



North of England Critical Care Network

A map of the North of England region is shown in light blue. Overlaid on the map are concentric circles in a light grey color, representing distances from a central point. The circles are labeled with numbers: 15, 30, 45, and 60. Various cities are marked with purple dots and labeled: Carlisle, Whitehaven, Cramlington, Newcastle, Gateshead, Durham, South Shields, Sunderland, Darlington, Stockton, Middlesbrough, and North Merton. The text 'Distances in miles' is written in small letters at the bottom left of the map.

Guidelines for the Safe Interhospital Transfer of the Adult Critical Care Patient

March 17

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NoECCN Transfer Group

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1 Introduction

An interhospital critical care transfer is defined as the secondary transfer of a critically ill patient from any hospital facility (Emergency Department, Critical Care Unit, Ward, Operating Department) to another centre to continue critical care support.

This guideline addresses the interhospital transfer of **adult** critically ill patients. All transfers of paediatric critically ill patients are performed by the newly formed **NECTAR** (North East Children Transfer and Retrieval) service. For information about this service please check Appendix 5.

The decision to transfer any critically ill patient will always be a balance of associated benefits and risk. The decision must always be made by a consultant in intensive care medicine or anaesthesia at the referring hospital, in discussion with consultant colleagues from the receiving hospital. The final decision to accept a patient lies with the critical care consultant in the receiving hospital. Assessment of risks associated with any inter-hospital transfer must benefits of transfer and the timing of transfer will reflect factors such as the need for time-critical interventions.

The consultant in charge of the patient's care should take this decision.

These guidelines for the Safe Interhospital Transfer of the Adult Critically Ill Patient are based on the following recommendations:

- Guidelines for the Transport of the Critically Ill Patient 3rd ed, (2011). Intensive Care Society Standards and Guidelines.
- **Interhospital Transfer (2009)**. Association of Anaesthetists of Great Britain and Ireland.
- Guidelines for the Provision of Intensive Care Services, 1st ed, (2015). The Faculty of Intensive Care Medicine.
- Recommendations for Standards of Monitoring during Anaesthesia and Recovery, (2015). Association of Anaesthetists of Great Britain and Ireland.
- Head Injury: triage, assessment, investigation and early management of head injury in infants, children and adults (CG56 NICE, 2007).

The aims of the document are:

- To provide guidelines for the safe transportation of level 2 and level 3 adult patients
- To minimise adverse events during transport of the critically ill patients
- To ensure that transfers are:
 - Carried out in a safe, timely manner by appropriately trained personnel
 - Only undertaken following optimal pre-transfer stabilisation
 - Supported by clear and effective communication

2 Transferring of Patients

These guidelines do not advocate which patients should or should not be transferred or indeed how this decision is made. However, it is expected as a measure of good practice that all admissions, discharges and transfers are made on a consultant to consultant basis.

The aim of any transfer is safe transport with continuing medical treatment without detrimental effect to the patient (ICS, 2011). Algorithms of safe practice in critical care transfers within a range of contexts have been drawn up highlighting the value of effective communication with the ambulance service (Appendices 1 & 3).

The level of care a patient is receiving (DH, 2000) will inform the extent of transport support required. Level 2 and 3 patients require the level of support as specified in the ICS (Levels of Critical Care for Adult Patients, ICS 2009) guidelines in that these patients are deemed as critically ill.

In all cases the patient and/or next of kin must be promptly informed of the need for transfer.

Transfer of staff should follow the ICS recommendations (Guidelines for the Transport of the Critically Ill Adult Patient, ICS 2011). The precise requirement for accompanying personnel will depend upon the clinical circumstances in each case. The recommendations are summarised in Roles & Responsibilities of transferring staff (Appendix 6). Critically ill patients should be accompanied by a minimum of two attendants:

- A detailed risk assessment to determine the level of risk of the patient should be performed by an experienced clinician prior to the transfer.
- For all level 3 and most level 2 patients one attendant should be a medical practitioner with appropriate training in intensive care medicine, anaesthesia, or other acute specialty. They should be competent in resuscitation, airway care, ventilation and other organ support. They should have had previous experience of transport in a supernumerary capacity, have demonstrated competencies in transport medicine and be familiar with the transport equipment.
- The responsible medical practitioner should be accompanied and assisted by another suitably experienced nurse or practitioner familiar with intensive care procedures and with the transport equipment. In most cases the second attendant will be a nurse with independent professional responsibility towards the patient. Nursing staff should be appropriately qualified and experienced and familiar with the critical care transfer trolley and equipment. Ideally they should hold a post registration qualification in critical care that should have included educational elements on transfer of the critically ill patient. Advanced Life Support (ALS) certification is also useful.
- Some stable level 2 patients may only need to be accompanied by a nurse or practitioner with a paramedic acting as the second attendant
- The ambulance crew is responsible for securing the patient in the trolley and securing the trolley in the ambulance.

The identification of a suitable bed for the transfer of critically ill patients either for clinical upgrade of care or for non-clinical reasons (bed pressures) must follow the process outlined on the algorithms in Appendix 7 for the transferring unit and Appendix 8 for the receiving unit.

Once the bed has been identified and agreed, the transfer of critically ill patients structured approach is as follows:

- The critical care and specialist consultants will refer the patient and confirm the transfer with the critical care and specialist consultants in the receiving hospital.
- The nursing staff will give a verbal summary of the patients' clinical details to the nursing staff at the receiving hospital.
- As soon as the consultant to consultant referrals have been made the patient needs to be prepared for transfer. The transfer preparation checklist must be completed.
- As soon as the patient is ready on the transfer trolley, the nurse in charge should request an ambulance (Refer to Appendix 1 & 3 for adults).
- Please complete an Adult Critical Care Transfer Request Proforma (Appendix 2). Inform NEAS of a critical care transfer using the critical care transfer trolley and request **C2 response** (vehicle will attend within 18 minutes, Appendix 16). A police escort should be arranged at this time if required by the Ambulance Service.
- There is usually no need to request a blue light transfer for critical care patients. Critical care patients benefit from steady transfers with minimum accelerations. Blue lights should be used at the discretion of the crew to get through heavy traffic.
- A suitably trained doctor and nurse, deemed competent in the transfer of critically ill patients, from the transferring hospital, will accompany the patient on the transfer.
- The NoECCN has a list of the Training for Transfer courses in the region suitable for doctors and nurses. Please contact the [NoECCN administration team](#) for details.
- The NoECCN Interhospital transfer chart must be completed during the transfer (Appendix 9).
- On admission to the receiving critical care unit the transferring doctor and nurse will give a formal handover to the receiving team. Please follow the Standard Operating Procedure for Critical Care Handover (Appendix 10).
- Accountability will be transferred to the receiving team when they are satisfied with the handover and signed the transfer chart.
- Full reporting mechanisms must be adhered to. Please complete the [Adult Critical Care Transfer electronic audit form](#).

The NoECCN inter-hospital transfer chart (Appendix 9) should be signed dated and filed in the receiving hospital patient notes. A photocopy should be given to the transfer team for the transfer notes.

From April 2012 there are specific guidelines for the transfer of trauma patients with GCS \leq 13 with time-critical lesions to the Major Trauma Centres (Appendix 11 & 12).

3 Types of transfer

In an agreement between NoECCN and North East Ambulance Services (NEAS), it has been decided that all types of critical care transfer will meet the same level of response as this will best meet the needs of the critical care patients.

Definitions:

- **Clinical Transfers** (upgrade or tertiary referrals)

Clinical transfers are defined as the inter-hospital transportation of patients between hospitals for the purpose of upgrading clinical care and providing specialist services, investigations and interventions that are not available at the host location. Examples include neurosurgical, ENT, renal, liver unit, cardiothoracic and spinal cord injury.

- **Capacity Transfers** (bed/resource pressures)

These transfers occur when there are no available resources to care for the patient in the host hospital and involve transferring a patient to the nearest, appropriate available level 3 bed within the host hospitals predefined Transfer Group (Appendix 14). Following ICS guidelines (2011), the term non-clinical transfer should be avoided and use the term capacity transfer instead. All capacity transfers should be avoided as much as possible and local escalation policies adhered to. This means that the individual hospital critical care escalation plans internal solutions have been explored and activated. In the event of a capacity transfer the critical care consultant will decide which patient is the most suitable to transfer based on sound ethical principles.

- **Repatriation**

When a patient is transferred back to the referring hospital or to a hospital nearer the patient's home address, as soon as a suitable bed there is available.

The accountability of the patient care remains with the transferring team until the transfer is complete, a full handover has been given by the transferring team to the receiving team and the receiving critical care doctor and nurse has accepted responsibility by signing the transfer documentation.

4 Transfer Groups

Each hospital has a predefined **Transfer Group**, which are based upon historical transfers, geography and bed capacity (Appendix 14). For clarity, a **Transfer Group** is: ***“A group of hospitals that serves any individual hospital to which capacity transfers can be made”.***

Transfer of any patient outside of their host hospitals predefined **Transfer Group** for capacity reasons is considered a critical incident by NHS England and must be sanctioned by the Chief Executive (or nominated deputy) of the transferring hospital to ensure that all escalation policies have been followed. These transfers must then be reported to the North of England Critical Care Network using the critical incident form. The NoECCN will in turn inform the appropriate bodies (Area Team and NHS England)

It is recommended that the specialist tertiary beds are not used for capacity transfers *except* to avoid long distance transfers of patients at times of bed shortage. It is expected that all other contingencies are explored prior to this course of action.

Each Independent Sector Organisation should have a service level agreement with a local NHS provider for patients who unexpectedly require critical care (Appendix 24). When a bed is required this critical care unit should be the first port of call. If no beds are available then the same guidelines for sourcing a bed apply as to NHS critical care units and the [Directory of Services](#) should be consulted. Independent sector organisations should adhere to the same standards and guidelines for transfer as the NHS (Independent Health Advisory Service, 2009).

A list of NHS and Independent Hospital within the NoECCN is available in Appendix 23.

