitions and general duties

Transfer	The movement of a patient from their base ward/ department to another area/department either within or outside of the Trust
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 e.g. Planned transfers; from an acute bed into a rehabilitation facility, transfer of patients from the Emergency Department who require admission, transfer of patients from one area to another within the Trust during times of bed crisis e.g. outliers, or patients transferring from higher level care to other wards within one of the hospitals of the Trust.
Critical Care Transfer	The elective or emergency transfer of an adult, child or young person either internally or externally to this Trust into a higher level of care facility for either specialised care or when local critical care beds capacity has been reached.
General Care Transfer	The transfer of an adult, child or young person whose condition is stable and who may or may not require an escort.
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.
Discharge	The movement of a patient from their base ward/ department to their usual, or a temporary, place of residence

General Duties

Chief Operating Officer
Executive Lead who is accountable to the Trust Board for ensuring compliance with this policy in all parts of the Trust

Managerial staff, including Clinical Site Managers
Managerial staff including clinical site managers are responsible for organising and prioritising Trust resources to provide an environment in which clinical staff can discharge their responsibilities by;

- Expediting the transfer of urgent inter-site patient transfers by directing total Trust patient flow.
- In discussion with the accepting team Consultant, prioritise the clinical needs of patients when capacity is limited within the Trust.
- Communicate with the referring and accepting team Consultants and ward staff when the transfer process has been delayed for organisational issues. If the Clinical Site Manager is responsible for identifying when the accepting site is able to receive a patient and authorise the movement of a patient from one site to another, it is his/her responsibility to ensure all parties are informed and the accepting hospital and team are aware of the patient.

Referring medical staff
Referring medical staff are responsible for ensuring:

- A named doctor has accepted the transfer of medical care of the patient to the accepting hospital.
- That the accepting hospital has received sufficient information to allow them to prepare a suitable environment to accept the patient.
- The patient is stable enough to transfer and that any continued care or observation required during transfer is identified. (including the need for escort / infusions / monitoring)
- All relevant information for the patient's continuing medical care accompany the patient e.g. photocopies or original notes, results of tests, Radiological images which may have to be downloaded onto CD or printed in hard copy from PACS

Accepting medical team

It is the responsibility of the accepting medical team to ensure on-call staff are aware of an imminent transfer, the condition, and proposed treatment plan for the patient, if they will no longer be on duty when the patient is transferred.

Responsibility of Nurse Escorts (See Escort Quick Reference Guide - Appendix 4)

A nurse escorting a patient during any transfer must be familiar with the patient's condition, medical history, and social history and planned programme of care. The role of the nurse during transfer is to:

- Provide reassurance and support for the patient where appropriate
- Monitor the patient's condition during transfer
- Manage any interventions where appropriate i.e. infusions, oxygen therapy
- Provide a comprehensive and accurate hand-over to the receiving hospital / ward.
- Return all equipment to SaTH.

The Clinical Site Manager will be informed immediately by the nurse in charge of the department where the patient is transferring from and will be required to facilitate the allocation of a suitable nurse to support the transfer from the department to maintain business continuity and reduce any risks to departments. A risk assessment will be required to support this decision.

The Role of Student Nurses in Transferring Patients

When a patient is transported from an NHS hospital in an ambulance, the liability for the patient care rests with that Trust, NOT with the ambulance Trust. If a patient needs to be escorted, the escorting nurse has responsibility for patient care during the journey, not the ambulance crew. It is not acceptable that this responsibility should rest with a Student Nurse and they MUST NOT be asked to act as the escorting nurse.

However, Student Nurses may experience escort duty if they are accompanying their mentor or other registered nurse as part of their learning experience.

The Role of Health Care Assistants in Transferring Patients

A Health Care Assistant may only escort a patient if the registered Nurse caring for that patient has assessed the needs of the patient and deemed this appropriate. The Health Care Assistant should be able to respond to a change in the patient's condition as necessary.

The Health Care Assistant must not be asked to escort patients who are unstable or to escort emergency transfers. The responsibility remains with the registered nurse making the assessment. Health Care Assistants may not take Student Nurses with them on a transfer.

Relatives escorting patients

Relatives should be instructed to make their own way to the hospital. They should not under any circumstances attempt to follow an ambulance as this could result in an accident.

- In Accident & Emergency ambulances, relatives are not usually permitted to escort the patient. However, if the patient's condition dictates that a relative should accompany the patient this should be discussed with the ambulance service.
- Usually one parent is permitted to escort a paediatric transfer, whatever the condition of the child.
- In PTS ambulances, a relative can escort a patient. However, this must be arranged at the time of booking and the relative must make their own way home.

Nursing staff and other allied health professionals

Nursing staff and other allied health professionals are responsible for facilitating the transfer process by;

- Continuing to observe the patient in his/her care and alert the medical team to any deterioration in the patient's condition or contra-indication to transfer.
- Organising the resources required for a smooth and organised transfer of care.
- Ensuring relatives are informed of the transfer.
- Communicating with both referring and accepting teams and Clinical site managers over progress of the transfer.