PLEASE NOTE:

Whilst the review date for this policy has passed, it is still the current version that should be used by staff.

Director of Nursing and Medical Director, April 2014

Transfer of Patient Policy (including Intra & Inter Hospital Transfers)
DOCUMENT CONTROL

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Date: 20/07/2010

Please note that the Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as “uncontrolled” and as such, may not necessarily contain the latest updates and amendments.

Approved policies related to this policy

<table>
<thead>
<tr>
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<td>The Safe Inter-hospital transfer of Patients</td>
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Statement of changes made

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<td>19/01/2010</td>
<td>Approved at Governance Committee</td>
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<tr>
<td>1.1</td>
<td>17/05/2010</td>
<td>Amendment of policy due to an issue raised by the Quality Care Commission relating to ‘patient dignity’ and the movement of patients between wards, within a ward &amp; during visiting hours.</td>
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This policy was Impact Assessed on 23rd March 2010
SUMMARY

The Transfer of Patient Policy to include Intra and Inter Hospital transfers has been developed to improve continuity of care and safety, when transferring adult and paediatric patients within the hospital environment, to external hospitals and tertiary centres ensuring that same level of care is maintained throughout the transfer process.

In the year 2000 ‘Comprehensive Critical Care’ was published by the Department of Health. This document is a review of adult critical care services and was commissioned by the Department of Health. One of the recommendations from the expert panel that carried out the review was:

“the existing division into high dependency and intensive care beds be replaced by a classification that focuses on the level of care that individuals need regardless of location”

There is no specific reference for the inclusion of the level 0.5 in the ‘Levels of Care’, however we have introduced this level as there are certain patients especially the elderly and confused who do not necessarily require physiological care throughout their intra hospital transfer but may require the presence of a familiar carer or a carer who at least knows about the patients usual state of mental and emotional health.

Reasons for transfer:

- Upgrade / Specialist Care
- Definitive Investigations / Procedures
- Repatriation
- Bed Pressures

To reduce all risks involved in the safe transfer of patients, effective communication channels and a comprehensive handover must be provided.

In all cases the preferred option is a ‘face to face’ handover and must occur for patients with a Level of care 1,2,3 (7.2 / Levels of Care Assessment Tool) ensuring there is a written account of the information in the patients nursing and/or medical notes.

Where a telephone handover has been assessed and deemed as appropriate by a qualified nurse for patient’s with a Level of care 0 & 0.5 (7.2 / Levels of Care Assessment Tool) the following actions must occur:

- Nursing documentation must include all aspects of the plan of care required for that patient.
- The nurse receiving the handover must document the plan of care required for the patient.
- The plan of care is clarified when the patient is accepted on the ward by a qualified nurse.
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1. **INTRODUCTION**

Transferring patients from a ward / department or to another hospital involves removing the patient from a safe environment and placing them in a potentially unsafe environment, until they reach their destination. In order to minimise the risk of danger to the patient, it is vital that patients are accompanied by appropriately qualified escorts with equipment throughout the transfer. (Especially with patients who have a level of care of 1, 2, 3) Patients should not be required to exert themselves for example when they opt to walk between departments they should not walk for long distances e.g. they should use a lift and not walk more than one flight of stairs.

There is a great potential for the patients level of care to deteriorate (DOH 2002), and the environment in which the patient is placed can be unpredictable and not well controlled.

The ‘Levels of Care’ classification is an appropriate and universal tool to use and will be used throughout this policy as a guide.

Transferring patients also increases the possibility for errors in patient identification and for their medical data to go astray.

Healthcare practitioners will be expected to utilise their own clinical judgement in application of this guide to the classification of patients when a level of care needs to be escalated

2. **PURPOSE OF THE DOCUMENT**

This policy aims to promote patient safety by:

- providing guidance regarding thorough patient assessment before transferring patients
- aiding decision-making regarding the need for escort and method of transport
- ensuring members of the multi-disciplinary team are aware of their responsibility in maintaining patient safety during transfer
- to ensure that the patient is transferred in a systematic safe and competent manner by trained personnel who will provide the required level of care to the appropriate department/hospital using the correct mode of transport at the requested time.
- to ensure that the patient is fully aware (if appropriate) of why they are being transferred to another section within a ward or another department within the hospital.
- To ensure that the moving of patients during visiting hours is kept to a minimum and only in exceptional circumstances and the reason must be explained to the patient and any visitors at that time.

This policy applies within and outside normal working hours
3. DEFINITION OF TERMS USED

NCHUT  North Cumbria University Hospital Trust  
AED  Automated external defibrillator  
BP  Blood Pressure  
COPD  Chronic Obstructive Pulmonary Disease  
ECG  Electrocardiogram  
GCS  Glasgow Coma Score  
LDRP  Labour Delivery Recovery & Post natal  
NWas  North West Ambulance Service  
NIBP  Non invasive blood pressure  
NIPPB  Non invasive positive pressure breathing  
NIV  Non invasive ventilation  
PCA  Patient Controlled Analgesia  
RMN  Registered Mental Health Nurse  
SCBU  Special Care Baby Unit  
SpO2  Oxygen saturations

4. SCOPE

This policy and procedure applies to all Healthcare Practitioners involved in the assessment, transfer and escort needs of Adult, Mental Health and Paediatric Patients when being transferred internally between wards / departments on a single hospital site, and to other NCUHT sites and to tertiary centres.

5. DUTIES

5.1 CEO / Board Responsibilities

The Chief Executive overall responsibility is to support the implementation of this policy across NCUHT.

5.2 General Manager / Clinical Director Responsibilities

Director of Nursing responsibility is to implement this policy and support Divisional Leads / Matrons across the Trust.