5 Network Escalation Plan

The NoECCN Adult Critical Care Escalation Plan (Appendix 16) is the operational process that is referred to when there is a shortage of critical care beds across the Network. The algorithms for the Adult Critical Care Escalation Plan (ACCEP), Paediatric Critical Care Escalation Plan (PCCEP) and the Ethical Framework can be found on the [NoECCN website](#).

6 Critical Care Transfer Trolley

NEAS has provided each level 3 critical care unit with a fully equipped bariatric critical care transfer trolley to facilitate the safe transfer of critically ill patients in compliance with the quality and safety standards set out by CEN and BS EN1789 BS EN 1865. This trolley can safely transport up to 250 Kg (39 stones).

Each FERNO CTSIX-P and FERNO CCT SIX-P bariatric trolley is equipped with:

- 1 Draeger Oxylog® 3000 transport ventilator
- 1 Mindray® monitor with ECG, ETCO₂, Pulse Oximetry, NIBP and invasive pressures.
- 4 Alaris® GH syringe drivers in an Alaris® GH docking station
- 1 Laerdal® suction unit
- Bio-Safe Harness and Straps
- Special folding IV pole
- Flat pressure reducing mattress in black
- A vacuum mattress and pump are supplied with the trolley.

A critical care transfer bag is also supplied with each trolley by NEAS. It is the responsibility of each unit to decide the content of the transfer bag, however a generic content list is available (Appendix 17). This bag fits into the cupboard on the ambulance designed for this purpose and will replace the paramedic bag during the transfer of a critically ill patient.

To coordinate servicing of the trolley NEAS need to have up to date information on the location of the critical care transfer trolley and the contact details of the link person allocated by each hospital to be responsible for each trolley.

The trolley and equipment will be maintained by NEAS (excluding consumables, such as ventilator tubing and ETCO₂ lines). When the trolley needs to be serviced NEAS will arrange a date and time for collection with the link person designated by the critical care unit. The trolley will be replaced with an identical trolley.

If any of the transfer equipment is missing from the trolley when the NEAS maintenance team comes to collect it they will not take the trolley or leave a replacement trolley until all the equipment is back in place.

In order to facilitate the servicing and tracking of equipment by NEAS all items are marked or numbered. It is imperative that equipment is not swapped between trolleys as this makes the servicing and tracking of equipment more difficult and could lead to critical incidents.

Any problems with the trolley or equipment should be reported immediately to NEAS on **0191 566 4326** during office hours or to Ambulance Control on **0191 4143144** out of hours (after 5pm and at weekends). NEAS will arrange for the trolley to be replaced.

It is expected that daily safety checks to ensure the equipment is fully charged and functional will be carried out as specified by the manufacturers. This will ensure problems are dealt with in a timely manner. An example checklist has been added as Appendix 18 and is also available at [NoECCN website](#).

The transfer trolley and the transfer bag must be checked after every use and weekly as a minimum standard. The unit should keep a record of who and when these checks have been done.

Guidance on cleaning the trolley between patients is included as Appendix 19.

Operational flowcharts guiding the use of the bariatric trolley for the NHS hospitals and for Independent Sector Organisations are available in Appendices 1 -4.

The operational flowchart for the retrieval of critically ill children by NECTAR is available in Appendix 5.

7 Helicopter and Fixed Wing Airplane transfers

This North of England Critical Care Network guidance does not include advice for transferring critically ill patients by either helicopter or fixed wing aeroplanes. Individual Trusts will need to risk assess these types of transfers for their staff and patients and contract a suitable service when needed.

To help with the decision of considering these methods of transportation please read the following points.

There are a number of important factors to consider before deciding on transferring a patient by air. Due to the speed of the vehicles, air support should be considered for longer distance transfers, typically where the anticipated length of transfer is over an hour. Weather does have implications for air vehicles (in particular fog) and in situations of severe weather the advice of the air support unit should be sought to see if air transit is feasible. Most air transfers currently occur in daylight hours although it is possible to transfer by helicopter at night between hospitals with lit helipads.

The Great North Air Ambulance has a dedicated transfer line **07554453496** that is manned 24 hours a day. Please refer to the flowchart in Appendix 20.

The transfer of patients by air presents medical escorts with many problems unique to this mode of transport therefore staff involved must have a high level of expertise, specialist knowledge and practical training. Staff without this training should not take part in aero medical transfers. Minimum requirements include safety training, evacuation procedures for the aircraft and basic on board communication (this is particularly relevant in helicopters). Training should also include the special physical, physiological and psychological stresses associated with flying as well as detailed knowledge of how medical conditions can be affected by this environment and the necessary precautions to facilitate a safe transfer (ICS, 2011).

In all cases of transfer of an adult patient the Great North Air Ambulance will provide the transferring team which avoids many of these issues. In the case of paediatric transfers NECTAR services will provide trained staff for transfer.

Equipment used in the transfer of patients by air must not interfere with the flight instruments in the cockpit. Equipment must therefore be fit for this purpose and only equipment, which has been specifically approved, can be used on an air transfer. A selection of critical care equipment is carried as standard on the aircraft (pumps, ventilator, etc).

The critical care transfer trolleys will not fit into the tracking used on the floor in the aircraft and they are too high for the height space available. The aircrafts own stretcher must be used.

There are a number of contraindications to transfer by air. In general if a patient is not stable enough to transfer by ground they will be inappropriate to transfer by air. All patients should be discussed in full with air support prior to transfer to ensure there are no contraindications to flight.

The financial agreements for aero medical transfers need to be agreed in each Trust. A member of the Trust Board may have to sanction aero medical transfers because of the additional costs. The appropriate level of insurance cover for medical and nursing staff taking part in aero medical transfers should also be explored.

8 Audit and Transfer Critical Incidents

It is recommended to audit all critical care transfers. The North of England Critical Care Network has an electronic audit that can be access from the following [link](#) or via the [NoECCN website](#). Please note that at present the password is **north**. Check with network administrator if any problems accessing the online form. All transfers should be documented by the transferring team using this system.

The inter-hospital transfer record (Appendix 9) provides a contemporaneous record of the transfer and should form part of the patient notes. A photocopy should be taken at the receiving hospital for the transfer team to place in the host unit notes.

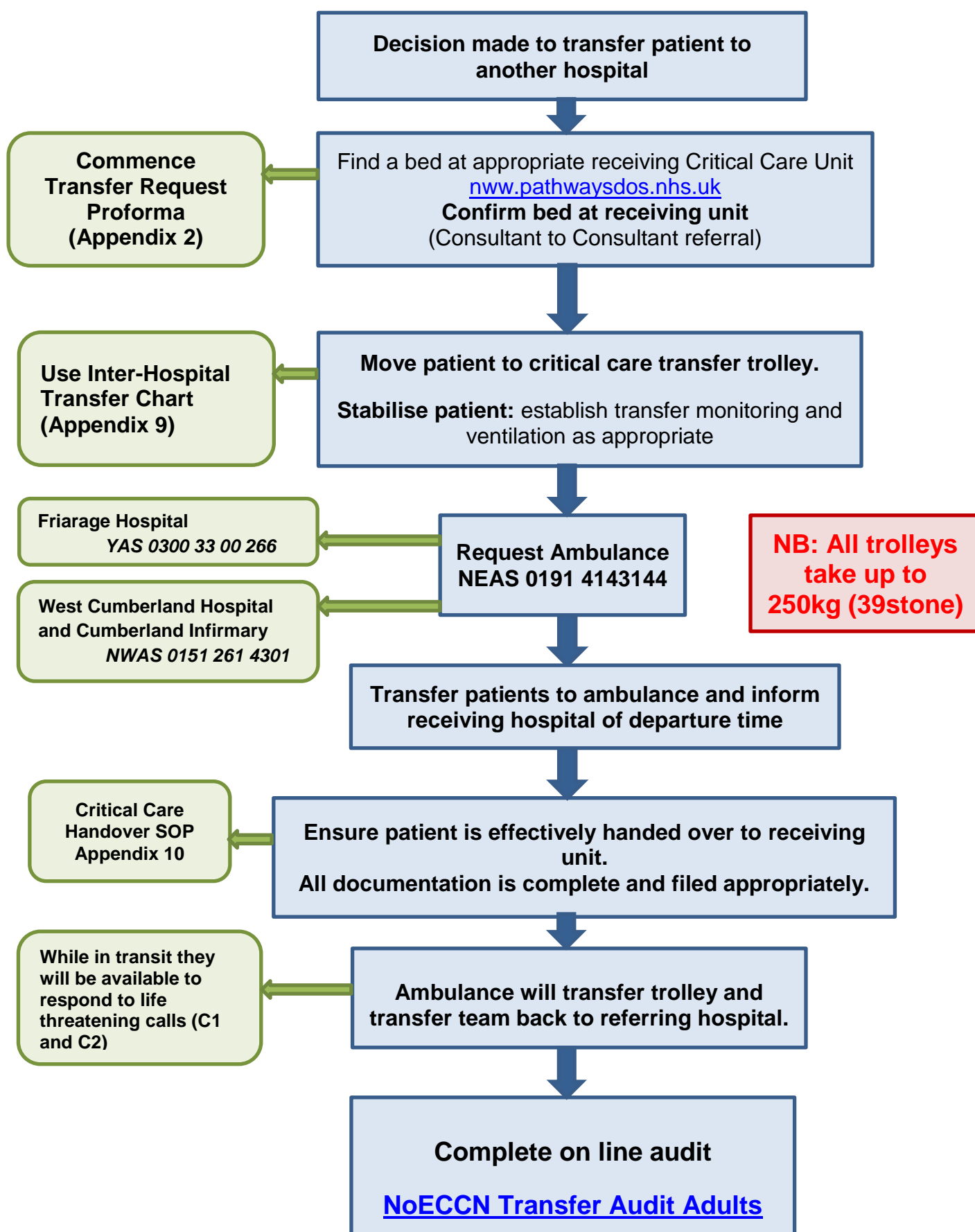
All untoward incidents that occur during a critical care patient transfer should be reported to the NoECCN office by email using the [NoECCN Critical Incident Form](#) within 24 hours in order that an investigation of the circumstances surrounding the incident can be undertaken (Appendix 21 & 22).

