Network Transfer Policy
Including Transfers by Air for Spinal Patients from existing care provider to specialised rehabilitation

1. Introduction:

This policy relates to the transfer of Trauma patients either as:

a) **emergency transfers or**
b) **urgent transfers of critically ill patients (level 2 and 3))**
c) **non-urgent transfers for enhanced care, or the repatriation of patients for continued care nearer to home.**

Primary Transfers

- From scene directly to appropriate level of care facility, usually to MTC or TU.
- Communication to the receiving hospital will be through the Regional Trauma Desk.

Secondary transfer

- From existing care provider to enhanced, specialised or step-down care closer to home / rehabilitation care provider. E.g. TU to MTC, MTC to Specialised Rehabilitation, MTC back to TU,
- From Specialised Rehabilitation onto 'continued care closer to home'.

No critically ill patient will be transferred without first being adequately resuscitated and stabilised.

All relevant parties, including the relatives, must be fully informed that the transfer is taking place.
The transfer of a patient for continued care closer to home should take place within 48 hours of referral/acceptance, therefore transport must be booked in a timely fashion.

For secondary transfers,

- The patient is to be transferred in an appropriately equipped vehicle
- The patient must be accompanied by skilled and competent staff (Medical staff, Nurse Consultant, operating department practitioner, paramedic or Accident and Emergency nurse).
- All accompanying personnel should be familiar with the patient's clinical condition, transfer procedure and associated equipment.

A critically ill patient should be transferred in line with the Midlands Critical Care Networks Transfer policy.

Transfers by Air for Spinal Patients from existing care provider to specialised rehabilitation.

Longer and time critical journeys may require air transport. The decision to move a patient by air should take into consideration all the difficulties currently associated with this mode of transport.

Brittle, unstable patients should not be transferred to specialist rehab centres, i.e. only stable patients should be considered for transfer by land or air.

There is no NICE guidance on this subject, however there is evidence to suggest that where the transfer time is greater than 90 minutes by road, air transport should be considered. The transfer time should include packing note/document check and transfer onto a vacuum mattress.
There is no evidence to support the motion that stable patients with serious injury are more likely to deteriorate during transfers to specialist rehabilitation units by road, so the decision to transfer a patient by air must be carefully considered by the most senior

clinician caring for the patient, in view of the clinical experience of the transfer crew and the equipment available.

(Comparison of helicopter versus ground transport for the interfacility of transport of isolated spinal injury. Foster NA et al The Spine Journal 14 (2014) 1147-1154)

2. Equipment:

- There should be a dedicated set of equipment available for transfer which should be stored near or on the critical care unit or Emergency Department.
- Staff accompanying the patient are responsible for checking the correct functioning of this equipment prior to departure. In particular, there should be sufficient battery power in any monitors and infusion pumps.
- Back-up equipment should be taken on longer journeys.
- A basic box of emergency drugs should also be available. The accompanying doctor should decide what other drugs and fluids, e.g. sedation and inotropes, should be taken in addition

3. Preparation for Transfer:

Meticulous preparation, resuscitation and stabilisation of the patient before transfer is the key to avoiding complications during the journey.

- The transfer personnel should fully familiarise themselves with the patient's history, present condition and treatment up to the point of departure.
- Prior to departure they should make a full clinical assessment to ensure that the patient is ready for transfer.
- In addition, the accompanying personnel should ensure that they are adequately prepared for the journey. Suitable clothing should be worn, refreshments must be available for longer journeys, mobile phones and money should be taken in case of emergency.
- They should also know the precise destination of the patient and have a named contact in the receiving unit.

The team **must** contact the receiving hospital immediately before they set out for confirmation that a bed is still available at the receiving unit.

For enhanced care (TU to MTC) this should be communicated through the Regional Trauma Desk.

4. Monitoring during Transfer:

During transfer, the standard of monitoring should reflect the patient's condition and for critically ill patients this should remain as high as in the Resuscitation room or Critical Care Unit.

- Non-invasive blood pressure measurement suffers from motion artifact and invasive blood pressure monitoring is preferable.
- End tidal carbon dioxide monitoring should be used with all ventilated patients.

5. Paediatric Patients:

The trauma desk should ring **KIDS 0300 200 1100** to arrange any paediatric transfers.
The normal receiving area will be the ED for primary transfers and for children secondary transfers will be to the PICU

Documentation: The network transfer form should always be used to record details of ALL transfers.