5.3 Line Managers Responsibility

Line manager’s responsibility is to ensure that staff are aware of this policy and that patients are transferred safely.

5.4 Staff Responsibility

All Staff Trust –wide must read and adhere to this policy and have a working knowledge of this policy and other policies related to patient transfer which are:
- The Trust Control of Infection Policy
- The Trust Safe Identification of Patients using Identity Bands
- The Trust Transfer of Patients Between Specialities Policy
- The Trust Health & Safety Policy
- The Trust Safe Keeping of Patients Property, Money and Valuable at the North Cumbria University Hospitals NHS
- The Maintenance of Patients Privacy Dignity & Respect Policy
- The Safe Inter-hospital Transfer of the Critically ill Patient
- Moving and Handling Policy

- Apply the levels of care table when deciding who should escort the patient.
- Complete Risk Management incident forms as necessary.
- Ensure (Patient Administration System) PAS is updated

5.5 Transferring Staff Responsibilities

Aware of their own responsibilities and accountability, re: patient transfer as set out within this document.

The nurse in charge of the ward/department will identify which patients are to be transferred to another ward or within a ward/department/hospital and the reason must be explained to the patient and any visitors at that time if it is appropriate.

The ward/department/hospital must ensure they have provided a comprehensive handover prior to transferring the patient and documented clearly within the patients nursing and/or doctors notes.

5.6 Receiving Staff Responsibilities

The ward/department/hospital must ensure they have received a comprehensive handover prior to accepting the patient and documented clearly within the patients nursing and/or doctors notes.

5.7 Doctors and Nursing Staff Responsibilities

Doctors and Nurses have a responsibility to ensure their own safety during the transfer

- Non sterile gloves to be worn where appropriate
- Safety spectacles or goggles to be worn when dealing with body fluids
- All waste should be appropriately disposed of in sharps containers and clinical waste bags

5.7.1 Moving and handling procedures

All staff involved in transferring patients must receive moving and handling training and yearly updates
5.7.2 Appropriate clothing when transferring patients to another hospital

All staff should ensure they are wearing appropriate clothing and foot wear [weather conditions can change significantly en route]

- High visibility vest to wear on top of uniform / clothing (ITU / CCU transfer bag)
- Warm clothing and substantial footwear

5.7.3 Doctors and Nurses role in the ambulance

Doctors and Nurses should ensure that when they are in-side the ambulance vehicle that:

- That the ambulance crew are responsible for the general safety of the patient and the accompanying staff
- They should familiarise themselves with the general layout of the interior and special features such as grab rails
- Seat belts must be worn
- If it is necessary to leave your seat inform the driver and the ambulance should be stopped.

5.7.4 Patient Safety

Doctors and Nurses should ensure the safety of the patient at all times during the transfer

- Those responsible for the care of the patient during transit must make an initial assessment of the patient, and re-evaluate prior and during the transfer
- A handover from the medical and nursing team responsible for the care of the patient up to the point of transfer is essential
- Necessary preparation of the patient is essential as the transfer environment can be hostile
- The patient is at risk of exposure and inertial forces
- The medical staff escorting the patient should dictate the approximate speed of the vehicle to prevent inertial forces
- Ensure that the exact location of the hospital is known and the appropriate ward within that hospital
- Clarification for the access route to the hospital is essential

When transferring critically ill patients the safety of both staff and patients is essential. Should the patient’s condition deteriorate at any time during the transfer, [even if you have departed the hospital] either return to base or continue to the tertiary centre if this is in the patient’s best interest.
6. **METHOD OF TRANSFER**

It is the responsibility of the registered nurse / midwife allocated to the patient, within the originating ward or department, to assess the patient needs for transfer e.g. walking, a wheelchair, a trolley, a transfer on a bed or an ambulance transfer to another hospital.

The physical condition of the patient should be considered when deciding how to transfer them to their destination.

If the decision is taken for the patient to walk to their destination this must be with an escort, with the agreement of the patient and must not involve unnecessary exertion i.e. the patient should be taken in the lift if they need to go up or down more than one flight of stairs.

A ‘yes’ a response is required to all statements.

- Does the patient need to be transferred?
- Are the personnel undertaking the transfer appropriately trained to transfer patients?
- Is the patient stable to transfer?
- Has the patient identification procedure been followed and is the patient wearing an identification band prior to the transfer (refer to the policy of ‘Safe Identification of Patients using Identity Bands’) Do the personnel undertaking the transfer have adequate knowledge of the patient for whom they are taking responsibility?
- Do the receiving personnel have the adequate skills to manage the patient/patients condition?
- Are patient’s notes, relevant documentation organised and labelled correctly? (medical notes/nursing notes)
- Has communication with the receiving department/ward taken place to ensure they are ready to accept the patient for admission/treatment?
- Has the need for a medical escort been considered where necessary?
- Moving and handling issues must be considered, minimised and documented prior to transfer in accordance with the Trust Moving and Handling Policy.
- An assessment must occur to judge if the patient requires any medication/IV/drug infusions, oxygen, ward transfer bag with emergency equipment during the transfer?
These should be taken from the transferring department and remain the responsibility of the transferring personnel until the patient is accepted by the recipient department/ward.

This policy applies in its entirety 24 hours a day, seven days a week.

6.1 On Departure From The Ward Or Department

Prior to transferring a patient a comprehensive handover will have been received by the accepting ward/department and are aware that the transfer is imminent.

6.2 On Arrival At The Destination

On arrival at the destination, the accepting ward/department will direct the patient into an appropriate bed / trolley space and receive a comprehensive hand over of the patient’s medical/nursing notes, drugs and patients property.