The North of England Critical Care Network Management of Transfer-related Critical Incidents Standard Operating Procedure is available as a separate document. This document can be found on the [NoECCN website](#).

The NoECCN will keep a registry of all critical incidents related to interhospital transfers of critical care patients, the investigations performed and the outcome and actions taken. Lessons learnt will be shared with all the leads from the critical care units of the NoECCN.

The NoECCN will produce regular reports from the auditing of critical care transfers and critical incidents. The reports will be available on the [NoECCN website](#) and on request.

Appendix 1 - Adult Critical Care Transfers for NHS Hospitals Flowchart



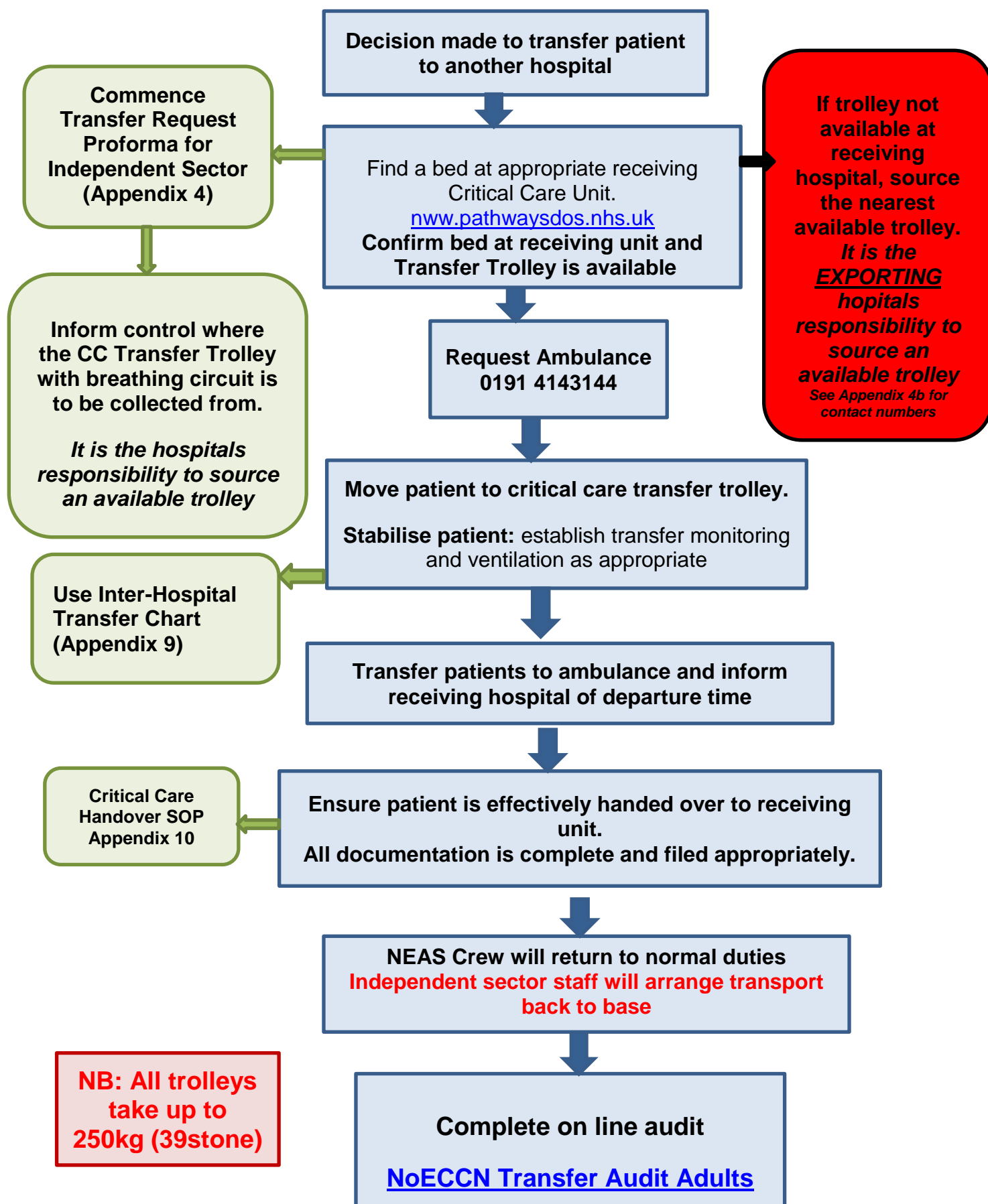
Appendix 2 - Adult Critical Care Transfers for NHS Hospitals Request Proforma



Adult Critical Care C2 Transfer Request Proforma	
Patient name	
Patient Number	
Consultant Requesting transfer	
Identify and confirm bed with receiving hospital and receiving Consultant	
Hospital:	
Unit:	
Consultant:	
When the patient is stable on the transfer trolley inform NEAS that you need a Critical Care transfer:	
0191 4143144	
"This is a Critical Care Transfer using the Transfer Trolley requiring a C2 response.	
A paramedic crew is not required"	
Dispatch NEAS job number:	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Referring Department	
Picking up point	
Receiving Hospital	
Receiving Department	
Name of Patient	
Principle diagnosis	
Who is accompanying the patient.	
How much Oxygen is required	
Ambulance Arrived:	Time:
Ambulance Delayed – Follow-up Calls	
Time:	
Person Requesting Ambulance	Name:
Speak to Duty Manager	Name:
Problem - ETA	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Problem - ETA	

NoECCN Transfer Group 24/10/17

Appendix 3 - Adult Critical Care Transfer for Independent Sector Flowchart



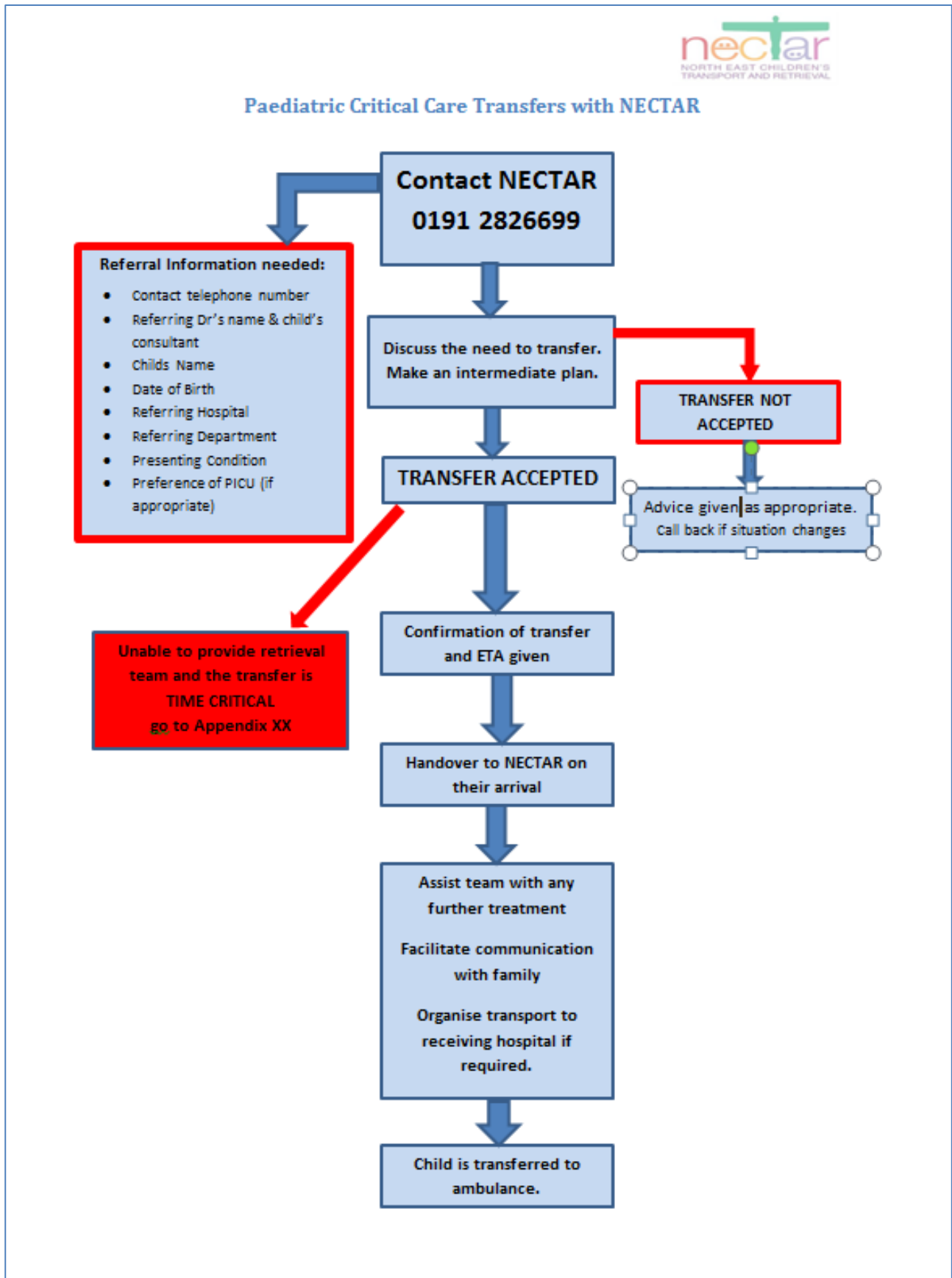
Appendix 4a - Adult Critical Care Transfer for Independent Sector Request Proforma

