Patient Centred Emergency Access Health Service Directive

Protocol for Road Inter Hospital Transfer of critically ill patients

1. Purpose

This Protocol provides mandatory steps regarding best practice for the Inter Hospital Transfer (IHT) road transportation of critically ill patients.

2. Scope

This Protocol applies to all Hospital and Health Service (HHS) employees and all Queensland Health employees working in or for HHSs. This Protocol also applies to all organisations and individuals acting as an agent for HHSs (including Visiting Medical Officers and other partners, contractors, consultants and volunteers).

3. Process for Road Inter Hospital Transfer of a critically ill patients

3.1 Principles

3.1.1 This protocol recognises that critical care infrastructure is a finite resource.

3.1.2 All decisions to transfer a critically ill patient must be based on clinical judgement assessing patient overall risk, benefit and appropriate utilisation of available resources.

3.1.3 The two reasons for transferring critically ill patients are;

   a) Clinical reasons or up-transfer for specialist care and investigation (when a higher level or capability of clinical care is required).

   b) Logistical reasons or sideways/step down transfer (Due to lack of capacity or clinical care resources).

3.2 Establishing an inter hospital referral network and transfer system

3.2.1 HHS Chief Executive (CEs) will ensure:

   • Formalised inter-service referral arrangements exist for the transfer of critically ill patients;
• A senior HHS Executive is available as a 24/7 single point of contact for clinicians to address access issues related to critically ill patient transfers;

• All options must have been explored to manage a critically ill patient before considering transfer for logistic reasons;

• A dedicated transport mobile phone is available for health care professionals undertaking road IHT of critically ill patients;

• In the event of a dispute between the receiving facility ED and inpatient units over the acceptance of a patient, the issue shall be escalated to the Executive Director Medical Services (EDMS) or equivalent for arbitration as a matter of priority;

• Staff receive the appropriate training as per the Guidelines for Transport of Critically Ill Patients endorsed by Australasian College for Emergency Medicine, Australian and New Zealand College of Anaesthetists and College of Intensive Care Medicine of Australia and New Zealand prior to undertaking road IHT;

• Training for safety and other operational issues will occur on a regular and recurrent basis with due consideration for patient safety, occupational health and safety and infection control issues;

• A designated and appropriately skilled clinician is responsible for the implementation and monitoring of road IHT standards for the critically ill patient;

• Staff undertaking road IHT of critically ill patients have access to transfer equipment which meets the Guidelines for Transport of Critically Ill Patients endorsed by Australasian College for Emergency Medicine, Australian and New Zealand College of Anaesthetists and College of Intensive Care Medicine of Australia and New Zealand;

• Establish a Road Transfer Committee (or equivalent) with representation from relevant stakeholders within the HHS and;

• The HHS Road Transfer Committee (or equivalent) is responsible for clinical audit, safety and oversight of critically ill patient transfer Information from the Adult IHT Chart and disseminate findings to all relevant stakeholders bi-annually.

3.3 Pre transfer requirements

3.3.1 Pre transfer agreement can happen under the following circumstances:

a) The accepting Medical Officer shall obtain approval from the Consultant/SMO/delegate (ED or inpatient) at the accepting facility if required, prior to the patient’s departure from the referring hospital.

OR

b) As determined by Retrieval Services Queensland when urgent critical transfer is required as per the Retrieval services Queensland Use Of Health Service Directive Effective From: 20 December 2016
3.3.2 If the Consultant/SMO at the appropriate receiving unit is subsequently unable to accept the patient, the receiving unit Consultant/SMO shall assist the transferring/referring unit to find an appropriate alternative service.

3.3.3 Critically ill patients undergoing IHT are transferred directly to an appropriate unit, unless the patient is expected to require Emergency Department (ED) treatment. The exception to this principle is patients with undifferentiated conditions.

3.3.4 Incoming IHT patients shall only be treated in the ED under the following circumstances:

a) Accepted by the ED Consultant (or delegate) for specialist emergency care or primary transfer triage.

b) Undifferentiated trauma / critically ill patient requiring emergent assessment.

c) Severely injured / multi system / unstable trauma patients within 24-48 hours of accident, as per local Trauma alert activation procedures where available.

d) If a patient deteriorates in transit or the accompanying health personal believes that emergency department assessment and management is required.

3.3.5 The ED Consultant (or delegate), accepting Medical Officer and accepting Bed Manager shall be notified as soon as possible.