7.0 ASSESSMENT OF ESCORT REQUIREMENT

In all cases of transfer the allocated registered nurse / midwife or nurse / midwife in charge should use their clinical judgement and identify whether an escort is required to support the transfer, patients with a level of care of 1, 2, 3 must be accompanied by a qualified nurse.

Nurses must use the levels of care assessment tool criteria (section 7.1) and levels of care assessment tool (section 7.2) to assist them in making this judgement. When using the assessment tool, the level of care from the assessment should be documented clearly in the patient records. If the patient’s condition changes prior to transfer, then the score should be reassessed. This tool is helpful when the patient has complex needs and/or assistance is required in determining the competencies required by the escort.

The nurse must also assess the need for the equipment to be used to assist the transfer and ensure that this is available prior to transfer.

The medical or surgical team and Critical Care Outreach Team should be involved in the assessment of acutely unwell patient
7.1 Levels of Care Assessment Tool Criteria

<table>
<thead>
<tr>
<th>Level</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>0</td>
<td>Patient whose needs can be met through normal ward care</td>
</tr>
<tr>
<td>1</td>
<td>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</td>
</tr>
<tr>
<td>2</td>
<td>Patients requiring more detailed observation or intervention including support from a sing failing organ system or postoperative care and those ‘stepping down’ from higher levels of care.</td>
</tr>
<tr>
<td>3</td>
<td>Patients requiring advanced respiratory support alone or basic respiratory together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.</td>
</tr>
</tbody>
</table>

Refer to the table below for an appropriate escort and essential equipment that is required to transfer the patient.

If patients are to be transferred between wards and departments it should be acknowledged at each shift change what mode of transport they will require.

CH: - CHAIR TR: - TROLLEY B: - BED
Independently Mobile / 1 person move / 2 or more person move.
7.2 Levels of Care Assessment Tool

<table>
<thead>
<tr>
<th>LEVEL OF CARE</th>
<th>VITAL SIGNS/SPECIAL CIRCUMSTANCES</th>
<th>Mode of Transport</th>
<th>MINIMUM ACCOMPANYING PERSONNEL</th>
<th>SKILLS THAT ARE REQUIRED</th>
<th>ESSENTIAL EQUIPMENT</th>
</tr>
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<tbody>
<tr>
<td>Level 0 (Normal)</td>
<td>Patent and protected 'normal' airway Saturation above 95% on room air HR, BP Temp, SpO2, RR stable.</td>
<td>CH</td>
<td>Porter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 0.5</td>
<td>Elderly confused /agitated patient Distressed patient</td>
<td>CH/BED</td>
<td>Porter / HCA HCA – primarily to care for the patient but also to assist with guiding the bed if patient requires a bed</td>
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<tr>
<td>Level 1 (At Risk)</td>
<td>Permanent/ Long term stable Tracheotomy Trauma head injury/head blocks Up to 50% oxygen via Face Mask or Trachy Mask Saturation above 95% consistently Less than 48 hours post major surgery Epidural / central line insitu Cytotoxic infusion Recent episodes of chest pain Normal and stable vital signs</td>
<td>BED/TR</td>
<td>Registered Nurse (with appropriate experience and skills to provide all of the patients care needs) Porter</td>
<td>Immediate Life Support Course ALERT™ Acute Life Threatening Emergencies &amp; Recognition &amp; Treatment of Sick Patients Gas Cylinder Training Oxygen</td>
<td></td>
</tr>
<tr>
<td>Level 2 (Unstable/ at Risk)</td>
<td>Any of the Above Plus: Shocked patients Mild airway compromise – (tracheostomy with copious secretions, nerve palsy, reduced level of conscious. Infusion of Inotropes Needing a greater amount of nursing intervention to maintain normal and stable vital signs Requiring CPAP</td>
<td>BED/TR</td>
<td>Registered Nurse (with appropriate experience and skills to provide all of the patients care needs) &amp; Porter</td>
<td>Immediate Life Support Course ALERT™ Acute Life Threatening Emergencies &amp; Recognition &amp; Treatment of Sick Patients Gas Cylinder Training Oxygen</td>
<td>HR and BP monitors</td>
</tr>
<tr>
<td>Level 3 (Unstable &amp; at High risk)</td>
<td>Unprotected Airway Intubated patient Respiratory or Cardiovascular instability</td>
<td>BED/TR</td>
<td>Anaesthetist / Doctor Registered Nurse/ODP Porter (with appropriate experience and skills to provide all of the patients care needs)</td>
<td>All the above plus Management of Critically Ill Patient (A senior doctor will make the final decision on the circumstances of a patient’s transfer and who will transfer the patient medically).</td>
<td>Full ICU portable monitoring and transfer equipment.</td>
</tr>
</tbody>
</table>
8. **INPUT FROM CRITICAL CARE OUTREACH SERVICES**

Nursing / Midwifery staff at NCUHT must be aware of the calling criteria for the Critical Outreach Team and liaise with them as per the calling criteria.

9. **COMPETENCY REQUIREMENTS OF ESCORTS**

Escorts are required to be competent to care for the patient being transferred. This competence should be demonstrated through existing Trust assessments, for example, health care professionals escorting patients with intravenous fluids which will require intervention during the transfer, must have completed the intravenous drug administration competency assessment and scope of practice.

For clinical skills where formal Trust assessments do not exist, the nurse / midwife in charge must ensure that the escort is competent to care for the patient.

10. **STABILISATION OF PATIENTS PRIOR TO TRANSFER**

Patients must be stabilised whenever possible prior to transfer. The following are examples of conditions which must be stabilised:

- Compromised airway
- Chest pain

11. **ESCORT REQUIREMENTS WITHIN THE DESTINATION DEPARTMENT**

In the case of transfer from another hospital to a NCAUT department for a procedure, the escort should remain with the patient in order to facilitate timely and safe return transfer. The destination department should agree this with the originating ward / department prior to transfer.