Adult Critical Care C2 Transfer Request Proforma- Independent Sector	
Patient name	
Patient Number	
Consultant Requesting transfer	
Identify and confirm bed and transfer trolley available with receiving hospital and receiving Consultant	
Hospital:	
Unit:	
Consultant:	
<p>"This is a Critical Care Transfer you will need to collect a Critical Care Transfer Trolley and Breathing Circuit from – <u>identify hospital</u>. A paramedic crew is not required"</p> <p>0191 4143144</p>	
Dispatch NEAS job number:	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Referring Department	
Picking up point	
Receiving Hospital	
Receiving Department	
Name of Patient	
Principle diagnosis	
Who is accompanying the patient.	
How much Oxygen is required	
Ambulance Arrived:	Time:
Ambulance Delayed – Follow-up Calls	
Time:	
Person Requesting Ambulance	Name:
Speak to Duty Manager	Name:
Problem - ETA	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Problem - ETA	

Appendix 4b – Contact Numbers for Units with a Critical Care Transfer Trolley

Trust & Hospital	Unit Type	Direct Line
North Cumbria Acute Hospitals NHS Trust		
West Cumberland Hospital	ICU/HDU	01946 523 443
Cumberland Infirmary	ICU/HDU	01228 814 114
Newcastle Upon Tyne Hospitals NHS Foundation Trust		
Freeman Hospital	Ward 21 Cardio ICU	0191 223 1015
	Wd 37 Combined ICU/HDU	0191 223 1176
Royal Victoria Infirmary	Ward 38 General ICU/HDU	0191 282 4616
	Ward 18 Neuro ICU/HDU	0191 282 1788
Northumbria Healthcare NHS Foundation Trust		
Northumbria Specialist Emergency Care Hospital (NSECH)	Combined ICU/HDU	0191 6072513/ 0191 6072511
South Tyneside NHS Foundation Trust		
South Tyneside General Hospital	Combined ICU/HDU	0191 404 1030
City Hospitals Sunderland NHS Foundation Trust		
Sunderland Royal Hospital	Combined ICU/HDU	0191 541 0238
Gateshead Healthcare NHS Foundation Trust		
Queen Elizabeth Hospital	Combined ICU/HDU	0191 445 2007
County Durham & Darlington NHS Foundation Trust		
University Hospital of North Durham	Combined ICU/HDU	0191 333 2019
Darlington Memorial Hospital	Combined ICU/HDU	01325 743212
North Tees & Hartlepool NHS Foundation Trust		
University Hospital of North Tees	Combined ICU/HDU	01642 624 562
South Tees NHS Foundation Trust		
James Cook University Hospital	ICU2/3 General ICU	01642 282 680 / 01642 854 539
	Cardio ICU	01642 282 676
Friarage Hospital, Northallerton	Combined ICU/HDU	01609 764 011

Appendix 5 - Paediatric Critical Care Transfers NECTAR



Appendix 6 - Roles and Responsibilities for Critical Care Transfers

Roles and Responsibilities for Critical Care Transfers

Referring Critical Care Consultant

- To give comprehensive verbal handover to the receiving critical care consultant
- Ensure accompanying doctor is familiar with the patient's condition and history and suitably trained
- Ensure written documentation is completed
- Maintain full responsibility for the patient until handover has been complete at the receiving hospital.

Referring Specialist Consultant

- To give comprehensive verbal handover to the receiving specialist consultant
- Ensure written documentation is complete

Nurse Lead on Transferring Unit

- To find an appropriate bed to transfer to
- To organise transfer
- Ensure accompanying nurse is familiar with the patient's condition and history and is suitably trained
- Ensure all written documentation is complete
- Telephone the receiving unit when the patient is leaving

Transferring Team (Doctor and Nurse)

- Maintain continuation of medical and nursing treatments and cares throughout the transfer
- Ensure all equipment required for transfer is available and in full working order
- Complete transfer documentation throughout the transfer
- Give a full and comprehensive handover to the receiving team
- Take appropriate part of transfer form place in the patients' notes at the transferring hospital
- Complete the online audit at the destination hospital once the patient is handover over

Ambulance Crew

- To provide a safe, appropriate transfer of patient and staff from the transferring to receiving hospital
- Ensure requested equipment/gases are available within the vehicle
- Ensure that ambulance is fully stocked with functional, standard equipment
- Return the trolley and transferring team to the referring hospital

Receiving Critical Care Medical staff

- Accept referral and verbal handover from referring critical care consultant
- Accept full responsibility for the patient following handover from the transferring doctor
- Sign transfer form including any appropriate comments

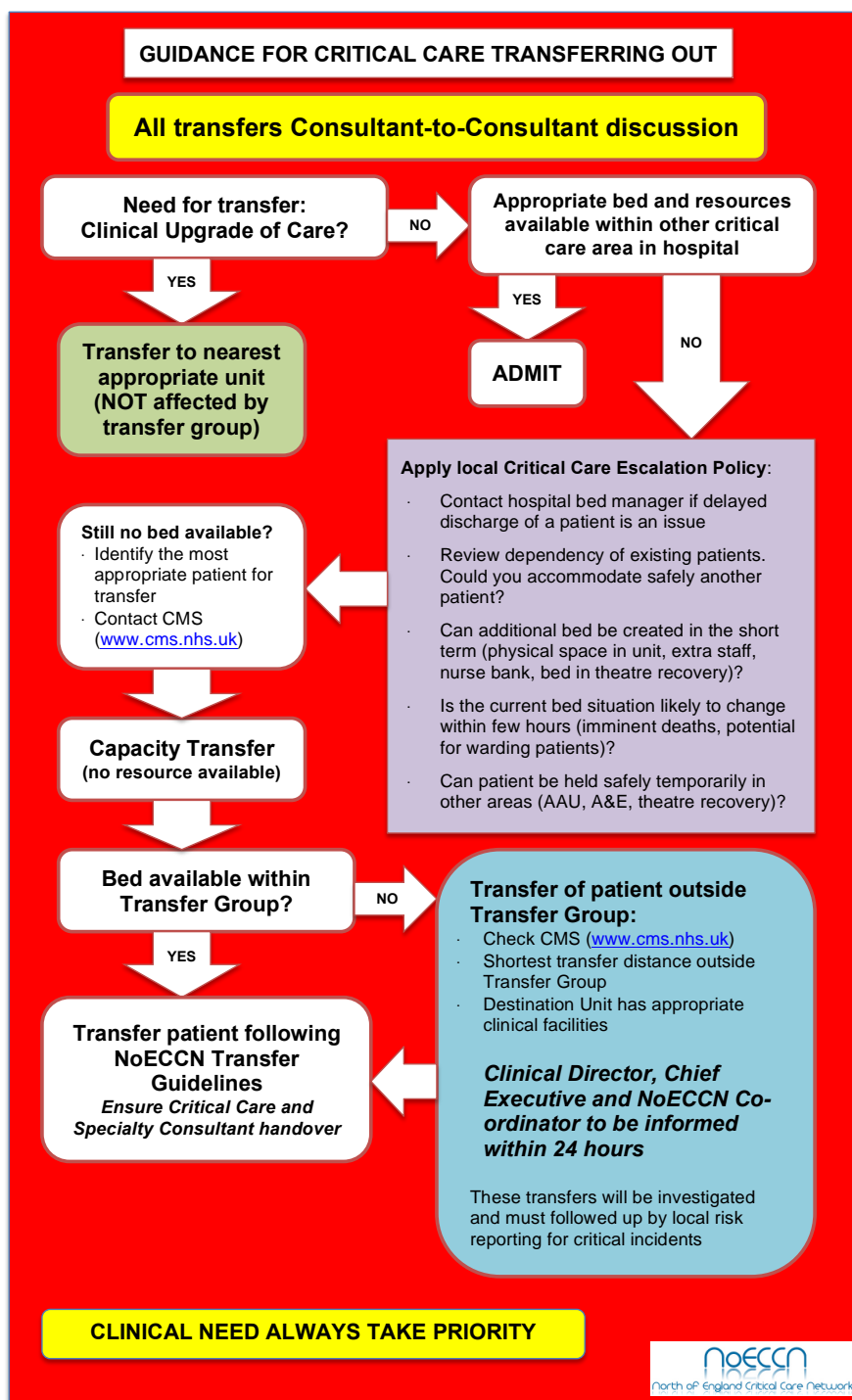
Receiving Specialist Consultant

- Accept referral and verbal handover from referring specialist consultant
- Visit and assess the patient as soon as possible following the transfer