3.3.6 The Consultant/SMO at the referring unit should ensure the patient or decision-maker (if they do not have capacity) and next of kin, are informed as early as possible of the decision to transfer, the reasons for that decision and the patient’s destination. In some circumstances, it may be necessary to obtain consent from the patient or surrogate decision-maker prior to the decision to transfer being made. The Queensland Health Guide to Informed Decision-making in Healthcare can provide additional details on consent requirements.

3.3.7 Any decision to transfer a patient out of the receiving unit to create capacity for the incoming patient should be documented in the medical chart, including the reasons for the transfer, patient risk assessment, consent information and details of the executive contacted for approval of patient transfer out.

3.3.8 The Consultant/SMO (or delegate) of the receiving unit, shall receive a verbal handover of the patient’s clinical status prior to the transfer and
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3.3.9 Transfers of critically ill patients are not to be delayed due to bed availability.

3.3.10 Under no circumstances are clinicians to delay the emergent transfer of an unstable patient in order to complete the IHT request form.

3.4 In-transit requirements

3.4.1 The governance, safety and conduct of the transfer remains the responsibility of the Consultant/SMO authorising the transfer. Redirection of IHT patients from the intended receiving facility for clinical reasons is the responsibility of the transferring Consultant/SMO or escorting clinician conducting the transfer and should only occur based on clinical need.

3.4.2 Health care professionals undertaking road IHT of critically ill patients shall utilise the endorsed statewide Adult IHT Chart for the purpose of standardisation, data collection and audit.

3.5 Post transfer requirements

3.5.1 If the referring facility provides the transfer team, the clinical handover shall occur at the receiving unit which then assumes responsibility for the patient.

3.5.2 If the receiving unit provides the transfer team, the clinical handover shall occur at the referring unit which then assumes responsibility for the patient.

3.5.3 If a transfer is undertaken by a third party i.e. transfer service, the clinical handover shall occur at the receiving unit which then assumes responsibility for the patient.

3.5.4 The health care professionals providing the escort during the road IHT shall complete the Adult IHT Chart and ensure that one copy is retained by the referring unit, one copy be given to the receiving unit to be inserted into the patient’s hospital records.

3.5.5 Any adverse events during transfer must be reported and written clearly in the patient record by the transferring team.

3.5.6 Health care professionals providing the escort during the road IHT of critically ill patients are responsible to report critical incidents and/or adverse events, which occur during a road IHT, utilising the PRIME system.

3.5.7 The HHS Road Transfer Committee shall ensure arrangements exist to support the timely and efficient return of equipment and personnel to the originating hospital.

4. Supporting and related documents

- Hospitals and Health Boards Act 2011
Authorising Health Service Directive

- Patient Centred Emergency Access Health Service Directive
- Retrieval Services Queensland Health Service Directive

Procedures, Guidelines, Protocols

- Protocol for Inter Hospital Transfers of the non time critical patient
- Protocol for Patient Off Stretcher Time (POST)
- Retrieval Services Queensland Activation Flowchart
- Clinical Services Capability Framework for Public and licensed Private Health Facilities version 3.2
- Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney
- Guidelines for Transport Of Critically Ill Patients (2015); College of Intensive Care Medicine of Australia and New Zealand, Australasian College for Emergency Medicine, Australian and New Zealand College of Anaesthetists.
- Queensland Health Guide to Informed Decision-making in Healthcare

5. Definition of Terms

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<th>Term</th>
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| Hospital and Health Services (HHSs)     | From July 1 2012, Hospital and Health Services will be statutory bodies with Hospital and Health Boards, accountable to the local community and the Queensland Parliament. | Health statutory agencies website
| Intra-Service Referral                  | Formalised referral arrangements for the transfer of critically ill patients within the Hospital and Health Services | NSW Health Policy Directive: Critical Care Tertiary Referral Networks and Transfer of Care (Adults) |
| Adverse event                           | Incidents in which harm resulted to a person receiving health care                                  | Australian Institue of Health and Welfare website:                     |
| Bed Flow Manager (or equivalent)        | Accountable for promoting effective and cost efficient management of hospital resources and associated patient flow resources and services within a facility. | Role description Metro North                                           |
7. Approval and Implementation

Protocol Custodian
Healthcare Improvement Unit, Clinical Excellence Division.

Approving Officer:
Deputy Director-General, Clinical Excellence Division.

Approval date: 20 December 2016
Effective from: 20 December 2016

8. Version Control

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