12. **PATIENT MONITORING DURING TRANSFER**

The appropriate monitoring, recording of observations and documentation must continue during patient transfer in accordance with the patient’s condition and plan of care.

If the patient’s condition deteriorates during transfer then the medical team responsible for the patient should be contacted.

13. **AVAILABILITY OF STAFF FOR ESCORT**

When a patient requires an escort for transfer, the available staffing levels on the ward should be reviewed and an appropriate escort identified in accordance with the Assessment Criteria and Escort Requirements.

If the escort requirement results in the ward being short-staffed for the duration
of the transfer, the nurse /midwife in charge should review /re-allocate staffing and liaise with the Matron / site Co-ordinator to provide temporary cover. Patient safety should not be compromised.

If cover cannot be provided the need for transfer should be reassessed, and consideration given as to whether the transfer can be post-poned until staff availability improves or whether the procedure can be carried out on the ward, e.g. Chest X-ray, ultrasound scan.

14. **OUT OF HOURS PROCEDURES**

This policy applies in its entirety 24 hours a day, seven days a week.

15. **ESCORTING ITU / HDU PATIENTS TO ANOTHER HOSPITAL**

ASSESSMENT

This stage aims to stabilise the patient ready for transfer.

1. **Identify**: -the patient’s problem

2. **Action**: - Assess what is being done for the patient
   - A – Airway
   - B – Breathing
   - C – Circulation
   - D – Disability
   - E – Exposure

3. **Effect**: -Evaluate what effect the management of treatment is having on the patient

4. **Evaluate**: - Determine what management / treatment is required now for the patient

15.1 **Control Following Initial Assessment**

- Identify which Clinician is taking control of the transfer of the patient
- Identify the team leader: - the transfer team leader will be in overall control of the transfer
- They must be experienced in transferring critically ill patients, as they will have the responsibility for organising resources, contacting ambulance services, ensure communication is optimal, evaluate the need for transfer of this patient, over-see preparation of the patient and equipment, discharge the patient
- Allocate key roles to members of staff
- Close liaison with the clinical team leader is essential.
15.2 Communication

Successful transfer of a critically ill patient from one clinical area / department to another requires organisation, co-operation and co-ordination of many individuals from a number of specialities. Therefore effective communication is essential if this is to be achieved.

The clinician responsible for the decision to transfer the patient has the ultimate responsibility for any communication that occurs within the dispatching unit. The accepting clinician has ultimate responsibility for communication at the receiving unit. The clinicians are able to delegate some of these calls; however calls relating to those requesting the transfer to another hospital and accepting of the patient should be at Registrar / ST 3 and above level.

In all cases the preferred option is a ‘face to face’ handover and must occur for vel of care 1,2,3 (7.2 / Levels of Care Assessment Tool ) ensuring there is a written account of the information in the patients nursing and/or medical notes.

Where a telephone handover has been assessed and deemed as appropriate by a qualified nurse for patient’s with a Level of care 0 & 0.5 (7.2 / Levels of Care Assessment Tool ) the following actions must occur:
  o Nursing documentation must include all aspects of the plan of care required for that patient.
  o The nurse receiving the handover must document the plan of care required for the patient.
  o The plan of care is clarified when the patient is accepted on the ward by a qualified nurse.

A comprehensive handover must be provided either face to face or by telephone to the receiving ward / department / hospital;

15.2.1 What needs to be communicated to the listener?

- Who you are [state your status and who you are calling on behalf of]
- What is needed [state clearly and succinctly what is needed from the listener in terms of both personnel and services]?
- What are the relevant patient details [patients full name, date of birth, current location]
- What is the patient's problem [presentation of clinical details, any other pertinent information]
- What treatment/management has been instigated to address the problem
- Ask the receiving unit to re-iterate the information, so that no misunderstanding occurs.
15.2.2 Written Records

Written records must be accurate are essential from both clinical and legal perspectives. Data required is:-

- Patient details
- Timings
- Clinical baseline history and examination
- Clinical interventions and effects of those interventions
- Investigations carried out and their results
- Conditions during transfer
- Names of responsible clinicians at each stage of the transfer

This can be partially achieved by completing the structured transfer form, which is used throughout the North East and Cumbria. "INTER HOSPITAL TRANSFER FORM" [Appendix A] Coronary Care Transfer Documentation [Appendix B]

15.3 Evaluation

Evaluation is essential and this process commences from the first contact with the patient. It is necessary to identify whether the transfer is necessary or appropriate, if so does the patient take priority in comparison with others in the hospital. When requesting an ambulance follow the guidelines [Appendix F]

15.4 Transfer category

- Emergency: (Emergency ambulance for immediate transfer. Response time approx. 8 minutes)
- Urgent: (Urgent transfer is defined as a transfer that needs to be collected and transferred within a specific period of time, determined by the clinician [DoH 1992, 2.3 State time frame that the ambulance is required)

The clinician in charge of the patient will make this “transfer category” decision. Evaluate the need for medical & nursing personnel, equipment, and transport.