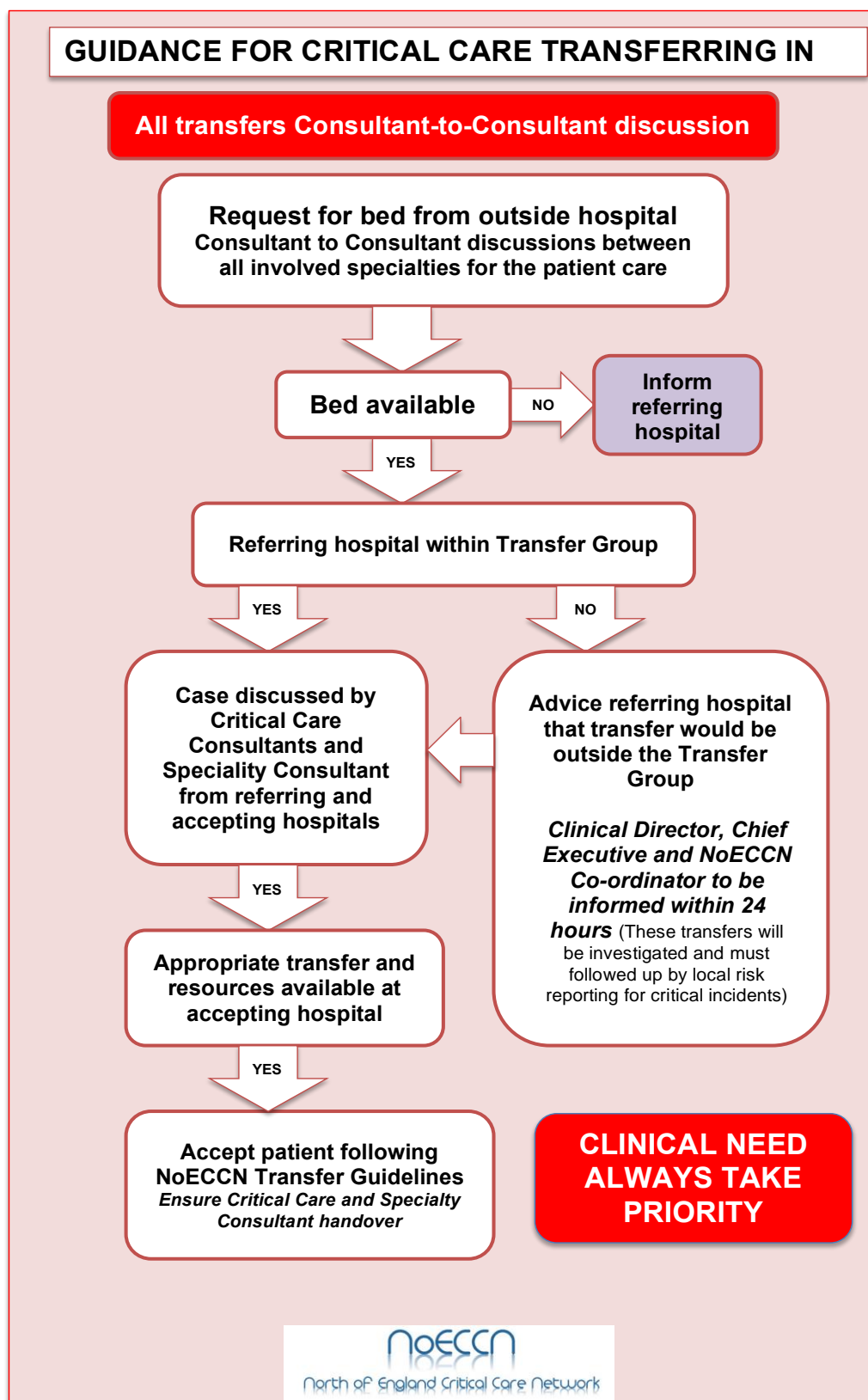
Receiving Nurse

- Accept full nursing responsibility for the patient following handover from the transferring nurse


Appendix 7 - Guidance for transferring out (TRANSFERRING UNIT)



Appendix 8 - Guidance for transferring in (RECEIVING UNIT)



Appendix 9 - Interhospital and Intrahospital Transfer Chart

INTERHOSPITAL AND INTRAHOSPITAL TRANSFER RECORD						 North of England Critical Care Network	
DATE		TIME		PATIENT DETAILS (Attach sticker)			
TRANSFERRING UNIT				Name		Age	
RECIPIENT UNIT				D.O.B.			
TRANSFER TEAM STAFF				ID Number		Sex M / F	
PRE-TRANSFER ASSESSMENT				INVESTIGATIONS			
History / Examination <div style="float:right;">Admission date / /</div> Trauma: Yes / No If yes, C-spine protection: Yes / No GCS prior to intubation / 15 Pupils R reactive / non-reactive, size.....mm L reactive / non-reactive, size.....mm Transferred from: <input type="checkbox"/> ICU <input type="checkbox"/> Ward <input type="checkbox"/> A&E <input type="checkbox"/> Theatre <input type="checkbox"/> Other..... Reason for transfer: <input type="checkbox"/> Upgrade care <input type="checkbox"/> Repatriation <input type="checkbox"/> No bed available unstaffed <input type="checkbox"/> No bed available full				Hb WCC Platelets PT APTT Fib Na Ur K Cr pH PaO ₂ PaCO ₂ HCO ₃ BXS Lactate ECG C-spine XR CXR Pelvis XR Special investigations			
CURRENT MEDICATIONS				ALLERGIES			
PRE-TRANSFER CHECKLIST							
Airway / Breathing <input type="checkbox"/> Airway safe or secured by intubation <input type="checkbox"/> Tracheal tube position confirmed on chest X-ray <input type="checkbox"/> Work of breathing acceptable <input type="checkbox"/> Patient improving or stable and not tiring <input type="checkbox"/> Adequate gas exchange confirmed on arterial blood gas <input type="checkbox"/> Head up tilt 15° – if not spinal cord injury Ventilated patients <input type="checkbox"/> Paralysed, sedated and ventilated plus analgesia <input type="checkbox"/> Ventilation established on transport ventilator <input type="checkbox"/> Adequate gas exchange confirmed on arterial blood gas <input type="checkbox"/> PaO ₂ > 13 kPa, SpO ₂ > 95%, PaCO ₂ 4.0-4.5 kPa Circulation <input type="checkbox"/> Circulating blood volume restored – remember empty patients travel badly! <input type="checkbox"/> Heart rate (HR < 120) and BP stable <input type="checkbox"/> Tissue and organ perfusion adequate <input type="checkbox"/> Capillary refill < 2 secs <input type="checkbox"/> Any obvious blood loss controlled <input type="checkbox"/> Haemoglobin adequate <input type="checkbox"/> Minimum of two routes of large bore venous access <input type="checkbox"/> Arterial line and central venous access if appropriate <input type="checkbox"/> Blood products available – to be sent with patient? Neurology <input type="checkbox"/> GCS (trend), pupillary responses, focal signs recorded <input type="checkbox"/> Seizures controlled, metabolic causes excluded <input type="checkbox"/> Raised intracranial pressure appropriately managed				Trauma <input type="checkbox"/> Cervical spine protected <input type="checkbox"/> Pneumothoraces drained <input type="checkbox"/> Intra-thoracic and intra-abdominal bleeding controlled <input type="checkbox"/> Intra-abdominal injuries adequately investigated and appropriately managed <input type="checkbox"/> Long bone/pelvic fractures stabilised Monitoring <input type="checkbox"/> ECG, Blood pressure (IABP gold standard), SpO ₂ <input type="checkbox"/> EtCO ₂ <input type="checkbox"/> Temperature <input type="checkbox"/> Oxygen calculation – twice anticipated need! <input type="checkbox"/> Infusions calculation – twice anticipated need! Metabolic <input type="checkbox"/> Blood glucose > 4mmol/l <input type="checkbox"/> Potassium < 6 mmol/l <input type="checkbox"/> Ionised calcium > 1.0 mmol/l <input type="checkbox"/> Acid-base balance acceptable <input type="checkbox"/> Temperature maintained Documentation / Communication <input type="checkbox"/> Recipient hospital consultant (plus specialty consultant) aware and accepted – bed available! <input type="checkbox"/> Case notes, X-rays, results, blood collected <input type="checkbox"/> Transfer letter written and documentation prepared <input type="checkbox"/> Transfer bag <input type="checkbox"/> Ambulance Service informed – give 20 minute warning! <input type="checkbox"/> Relatives informed			

NoECCN Critical Care Transfer Guidelines v 2.2 (October 2017)

Appendix 10 - Critical Care Handover Standard Operating Procedure

Standard Operating Procedure – Critical Care Handover

?

1. Prepare for transfer

- Use transfer checklist and over

?

2. Arrive on Critical Care

- Request presence of critical care doctor

?

3. Anaesthetist and nurse establish ventilation

- Connect capnography, ECG, pulse oximeter
- Assess sedation and administer if necessary

?

4. Team introductions

Team members introduce themselves

- Anaesthetist
- Critical care nurse
- Emergency department nurse
- Critical care bedside nurse
- Critical care doctor
- Critical care nurse
- Critical care nurse in charge, if available
- Critical care consultant, if available

?

5. Verbal handover

- Anaesthetist handover – use form overleaf
- Nurse handover
- Anaesthetist to assign roles for transfer

?

6. Transfer patient

- Critical care / Anaesthetist – lead and manage airway
- Nurses – monitoring, patient slide and equipment
- Critical care nurse to change arterial line transducer

?

7. Anaesthetist and Critical Care Doctor review observations

- Re-assess ABCDE, ensure stable before leaving

?

?

NoECCN / SOP Handover Checklist

TRANSFER CHECKLIST/HANDOVER

Airway

ETT

Intubation grade

Indication for intubation

Breathing

FiO₂

Ventilator settings

CXR

ABG

Circulation

Access

Fluids/output

CV support/inotropes

Disability/Drugs

GCS and pupils

Glucose/temperature

Antibiotics

Insulin/infusions

Exposure/Equipment

Infusions labelled

Log roll

Drains

Other

Date of admission:

Date of transfer:

