



West Midlands Ambulance Service   
NHS Foundation Trust

## **Standard Operating Procedure**

### **'INTER-HOSPITAL TRANSFERS'**

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<b>APPROVED BY:</b>	<b>Air Operations Manager</b>
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## 1. Introduction and scope

- 1.1. This SOP is intended for all personnel involved in the decision-making processes and execution of enhanced inter-hospital transfers involving the West Midlands MERIT and Midlands Air Ambulance (MAA).
- 1.2. There are many reasons why it may be necessary to transfer a patient from one healthcare facility to another, and it is important to consider the precise details when electing to deploy MERIT or MAA for this purpose.
- 1.3. The majority of cases will already be known to the EOC Trauma Desk having identified an on-going incident that requires initial reception at a Trauma Unit. There will however be unexpected requests for transfer to MTC following direct presentation at TU or following under-triage on scene, as well as other non-trauma reasons for inter-hospital transfer
- 1.4. The Trauma Desk will assess and task the MERIT/MAA to any transfers. Any requests for enhanced inter-hospital transfer must be passed to the Trauma Desk.
- 1.5. If the transfer request is accepted by the Trauma Desk, the role of the team changes from MERIT to Enhanced Care Team (ECT) which has significant implications relating to response capability to further major incidents.
- 1.6. The transfer itself must be meticulously planned and executed by appropriately trained and equipped crew in order to provide a safe and stable transfer whilst minimising the impact on the flexibility of the service.
- 1.7. The purpose of this SOP is therefore to provide a structure to aid the decision-making process when a transfer request is presented, provide a systematic planning process for the transfer and to outline the principles behind a safe inter-hospital transfer.
- 1.8. At no time will the duty MERIT platform (day or night) be used for routine inter-hospital transfers, or for MTC-TU transfers, however, other MAA assets may be used for this purpose after suitable permission from the charity.
- 1.9. Patients at a TU will be resuscitated and stabilised prior to transfer.

## 2. Indications for Inter-Hospital Transfer

2.1. A transfer request may be made for the following reasons:

- Social – to allow access to friends and family at a closer facility;
- Reducing care – to move from an acute facility to a rehabilitation facility
- Increasing care – to move from a rehabilitation facility to an acute facility

- Specialist care – to move from an acute facility to a specialist centre
- Operational – to move between similar facilities for operational reasons

## 2.2. The dependency of the patient may be as follows:

- Level 0: a patient in hospital with needs can be met through normal ward care.
- Level 1: a ward patient requiring additional monitoring and clinical interventions e.g. minimum four hourly observations, intermittent intravenous drugs, continuous oxygen therapy.
- Level 2: a high dependency patient requiring invasive or frequent (at least hourly) monitoring, single organ support or other reasons for high level nursing e.g. unstable spinal fractures.
- Level 3: an intensive care patient, requiring multiple continuous infusions, multiple organ support and often intubated and ventilated.
- Level 3+: a highly dependent intensive care patient requiring specialist organ support e.g. intra-aortic balloon pumps.

## 2.3. Other factors that may need to be taken into consideration

- Distance of transfer
- Road obstructions e.g. lengthy roadworks and standing motorway traffic
- Weather considerations

2.4. It is possible that any combination of indications, patient factors and other factors may result in non-acceptance of a request by the Trauma Desk.

## 3. Assessing a request

3.1. If the Trauma Desk is aware that a patient requiring MTC care is being taken to a TU for geographical or immediate medical reasons, the duty MERIT team should be informed immediately.

3.2. If the request is unexpected, an assessment of the time since injury, mechanism of injury, injuries sustained and reason for TU-MTC transfer should be made. Patients will typically be Level 2 or 3 as described above. Advice may be sought from the MERIT duty doctor.

3.3. If there are no other incidents requiring MERIT at that time, the team should mobilise towards the TU.

3.4. Arrangements should also be made by the Trauma Desk to identify a suitable vehicle to affect the transfer. If this is within flying conditions, the aircraft will fulfil this role. If not within flying conditions and the transfer would be concluded before

flying conditions occur, this would be a crewed front-line land ambulance with a minimum ECA/Tech crew.