15.5 Preparation of the patient and transferring personnel

When transferring a patient the same level of care should be maintained throughout. Therefore prior to transfer the patient needs: -

- Stabilise the patient to reduce physiological complications
- All necessary equipment must be checked prior to transfer
- Personnel undertaking the transfer must be fully prepared and aware of their role in its activity.
15.5.1 Equipment

Transfer equipment to be checked daily and after each transfer, this should be confirmed with a signature:-

- Transfer ventilator
- Transfer bag
- Transfer monitor
- Transformer
- Infusion pumps
- Transfer documentation

15.5.2 Anagram

When organising the medical and nursing staff follow the anagram to ensure that nothing is forgotten:

- **P** hone [access to a phone is essential]
- **E** nquiry number [contact numbers from both the recipient and receiving hospital]
- **R** evenue [money for any emergencies]
- **S** afe Clothing [health and safety, high visibility jackets must be worn]
- **O** rganised route [know exactly where the recipient hospital is]
- **N** utrition [food and drinks if it is a long journey]
- **A** to **Z** [Street map of town you are going to]
- **L** ift home [Once the patient is handed over to the recipient hospital ensure you have a lift back to base]

15.6 Transportation

Transportation of a patient is achieved in three distinct phases. The aim is to provide seamless appropriate care throughout.

- The patient is moved from the transferring unit to the transferring vehicle
- The vehicle, team, and the patient move from the referring to the receiving Unit
- The patient is moved from the transferring vehicle to the receiving unit trolley or bed

15.6.1 Prior to departure check

Prior to departure, during transfer, arrival at destination:

- **A** – Airway
- **B** – Breathing
- **C** – Circulation
- **D** – Disability
- **E** – Exposure
15.6.2 Drugs

- Ensure sufficient drugs available for the journey
- Ensure reliable infusion site/s for delivery
- Ensure battery lives of infusion pumps are adequate for the journey

15.6.3 Oxygen

Calculate amount required for the journey

- Patient’s minute volume 15L
- Journey time 50 min
- Ventilator driving gas pressure 1L + MV = 16L
- Expected journey time x2 50 x 2 = 100 min
- Amount of gas required 16 x 100 = 1600L

15.6.4 Monitoring

- Electro cardio graph
- Central venous pressure
- Invasive arterial pressure
- Capnography / End –tidal CO2
- Respiratory rate
- Neurological / Glasgow coma score
- Renal / urine output
- Temperature

15.6.5 Handover at receiving hospital

- Case notes
- Laboratory reports / x-rays / CT scans
- Evaluation of nursing care from admission to discharge
- Audit [ITU “INTERHOSPITAL TRANSFER FORM, retain green copy for audit]

Unstable patients should only be transferred when emergency investigation, procedure or treatment is required in order to stabilise the patient’s condition. These patients must be assessed by the medical team in charge of care prior to transfer, with referral to Critical Care Outreach and / or anaesthetics as appropriate (see section 8).
16. ESCORTING PAEDIATRIC PATIENTS

When utilising the assessment tool (appendix C), if the child scores 1 or above, the relevant Health Care Professional must also escort them. In addition, if the child is being escorted outside of the originating department building, the escort must be a registered Nurse / Midwife.

All Trust employees who independently escort a child must have Criminal Records Bureau (CRB) clearance.

Appendix C outlines the normal paediatric ranges for vital signs. Any deviation from these would indicate the need for medical review prior to transfer.

When neo-nates are being transferred to the Special Care Baby Unit (SCBU) from LDRP they must be transferred on a resuscitaire and not carried in the arms of a midwife or Consultant Paediatrician

17. ESCORTING MENTAL HEALTH PATIENTS

Patients sectioned under the Mental Health Act (1983) must be escorted by a Registered Mental Health Nurse. In addition if, based on clinical assessment the patient also requires an escort, an additional appropriately trained health care professional must accompany the patient. Dual trained RMN’s can independently escort patients who require a registered general Nurse.

Prior to transfer of patients sectioned under the Mental Health Act (1983) to another Trust, the Site Manager must be informed and must complete the form 24 (section 19 of the Mental Health Act). This, along with the original section papers must then accompany the patient.

Patient sectioned under the Mental Health Act (1983) leaving a hospital site must be transferred using NWAS for security and safety reasons.

Sectioned patients who have been granted Section 17 leave by their RMO (Responsible Medical Officer) may or may not require an escort off the ward. Leave may be granted for therapeutic purposes or to attend off-site appointments. Conditions of leave, including duration and escort requirements, should be clearly indicated on the leave form. Risk assessment should be undertaken before each period of leave is reviewed.

18. ESCORT BY PRE-REGISTRATION NURSING STUDENTS

Students should not independently escort patients with a Level of Care of 0.5 or above when assessed utilising the assessment tool. The allocated registered nurse / midwife or nurse / midwife in charge should use their clinical judgement and identify an appropriate escort prior to transfer.

Students should not independently escort patients outside the hospital grounds.
Staff should refer to the Practice Placement Guidelines for Pre-Registration Students for further information.

19. **ESCORT BY HEALTH CARE ASSISTANTS AND ASSISTANT PRACTITIONERS**

Health Care Assistants and Assistant Practitioners may independently escort patients with a score of 0.5 or below when assessed utilising the Levels of Care assessment tool.

20. **ESCORT BY THERAPISTS**

Occupational Therapists may be the required patient escort on home visit assessments.

Occupational Therapists and Therapy Assistants may escort patients with a score of 0.5 or below when assessed utilising the Levels of Care assessment tool. There will always be two members of staff, one of which will be a registered Occupational Therapist, present at the home assessment. The registered Occupational Therapist will be responsible for ensuring that they fully aware of the patients medical history, including any medical or functional changes in the last 24 hours, and have discussed these with the registered nurse responsible for the patients care on the ward.

Occupational Therapy staff will adhere to the guidance in the NCAHT Occupational Therapy Guidance for Working in the Community.

21. **ESCORT BY VOLUNTEERS**

All requests for volunteer escorts should go to the voluntary services department for risk assessment prior to agreement.

Volunteers may only escort patients with a score of 0.

