

# Guidelines for the inter-hospital transfer of critically ill patients from University Hospital Wishaw

## BACKGROUND

Transfer of critically ill adults to hospitals within NHSL and beyond is a common occurrence. The purpose of this guideline is to standardise the process as much as possible, improve communication, enhance patient safety and minimise critical incidents. You will receive training in transfer medicine within your first month at University Hospital Wishaw.

## PERSONNEL

Transfers should be performed by a doctor with appropriate training in anaesthetics/ICM and a trained staff nurse who are capable of dealing with complications that may occur en route. Trainees within 6 months of commencing anaesthetics should generally not perform transfers and trainees should be deemed competent at performing intra-hospital transfers prior to embarking on a inter-hospital transfer.

The trained staff nurse will normally come from the ED or from ICU. A consultant may be required to perform the transfer depending on the complexity of the case and the seniority of the trainee. Ultimately, the personnel performing the transfer will be influenced by the overall activity within the hospital at that time.

## IDENTIFYING AND PLACING PATIENTS

When transferring patients for capacity issues, generally the new patient will be the one who is transferred. This may not be the case if this patient is clinically unstable, or requires immediate intervention followed by assessment. In this case, a patient who is stable on their ICU therapy and can have all aspects of their care delivered at the receiving hospital should be selected. This decision will be made by the consultant in charge of ACCU.

When it is necessary to transfer the patient for ongoing care, a bed should be located. Our aim is to try to locate patients within NHSL hospitals prior to referring to NHSGGC and beyond. Wardwatcher is useful as a rough guide to capacity within individual units in Scotland, but it does not give a complete picture. Direct contact should be made with each unit. Within normal service hours, this is best done on a consultant to consultant basis. Where a patient is being transferred to receive a specific intervention, it should be decided in advance whether the patient will stay at the receiving hospital, or return to Wishaw afterwards.

## COMMUNICATION

Clear communication should occur between:

- Intensive care units transferring and receiving the patient.
- Primary specialties. Where appropriate, the patient's primary team should refer the patient to the primary team in the receiving hospital and provide a handover of care (e.g. a surgical to surgical referral).
- Transferring team and Scottish Ambulance Service.
- ED/ICU staff and the family of the patient, outlining the reasons for transfer and where the patient will be placed.

## DOCUMENTATION

Quality documentation improves patient care by communication, and acts as a legal record of events. The following items should accompany the patient:

- Medical transfer letter (not for time critical transfers). This should be as detailed as possible. Winvoice Pro Client allows typed discharge letters or step-down summaries. Both are acceptable. In addition to a general summary of clinical history and care given, it should specifically include:
  - Any key outstanding treatments or investigations that the receiving hospital will have to attend to when the patient arrives.
  - Known hazards e.g. difficult intubation, documented allergies.
  - Details of any infection control risks (MRSA, C. difficile, resistant organisms).
  - Duration of intravascular devices.
- Nursing transfer letter. This should include contact details for immediate family members.
- Transfer record. This should be completed by medical staff prior to and during the journey.
- A photocopy of the patient's NHSL notes

## LIAISING WITH SCOTTISH AMBULANCE SERVICE/REPATRIATION

Nursing staff will generally liaise with SAS. The response time should be requested based on the clinical scenario (typically immediate, one hour, four hours or eight hours). They should be informed that you wish to use our CCT6 trolley. SAS may or may not repatriate back to Wishaw. In instances where they cannot, a taxi is required. In these circumstances, the ACCU charge nurse should be contacted who will arrange a taxi via hospital cover.

## USE OF THE CCT6 TRANSFER TROLLEY

This is stored in ACCU and ideally should be used for all transfers (not all ambulances can take it however). It carries 2 size E oxygen cylinders, a Laerdal suction unit, a Philips Intellivue X2 monitor box, an Oxylog 3000 ventilator and number of IV infusion pumps. The CCT6 trolley should always be maintained in a 'ready to go' state with all equipment on charge through a single point. There is also AC-DC static inverter which when connected in the ambulance, allows you to continue to charge the equipment and should be used wherever possible.

It is important to ensure that all equipment is properly secured on the CCT6 trolley prior to transfer. Nothing should be placed on the patient as this has the potential to become a missile during deceleration.

## KEY POINTS IN EFFECTING SAFE TRANSFER

It is outwith the scope of this guideline to provide a detailed description of how to transfer critically ill adults. The following key generic points however are applicable to all scenarios:

- Consider the positioning of the patient in the ambulance (typically you will have access to the right hand side of the patient).
- Remove all infusion pumps that are not required.
- Keep all equipment on charge until leaving the hospital.
- Used piped wall oxygen until leaving the hospital.
- Establish patent and accessible IV access, and have fluid set up and ready to run.

- Replace intercostals drain bottles with one way valves and bag.
- Take the green adult resuscitation bag on your journey which should be checked for key items before departure including having an alternative method of ventilation.
- Have emergency drugs drawn up and readily accessible.
- Ensure advanced airways are secured firmly.
- Ensure you have twice the sufficient cylinder oxygen to complete the journey.
- Take an ABG once established on the Oxylog 3000.
- Establish monitoring as per AAGBI guidelines including end-tidal CO<sub>2</sub>.
- Transferring personnel should carry a charged mobile phone.
- Wear appropriate clothing for the time of the year.
- Consider thermal control for the patient en-route.
- Telephone the receiving hospital and notify them of your departure.
- Use the pre- and post-transfer checklists to ensure you have all the appropriate equipment and that you don't leave anything behind!
- The speed of the transfer should be dictated by the urgency of the situation.
- Overall, the transfer is directed by the accompanying doctor.

### NOTES ON TIME CRITICAL TRANSFERS

A proportion of adults will be transferred from Wishaw in time critical circumstances. Usually, this is in the context of a brain injury to the regional neurosurgical service at the INS, Glasgow, or a patient requiring immediate PCI at Hairmyres Hospital. These transfers differ from those brought about due to capacity issues. In general, do not delay these transfers unnecessarily. For example, do not wait to obtain central venous access when peripheral access will suffice, or wait for a CXR to be taken to confirm endotracheal tube position. These transfers should proceed with speed and a "blue light" service used. Oxylog, monitoring (inc. EtCO<sub>2</sub>) and pumps should all be readily available and charged in ED. If this is not the case, ICU can supply.

### NOTES ON SPINAL INJURY TRANSFERS

Occasionally patients will require transfer to the Queen Elizabeth Spinal Injuries Unit in Glasgow. These are not time critical transfers. You may be requested to place the patient in a vacuum mattress for the transfer. Ambulances should not drive at high speed in order to avoid acceleration/deceleration injury.

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