#### 4. Medical Escorts

- 4.1. Medical escorts are sometimes required to provide an appropriate level of care during the transfer. The carriage of an escort is not to be routine as there is the skill mix within MERIT/MAA to manage patients included within the scope of this SOP. In addition, most medical escorts will not be familiar with advanced transfer care and have unrealistic expectations of what may be achieved in terms of speed, room inside the aircraft / vehicle and equipment that can be carried or used which will tend to complicate the transfer.
- 4.2. Exceptions to this rule will be for complex ITU transfers when there is no critical care trained doctor available, or for complex paediatric transfers when there is no paediatric-trained doctor available.
- 4.3. In this case, an accurate pre-transfer briefing of the escort and provision of appropriate PPE must occur. Hospital doctors are not allowed to transfer in theatre scrubs and clogs.
- 4.4. It must be made clear at the outset that any hospital staff or equipment that is carried will be left at the receiving unit, and there is no obligation for MERIT/MAA to provide a return journey to the sending hospital.
- 4.5. In the case of children under the age of 16, it is permissible (seats allowing) to carry a relative.

#### 5. The Transfer

- 5.1. It is beyond the scope of this SOP to cover every eventuality involved in performing a transfer, but some principles apply to the majority of them. These are outlined below.
- 5.2. Once the decision has been taken to undertake the transfer, the MERIT/MAA platform should prepare for the mission. Generally, this should require little further work other than ensuring monitor batteries, fuel and oxygen are fully replenished/stocked. Attention should be given to preparing invasive monitoring and infusion devices.
- 5.3. Spinal boards should not be used for transporting patients. Wherever possible, use of a scoop stretcher ± vacuum mattress should be considered. Vacuum mattresses provide good support during longer transfers but are prone to failure and should not be relied upon as sole means of spinal support.
- 5.4. Once the vehicle and crew is prepared, the Trauma Desk should be contacted and notification passed to the sending hospital that MERIT/MAA is en route.
- 5.5. On arrival, the crew MUST go to the patient to provide time for a full assessment, handover and switch to the MERIT/MAA monitors and ventilator, if applicable. The patient must NOT be brought to meet the crew at the aircraft/vehicle.

- 5.6. There is very little facility to carry ancillary equipment in terms of weight, space and safety. The Zoll X-series, with invasive monitoring sets pre-prepared, MERIT/MAA syringe drivers and the MERIT/MAA Oxylog 3000 plus ventilator must be used for all transfers.
- 5.7. A full handover must be taken from the sending staff, along with notes, imaging CDs, names of the sending and receiving healthcare professional (SpR level or above) and any relevant results.
- 5.8. The identity of the patient is clearly and accurately designated. Patient identification and allergy bracelets must be in place.
- 5.9. Relatives, and if feasible, the patient, needs to be aware of the nature, timing and destination of a transfer. If it is not possible for this discussion to take place, the reason should be documented in the healthcare record.
- 5.10. In the event that a transfer occurs against the family's wishes, the reasons for overriding their wishes must be documented.
- 5.11. The clinical and legal responsibility for the patient rests with the MERIT/MAA team from the point of handover at the referring hospital until the point of handover at the receiving hospital. It is imperative that a full examination and assessment of the patient occurs. This point may be the first time that a full pre-hospital orientated trauma assessment has occurred and consideration should be made towards identifying and stabilising occult injuries such as pelvic fractures etc. prior to transfer.
- 5.12. Once patient stability has been achieved, handover completed and the receiving hospital contacted to ensure reception is anticipated, the patient can then be escorted to the aircraft / vehicle.
- 5.13. Minimum monitoring standards will be maintained during transfer and be of an equivalent standard to that provided in the referring site.
- 5.14. The care given during the transfer falls within the professional practice of the individual crew, and will not be addressed within this document. The paperwork involved in the transfer will be a standard WMAS EPRF. Transfers are a common source of complaints, and meticulous recording of observations, ideally at 5-minute intervals, is essential.

## 6. Following the transfer

- 6.1. Once the patient has been safely received and handover completed at the destination hospital, it falls to the crew to decide whether they are immediately available for operational duty or need to return to a base for restocking and refuelling.
- 6.2. The Trauma Desk should routinely be informed that the transfer is completed, the team has returned to MERIT service and whether or not there were any untoward incidents.

## 7. Serious untoward incidents

7.1. Any untoward incidents and near misses must be reported via the agreed reporting system.

7.2. The MERIT/MAA governance team will maintain a record of incidents related to transfer and review on a regular basis.