22. **DOCUMENTATION**

When the assessment tool is used to help assess escort requirements the score and the plan for transfer should be written into the Nursing / Midwifery notes

For all patients: The patient’s records folder should accompany the patient when he/she is transferred from one department to another in the trust.

For patients under a Mental Health Act: Section refer to section 17 for details of documentation that must accompany them

23. **IMPLEMENTATION AND TRAINING REQUIREMENTS**

Inter-hospital Transfer Training Course
As part of the job description of Intensive Care & Coronary Care Nurses they must complete the learning outcomes for the Inter-hospital transfer of Patients

24. PROCESS FOR MONITORING THE EFFECTIVENESS OF THE TRUST’S ESCORT ARRANGEMENTS

The effectiveness of the Trust’s escort arrangements will be monitored in the following ways:

- Review of incident reports and preparation of reports that would feed into Trusts’ risk management / governance arrangements every quarterly.

The Process for monitoring will be by a review of incident reports by the divisional facilitators who will then report to the Risk Management Assurance Committee on a monthly basis.

The divisional facilitator will inform the matron (of that department/ward) of all incidents and an action plan formulated and implemented.

A rolling programme of local audits (at department/Division level) may be carried out where adverse incident rates (e.g. incident reports, complaints and investigations) highlight problem areas.

The audit will investigate local compliance with the Trust’s escort arrangements, for example, are patients being escorted by appropriately trained staff, and is documentation accompanying patients? The findings of the audit will be reported to the local Divisional Clinical Governance meeting and to the Quality and Safety Committee if there are trust wide issues identified.

Compliance with this policy will be audited by monitoring adverse incidents arising from transfers.

Any serious untoward incident that involves transfer will be investigated under the SUI Policy and reported to the Quality and Safety Committee.

On a quarterly basis, as part of their agenda, the North East and Cumbria Critical Care Network meet to note the results of the findings from the ITU Inter and Intra Hospital Transfer form audit. Annually a report is prepared and the results are forwarded to all ITU’s in the northern region.

25. ASSOCIATED DOCUMENTATION

- The Trust Control of Infection Policy
- The Trust Safe Identification of Patients using Identity Bands
- The Trust Transfer of Patients Between Specialities Policy
- The Trust Health & Safety Policy
- The Trust Safe Keeping of Patients Property, Money and Valuable at the North Cumbria University Hospitals NHS
- The Maintenance of Patients Privacy Dignity & Respect Policy
- The Safe Transfer of the Critically ill Patient
- Moving and Handling Policy
26. REFERENCES


Department of Health (1983) Mental Health Act


34 (9) p 41 – 46


APPENDIX A  ITU INTER & INTRA HOSPITAL TRANSFER FORM

NORTHEAST & CUMBRIA CRITICAL CARE NETWORK
INTERHOSPITAL AND INTRAHOSPITAL TRANSFER RECORD

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>PATIENT DETAILS</th>
<th>(Attach sticker)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSFERRING UNIT</td>
<td></td>
<td>Name</td>
<td>Age</td>
</tr>
<tr>
<td>RECIPIENT UNIT</td>
<td></td>
<td>D.O.B.</td>
<td>Sex M / F</td>
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<tr>
<td>TRANSFER TEAM STAFF</td>
<td></td>
<td>ID Number</td>
<td></td>
</tr>
</tbody>
</table>

PRE-TRANSFER ASSESSMENT

History / Examination

Admission date

Reason for transfer:

Hb

WCC

PT

Platelets

APTT

FB

PaO₂

Na

K

PaCO₂

Ur

Cl

HCO₃

ECG

BKS

Lactate

Pelvis Xr

Normal

Special investigations

Trauma

Yes / No

if yes, C-spine protection: Yes / No

GCS prior to intubation: / 15

Pupils: reactive / non-reactive, size / mm

L: reactive / non-reactive, size / mm

Transferred from:

ICU

Ward

AME

Theatre

Other

CURRENT MEDICATIONS

Trauma

Cervical spine protected

Pneumothoraces drained

Intra-thoracic and intra-abdominal bleeding controlled

Intra-abdominal injuries adequately investigated and appropriately managed

Long bone/pelvic fractures stabilised

Airway / Breathing

Airway safe or secured by intubation

Work of breathing acceptable

Patient improving or stable and not tiring

Adequate gas exchange confirmed on arterial blood gas

Head up til 15° – if not spinal cord injury

Ventilated patients

Paralysed, sedated and ventilated plus analgesia

Ventilation established on transport ventilator

Adequate gas exchange confirmed on arterial blood gas

PaO₂ > 13 kPa, SpO₂ > 95%, PaCO₂ 4.0-4.5 kPa

Circulation

Circulating blood volume restored – remember empty patients travel badly!

Heart rate (HR < 120) and BP stable

Tissue and organ perfusion adequate

Capillary refill < 2 secs

Any obvious blood loss controlled

Hemoglobin adequate

Minimum of two routes of large bore venous access

Arterial line and central venous access if appropriate

Blood products available – to be sent with patient?

Neurology

GCS (trend), pupillary responses, focal signs recorded

Seizures controlled; metabolic causes excluded

Raised intracranial pressure appropriately managed

Monitoring

ECG, Blood pressure (IABP gold standard), SpO₂

Temperature

Oxygen calculation – twice anticipated need!

Infusions calculation – twice anticipated need!

Metabolic

Blood glucose > 4 mmol/l

Potassium < 6 mmol/l

Ionised calcium > 1.0 mmol/l

Acid-base balance acceptable

Temperature maintained

Documentation / Communication

Recipient hospital consultant (plus specialty consultant) aware and accepted – bed available!