Patient details

Affix sticker

Patient

PMH

Medication

Allergies

Problem

PC/IPC

Diagnosis

Examination/key findings

Investigation results

Critical incidents

Plan

Surgical

LMWH/UFH

Antibiotics

Drains

Feeding

Family aware

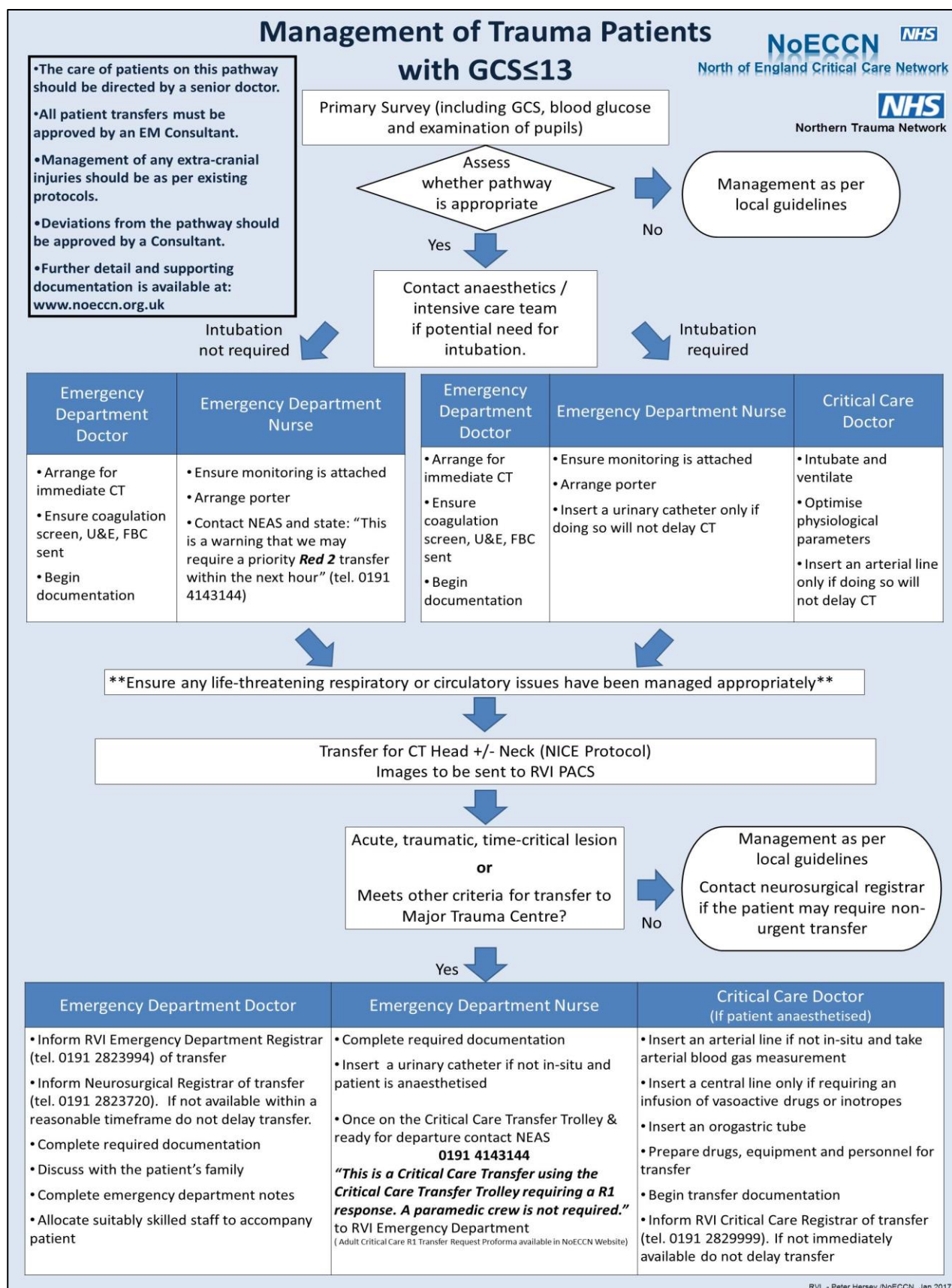
Outstanding issues

Targets MAP \geq 65 mmHg UO \geq 0.5 ml/kg/h PaO₂ \geq 100 mmHg PaCO₂ \leq 45 mmHg

Consultant critical care _____ Parent speciality consultant _____

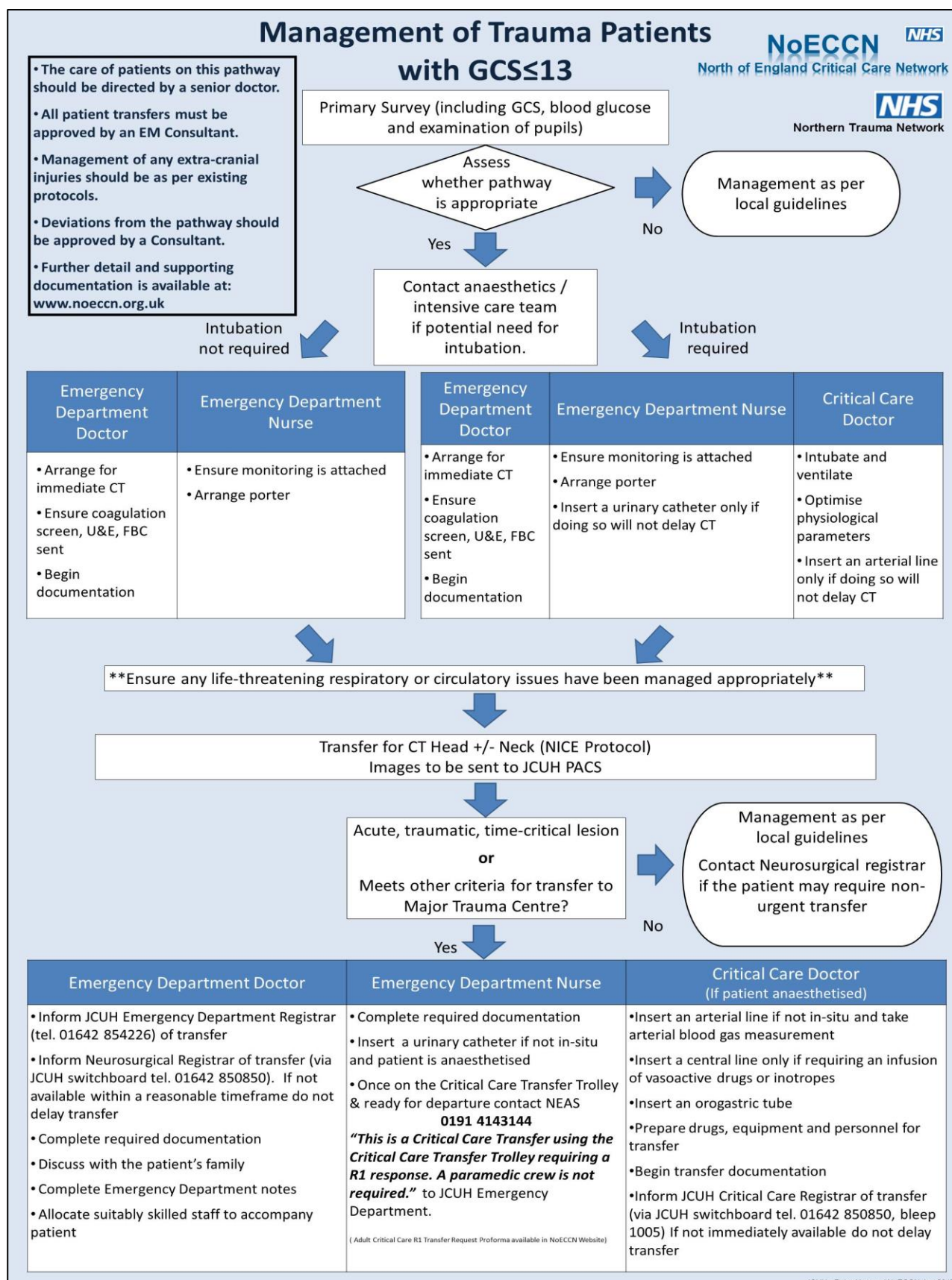
NoECCN SOP Handover Checklist

Appendix 11 - Management of Trauma Patients with GCS≤13 (RVI)



(This chart can be downloaded from www.noeccn.org.uk as pdf)

Appendix 12 - Management of Trauma Patients with GCS≤13 (JCUH)



(This chart can be downloaded from www.noeccn.org.uk as pdf)

Appendix 13 - NEAS category of transfers

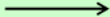
National Ambulance Response Programme

	Average response time	Access by calling
Category 1 is an immediate response to a life threatening condition. It should only be used for a patient who requires resuscitation or emergency intervention from the ambulance service, for example cardiac or respiratory arrest. Mortality rates are high where a difference of one minute in response time is likely to affect outcome and there is evidence to support the fastest response.	7 minutes	999
Category 2 is for serious condition, for example stroke or chest pain, that may require rapid assessment and/or urgent transport. Mortality rates are lower; a difference of an extra 15 minutes response time is unlikely to affect outcome and there is evidence to support early dispatch.	18 minutes	999
Category 3 is for urgent problems, for example uncomplicated diabetic that needs treatment and transport to an acute setting. Mortality rates are very low or zero; there is evidence to support alternative pathways of care.	At least 9 out of 10 times within 120 minutes	999
Category 4 is for a problem that is not urgent, for example all stable clinical cases including dermatology, gynaecology, ENT, neurology etc, and requires transportation to a hospital ward or clinic within 1, 2 or 4 hours (GP to confirm).	At least 9 out of 10 times within 180 minutes	999