Case notes, X-rays, results, blood collected

Transfer letter written and documentation prepared

Transfer bag

Ambulance Service informed – give 20 minute warning!

Relatives informed
### MONITORS
- ECG
- Ventilator
- SpO₂
- Temperature
- CO₂
- NIBP

### VASCULAR ACCESS
- CVP
- Urinary Catheter
- Right Arterial
- Left Arterial

### AIRWAY AND RESPIRATORY MANAGEMENT DURING TRANSFER
- Mechanical ventilation
- Intubated, SR
- Spontaneous

### DRUGS / INFUSIONS
- Stabilisation
- Start Time
- Time Ready for Transfer
- Transfer Start Time
- Destination Arrival Time

### ABDOMINAL / CHEST DRAINE
- PEEP
- PRAP

<table>
<thead>
<tr>
<th>SpO₂</th>
<th>ETCO₂</th>
<th>FIO₂</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
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<td>150</td>
<td>150</td>
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<td>80</td>
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<td>60</td>
<td>40</td>
</tr>
<tr>
<td>20</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### PUPILARY CHANGES
- CVP

### TIME
- IV Fluids
- Blood Loss
- Urine Output

---

**ON-LINE TRANSFER AUDIT COMPLETED**: YES / NO

**CRITICAL INCIDENTS DURING TRANSFER CAN BE REPORTED VIA THIS AUDIT SYSTEM**

**CRITICAL INCIDENTS / DIFFICULTIES / PROBLEMS**

Signature of escorting doctor: __________________________

GMC number: __________________________

Signature of receiving doctor: __________________________

GMC number: __________________________

**PLEASE PHOTOCOPY FORM AND GIVE TO TRANSFERRING TEAM FOR THEIR RECORDS**
APPENDIX B  CORONARY CARE TRANSFER FORM

North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>PATIENT DETAILS</th>
<th>TRANSFER DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME…………………………………………………</td>
<td>DATE OF ADMISSION/TIME…………………………</td>
</tr>
<tr>
<td>ADDRESS…………………………………………….</td>
<td>REASON FOR ADMISSION…………………………</td>
</tr>
<tr>
<td>POSTCODE……………………………………………</td>
<td>DIAGNOSIS………………………………………..</td>
</tr>
<tr>
<td>AGE/DOB………………………………………………</td>
<td>REASON FOR TRANSFER……………………………..</td>
</tr>
<tr>
<td>MALE/FEMALE………………………………………..</td>
<td>HOSPITAL…………………………………………</td>
</tr>
<tr>
<td>N.O.K………………………………………………</td>
<td>WARD………………………………………………</td>
</tr>
<tr>
<td>CONTACT…………………………………………….</td>
<td>DATE/TIME…………………………………………</td>
</tr>
<tr>
<td>NUMBER…………………………………………….</td>
<td>……………………………………………………</td>
</tr>
<tr>
<td>NAMED NURSE………………………………………</td>
<td>……………………………………………………</td>
</tr>
<tr>
<td>CONSULTANT………………………………………</td>
<td>……………………………………………………</td>
</tr>
<tr>
<td>DRUG ALLERGIES………………………………….</td>
<td>……………………………………………………</td>
</tr>
</tbody>
</table>

PREPARATION FOR TRANSFER

YES                  NO

PATIENT INFORMED/PATIENT INFORMATION PACKAGE

TRANSPORT STATE LEVEL REQUIRED EMERGENCY/URGENT DOCTORS LETTER

NURSING DOCUMENTATION

NOTES/XRAYS ETC [PHOTOCOPIED]

DISCHARGE SCRIPT/DRUG CHART

MEDICATION TRANSFERRED

FAMILY INFORMED

CONTACT RECIPIENT HOSPITAL ON DEPARTURE WITH E.T.A.

CANNULA INSITU

ESCORT

NAME OF DOCTOR………………………………………………………………………..

NAME OF NURSE…………………………………………………………………………

EQUIPMENT/TRANSFER

YES                  NO

- PORTABLE MONITOR
- OXYGEN
- TRANSFER BAG
- EMERGENCY DRUG BOX
- PUMPS/EQUIPMENT – TRANSFORMER
- PACING BOX

AMBULANCE CHECK LIST

YES                  NO

- CHECK OXYGEN SUPPLY
- PATIENT/STAFF SAFETY
- MONITOR EQUIPMENT – SAFE SET-UP
- IS INTUBATION EQUIPMENT AVAILABLE
- DEFIB & GEL PADS
- OPIATE ANALGESIA

HANDBOVER TO RECEIVING AREA

DATE……………………………………………………………………………………………..

TIME……………………………………………………………………………………………..

HANDBOVER GIVEN TO………………………………………………………………………..

DOCTOR/NURSE SIGNATURE………………………………………………………………………..

COMMENTS FROM RECIPIENT HOSPITAL…………………………………………………..
<table>
<thead>
<tr>
<th>TIME</th>
<th>DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MONITORING**

- Sa02
- CVP (mmHg)
- RESPS
- TEMP

**VITAL SIGNS**

**BLOOD PRESSURE (mmHg)**

**HEART RATE**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
</tr>
<tr>
<td>240</td>
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<td>80</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>40</td>
</tr>
</tbody>
</table>

**DRUGS ADMINISTERED DURING TRANSFER**

**TIME**

**SIGN**

**COMMENTS**
APPENDIX C  NORMAL PAEDIATRIC RANGES

The following table show the normal vital sign ranges for paediatric patients. Any deviation from this normal indicates the requirement for medical review prior to transfer.

<table>
<thead>
<tr>
<th>Heart Rate</th>
<th>Heart Rate (Beats per min)</th>
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<tbody>
<tr>
<td>&lt;1</td>
<td>110-160</td>
</tr>
<tr>
<td>1-2</td>
<td>100-160</td>
</tr>
<tr>
<td>2-5</td>
<td>95-140</td>
</tr>
<tr>
<td>5-12</td>
<td>80-120</td>
</tr>
<tr>
<td>&gt;12</td>
<td>60-100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory Rate</th>
<th>Respiratory Rate (breaths per min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>30-40</td>
</tr>
<tr>
<td>1-2</td>
<td>25-35</td>
</tr>
<tr>
<td>2-5</td>
<td>25-30</td>
</tr>
<tr>
<td>5-12</td>
<td>20-25</td>
</tr>
<tr>
<td>&gt;12</td>
<td>15-20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Systolic Blood Pressure (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>70-90</td>
</tr>
<tr>
<td>1-2</td>
<td>80-95</td>
</tr>
<tr>
<td>2-5</td>
<td>80-100</td>
</tr>
<tr>
<td>5-12</td>
<td>90-110</td>
</tr>
<tr>
<td>&gt;12</td>
<td>100-120</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Temperature</th>
<th>Core Temperature (degrees centigrade)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>36.5 – 37.5</td>
</tr>
<tr>
<td>1-2</td>
<td>≤ 37.1</td>
</tr>
<tr>
<td>2-5</td>
<td>≤ 37.1</td>
</tr>
<tr>
<td>5-12</td>
<td>≤ 37.1</td>
</tr>
<tr>
<td>&gt;12</td>
<td>≤ 37.1</td>
</tr>
</tbody>
</table>
APPENDIX D TRANSFERRING CRITICALLY ILL PATIENTS VIA AMBULANCE SERVICE

North Cumbria University Hospitals NHS Trust


When you are aware that there is a potential emergency/urgent transfer [DoH 1992, 2.2] to another hospital, the following guidelines are to improve communication and efficiency.

- Inform ambulance control that you have a potential emergency transfer. Provide as much information as possible.

- When the patient is stabilised and ready to be transferred, phone ambulance control and request:

  Emergency ambulance for immediate transfer.
  [Response time approx. 8 minutes, 14–19 mins “The Patients Charter”.]

When an ambulance is required for an urgent transfer to another hospital, inform ambulance control and provide as much information as possible.

Urgent transfer is defined as a transfer that needs to be collected and transferred within a specific period of time, determined by the clinician [DoH 1992, 2.3]

State time frame that the ambulance is required

# APPENDIX E  EIA COMPLETE SUMMARY REPORT

## Name of policy

Transfer of Patient Policy to include Inter & Intra Hospital Transfers

## Aim of policy / who is it intended to affect?

All staff that transfer patients, inter & intra hospital

## This policy is:

- Existing
- Proposed  **x**

## This policy is aimed at:

- Staff  **x**
- Public/Patients

## Details of the individuals (include name, job title, dept and base) carrying out the EIA (ensure the lead person is clearly identified)

**Lead Impact Assessor:** Diane Murchison  
**Impact Panel Members:** Joan Joyce, Jean Strong, Marion Gray

## Which groups of people were considered during the assessment that may be affected by the policy?

None identified

## What impacts did you identify?

<table>
<thead>
<tr>
<th>Positive Impacts</th>
<th>Negative Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust acknowledged patients with 0.5 level of care</td>
<td></td>
</tr>
</tbody>
</table>
What information / data / research / evidence was used? Is any additional information required?

<table>
<thead>
<tr>
<th>Information / data / research / evidence used:</th>
<th>Additional information required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 26 References</td>
<td></td>
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</tbody>
</table>

Which Groups / Organisations / Committees / Directorates involved in the policy development?

- New policy written amalgamating the safe inter and Intra hospital transfer
- Comments received from NHSLA assessor
- Final amendments made to formatting
- Section 15.4 Definition of Urgent / Emergency Categories
- Consultant Anaesthetist
- Comprehensive verbal and written handover added to summary section. Consultant Care of the Elderly
- Section 5.5.2
- Section 5.5.4
- Section 7.2 Levels of Care / Level 3 Criteria Consultant Emergency Medicine
- NWAS, availability of staff and appropriate time of transfer
- Consultant Emergency Medicine
- Section 6.0 Safe Identification of a Patient Quality & Performance Manager, Interserve
- Section 7.2 Levels of Care Consultant Oral Surgery
- Section 7.2 Levels of Care / Level 3 Criteria Consultant Anaesthetist
- Section 20. Clarification of paragraph Head of Occupational Therapy
- Section 16 Transfer of Neo-nates from LDRP to SCBU Head of Paediatrics
- Amendments to the policy Director of Nursing
- Update of policy to include ITU transfer form
- Recommendations/Action Plan by whom and by when

None

Lead EIA Signature

Date

Review date for assessment

Yearly
The Lead Impact Assessor is responsible for forwarding a signed hard copy of the summary report and screening checklist, along with an electronic version, to the Head of Clinical Planning / Equality and Diversity, WCH for publication on the Website.

Approved for publication onto Web Site

Jan Wharton
Head of Clinical Planning/Equality & Diversity
### EIA Checklist

<table>
<thead>
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<th>Document groups considered / how affected</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
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</thead>
<tbody>
<tr>
<td>Minority Ethnic groups</td>
<td>Lifestyle</td>
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<td></td>
<td>Services (Access and Quality)</td>
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<td>X</td>
</tr>
<tr>
<td></td>
<td>Physical Environment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Social Environment</td>
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<td></td>
<td>Equality</td>
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<td></td>
<td>Physical Environment</td>
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</tr>
<tr>
<td>Other</td>
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<td></td>
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</table>

**Document groups considered / how affected**

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