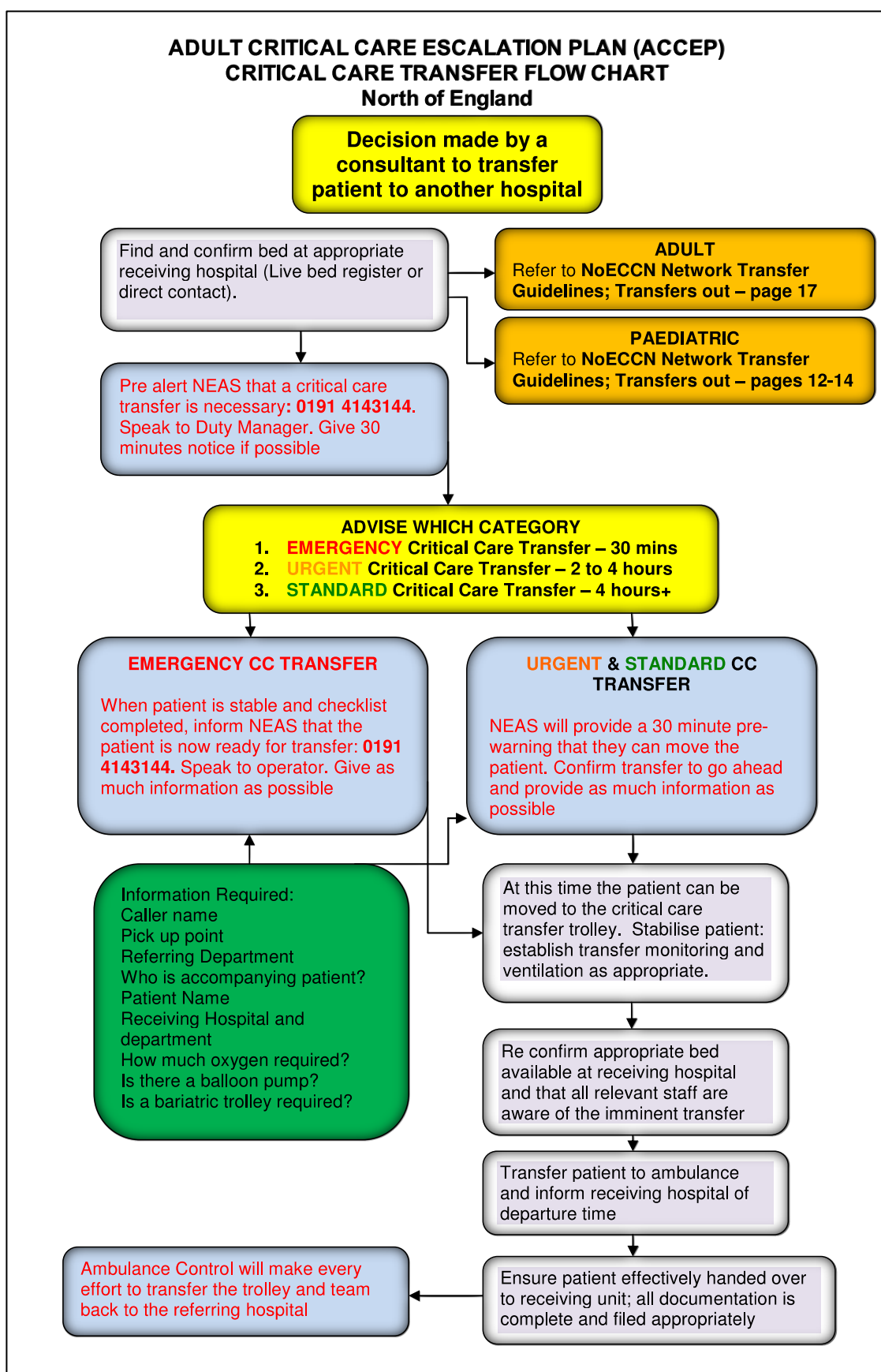
Appendix 14 - Transfer Groups and contact information (NHS)

Transferring Hospital	Receiving Hospital													
	Royal Victoria Infirmary NE1 4LP	Freeman Hospital NE7 7DN	Sunderland Royal Hospital SR4 7TP	South Tyneside General Hospital NE34 0PL	Queen Elizabeth Hospital NE9 6SX	Northumbria Specialist Emergency Care Hospital (NSECH) NE23 6NZ	Cumberland Infirmary CA2 7HY	West Cumberland Hospital CA28 8JG	University Hospital of North Durham DH1 5TW	Darlington Memorial Hospital DL3 6HX	James Cook University Hospital TS4 3BW	Friarage Hospital DL6 1JG	University Hospital of North Tees TS19 8PE	
Royal Victoria Infirmary 0191 2824616		3	14	11	5	21	59	98	19	38	43	58	38	NON CLINICAL TRANSFER GROUPS
Freeman Hospital 0191 2231014	3		16	12	6	15	62	100	21	40	46	61	40	<u>Friarage Hospital</u>
Sunderland Royal Hospital 0191 5699745	14	16		8	12	27	73	111	13	31	34	49	28	Harrogate District General = 37 miles
South Tyneside General Hospital 0191 4041030	11	12	8		8	21	70	109	17	37	40	55	34	York District Hospital = 35 miles
Queen Elizabeth Hospital 0191 4452007	5	6	12	8		23	66	104	14	33	41	56	32	
Northumbria Specialist Emergency Care Hospital (NSECH) 0191 6072011	12	7	19	13	12		69	110	26	46	47	63	42.6	<u>Cumberland Infirmary</u>
Cumberland Infirmary 01228 814114	59	62	73	70	66	74		39	70	80	100	89	93	Dunfries and Galloway = 34 miles
West Cumberland Hospital 01946 523443	98	100	111	109	104	113	39		109	104	121	113	115	
University Hospital of North Durham 0191 3332019	19	21	13	17	14	37	70	109		22	32	49	22	
Darlington Memorial Hospital 01325 743212	38	40	31	37	33	54	80	104	22		19	17	14	<u>West Cumberland</u>
James Cook University Hospital 01642 202680	43	46	34	40	41	56	98	121	34	19		23	11	Dunfries and Galloway = 72 miles
Friarage Hospital 01609 764011	59	61	49	55	56	71	89	113	49	17	23		26	Furness General Hospital = 49 miles
University Hospital of North Tees 01342 624562	38	40	29	34	32	51	93	115	22	14	11	26		

Appendix 15 - Transfer Groups and contact information (Independent Sector)

Transferring Hospital	Receiving Hospital													INDEPENDENT SECTOR TRANSFER GROUPS
	Royal Victoria Infirmary NE1 4LP	Freeman Hospital NE7 7DN	Sunderland Royal Hospital SR4 7TP	South Tyneside General Hospital NE34 0PL	Queen Elizabeth Hospital NE9 6SX	Northumbria Specialist Emergency Care Hospital (NSECH) NE23 6NZ	Cumberland Infirmary CA2 7HY	West Cumberland Hospital CA28 8JG	University Hospital of North Durham DH1 5TW	Darlington Memorial Hospital DL3 6HX	James Cook University Hospital TS4 3BW	Friarage Hospital DL6 1JG	University Hospital of North Tees TS19 8PE	
Green boxes indicates transfer group reading on direction of arrow 														
Royal Victoria Infirmary 0191 2824616		3	14	11	5	21	59	98	19	38	43	58	38	<u>Friarage Hospital</u>
Freeman Hospital 0191 2231014	3		16	12	6	15	62	100	21	40	46	61	40	Harrogate District General = 37 miles
Nuffield Hospital Jesmond 0191 2816131	2	2	14	11	4	8			20	38	43	58	38	York District Hospital = 35 miles
Sunderland Royal Hospital 0191 5699745	14	16		8	12	27	73	111	13	31	34	49	28	
South Tyneside General Hospital 0191 4041030	11	12	8		8	21	70	109	17	37	40	55	34	
Queen Elizabeth Hospital 0191 4452007	5	6	12	8		23	66	104	14	33	41	56	32	
Spire Healthcare Washington 0191 4151272	12	13	10	10	5	21			8	28	37	52	27	
Northumbria Specialist Emergency Care Hospital (NSECH) 0191 6072011	12	7	19	13	12		69	110	26	46	47	63	42.6	<u>Cumberland Infirmary</u>
Colbalt Hospital North Tyneside 0191 2703250	9	8	15	9	11	6			24	43	47	29	39	<u>Dunfries and Galloway = 34miles</u>
Cumberland Infirmary 01228 814114	59	62	73	70	66	74		39	70	80	100	89	93	
West Cumberland Hospital 01946 523443	98	100	111	109	104	113	39		109	104	121	113	115	
University Hospital of North Durham 0191 3332019	19	21	13	17	14	37	70	109		22	32	49	22	
Darlington Memorial Hospital 01325 743212	38	40	31	37	33	54	80	104	22	x	19	17	14	<u>West Cumberland</u>
Woodlands Hospital Darlington 01325 341700	38	42	32	39	34	50			22	3	17		11	Dunfries and Galloway = 72 miles
James Cook University Hospital 01642 202680	43	46	34	40	41	56	98	121	34	19		23	11	Furness General Hospital = 49 miles
Ramsey Healthcare Middlesborough 01642 737855	41	44	32	37	38	43			31	17	3		17	8
Friarage Hospital 01609 764011	59	61	49	55	56	71	89	113	49	17	23		26	
The Hawthorns, Peterlee 0191 5871251	24	27	15	20	21	28			20	32	23		17	
Cleveland Nuffield Stockton 01642 360100	37	39	27	33	34	47			23	14	9		2	
University Hospital of North Tees 01342 624562	38	40	29	34	32	51	93	115	22	14	11	26		



Appendix 16 - Critical Care Transfer: Adult Critical Care Escalation chart



Appendix 17 - Suggested contents of transfer bag

Advanced Airway	Breathing Pocket	Circulation Pocket
1 x ETT 6	1 x LMA/Igel size 3	2 x IV cannula size 14G
1 x ETT 7	1 x LMA/Igel size 4	2 x IV cannula size 16G
1 x ETT 8	1 x LMA/Igel size 5	2 x IV cannula size 18G
2 x Laryngoscopes handles and batteries	1 x HME filter	2 x IV cannula size 20G
1 x Laryngoscope Blades 3	1 x Catheter Mount	2 x IV cannula size 22G
1 x Laryngoscope Blades 4	1 x C-circuit	5 x non sterile gloves
1 x Elastoplast	1 x Stethoscope	4 x 20 ml syringes
1 x Magill Forceps	1 x Wave form Capnography line	4 x 50 ml syringes
2 x Lubricating gels	1 x Green anaesthetic Face mask	4 x 10ml syringe
1 x Gum elastic bougie	1 x Orange anaesthetic Face mask	10 x chloraprep skin wipes
1 x Scalpel size 10	1 x colorimetric CO ₂	1 x infusion giving set
1 x 10 ml syringe	Suction Pocket	1 x micropore tape
1 x FONA pack	2 x Yankauer suckers	4 x gauze
1 x Scissors	2 x 14F suction catheters	4 x cannula dressings
Self ventilating pocket	2 x 12F suction catheters	12 x ECG electrodes
1 x Guedel Green		10 x Sodium chloride flushes
1 x Guedel Orange	External Pocket	5 x Obturators
1 x Guedel Red	1x Self inflating Ambu bag and mask	4 x Drug labels
1 x NP airway size 6	Inside pouch on side of bag	Interventional circulation
1 x NP airway size 7	1 x fluid 500ml	5 x Green/drawing up needles
1 x Non rebreathe mask size 5		2 x Tourniquets
1 x Oxygen Tubing		

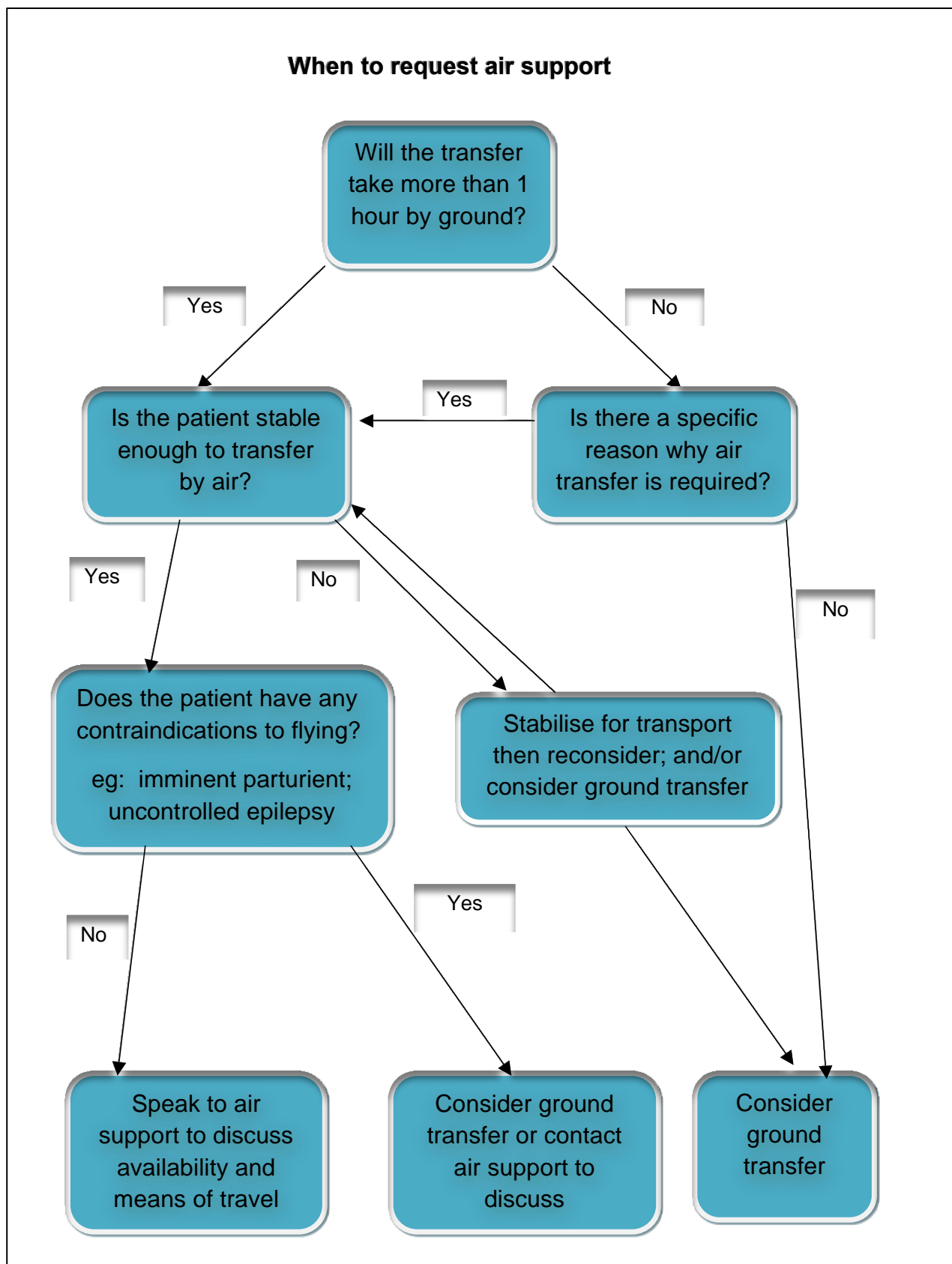
Appendix 18 - Critical Care Transfer Trolley Checklist

 Critical Care Transfer Trolley and After Use Check List	
1	Transfer trolley plugged into mains, all leads plugged into extension cable.
2	Oxylog 3000, Leardal suction unit, Mindray 1PM monitor and 4 x syringe drivers all on charge.
3	Oxylog 3000 device check passed. Correctly assembled hoses with HME, capnograph and test lung fitted.
4	Mindray: NIBP hose and cuff, IBP leads and transducers, ECG lead, capnography and Oximetry leads all fitted.
5	All brakes operation, back rest, leg elevation, side support and head rest mechanisms all functioning correctly.
6	Vac mat operational and free from punctures.
7	2 x C/D Oxygen cylinders full and correctly secured.
8	Transfer bag present and correctly stocked according to checklist.
9	Leardal suction unit operational and has: Tubing, Trachea –care and Yankeur sucker attached. Suction liner unused/empty.
10	All straps on trolley present, undamaged and clasps operational.
11	Trolley clean and free from bloodstains / soiling. Clean patient surfaces with neutral detergent (Use Chlor-clean if the patient has gastroenteritis of Clostridium difficile).
12	Check all items/devices remain securely mounted.
13	<p>Ensure sufficient disposables are available:</p> <ul style="list-style-type: none"> 10 x disposable ventilator circuits 10 x capnograph hoses 10 x suction lines <p>Either order or leave note for designated person if restocking required.</p>
<p>Any fault to be reported to Malcolm Wood (NEAS) 0191 566 4326 Out of hours: 0191 430 2210</p>	
 North of England Critical Care Network	

Appendix 19 - Critical Care Transfer Trolley Cleaning Guidelines

- The Critical Care Transfer Trolley should be thoroughly cleaned between each patient use in accordance with local hospital policy.
- Chlorine or Alcohol based products should not be used on the mattress as they will cause the rubber to degrade.
- Detergents are the best products for cleaning the mattress between patients under normal circumstances.
- Following the transfer of patients infected with Clostridium Difficile, MRSA, Salmonella or multi-drug resistant organisms, the following procedures based on the use of “Foam San”, an iodine based solution, are recommended by NEAS:
 - The mattress should be cleaned with “Foam San” which should be sprayed on then left for 30 seconds and wiped off.
 - Hard Surface Spray should be used to clean the hard surfaces of the trolley.
 - Maximum soak wipes can be used on the trolley as a “quick wipe”

Appendix 20 - Consideration for helicopter or fixed wing transfers



Appendix 21 - Transfer-related Critical Incidents Standard Operating Procedure



Management of Transfer-related Critical Incidents Standard Operating Procedure

Introduction

A critical incident is any event or circumstance that caused or could have caused (referred to as a near miss) unplanned harm, suffering, loss or damage. The purpose of incident reporting is to learn from the incident to improve practice and safety (ICS, 2006).

Responsibility

Any professional who is involved in the care of the patient during the critical care patient transfer has a responsibility to report incidents either by email or post to the Network Administrator at the relevant locality office who will in turn inform the NoECCN Transfer Clinical Governance Sub Group.

Documentation*

All incidents should be reported using NoECCN [Transfer Critical Incident Form \(TCIF 1\)](#). The report should be completed as comprehensively as possible, including the patient ID and names of staff involved. The documentation should be completed with 48 hours of the event occurring.

Process

Action	Time Frame	Responsibility
Complete NoECCN (TCIF 1) and send to the NoECCN	Within 48 working hours of the incident	Professional reporting the incident
NoECCN Administrator record the incident on the Critical Incident Database (TCIF log**) and inform NoECCN Transfer Clinical Governance Lead Sub Group	Within 48 working hours of receipt	NoECCN Administrator
Standard email response (TCIF 2) that incident has been received by the NoECCN and is being reviewed	Within 24 working hours of receipt	NoECCN Administrator
Investigation and reporting: For Green & Yellow incidents complete a Comprehensive RCA Investigation Form (TCIF 3) For Red & Orange incidents complete a Comprehensive RCA Investigation Form (TCIF 4)	According to severity of incident and complexity of investigation: - within a week for Green & Yellow - within a month for Red & Orange	NoECCN Administrator or Transfer Clinical Governance Lead Sub Group NoECCN Transfer Clinical Governance Lead Sub Group
Recommendations, feedback and action plan if appropriate, to organisations involved.	According to severity of incident and complexity of investigation.	NoECCN Transfer Clinical Governance Lead Sub Group
Following investigations, reporting and recommendations send standard closure email (TCIF 5). Closure of event on incident database.	Within 24 working hours of closure of incident	NoECCN Administrator
Feedback at Transfer Group	Quarterly Transfer meetings	NoECCN Transfer Clinical Governance Lead Sub Group

NoECCN / SOP TCI / June 2013

?

?

Feedback?

?

- Feedback to NEAS any relevant transfer related critical incidents as they happen and also a summary on a monthly basis. NEAS link is Gary Molloy, Operations Manager (gary.molloy@neas.nhs.uk).
- Feedback at the NoECCN Transfer Group Meetings.
- Feedback of investigation, recommendations and action plan to relevant critical care units involved in critical incident.

?

?

References?

?

- NoECCN Guidelines for the Safe Transport of the Critical Care Patient (2013)
- National Reporting and Learning Service. Root Cause Analysis Investigation Tools (NPSA) (2008)
- Standards for critical incident reporting in critical care. Intensive Care Society Standards and Guidelines (2006)

*Transfer Incidents Form Codes?

?

- Management of Transfer-related Critical Incidents SOP
- Excel Critical Incident Database (TCIF log)
- Transfer Clinical Incident Form (TCIF1)
- Standard Response Email Incident Received (TCIF2)
- NoECCN Concise Investigation Report Form (TCIF3)
- NoECCN Comprehensive RCA Report Form (TCIF4)
- Standard Response Email Closure of Incidents (TCIF5)

?

?

**Example of Incident Numbering Log?

?

Incident Log no:??


- C/(month)/(year)/(number), e.g. CI0413/01
- Date of Incident: 240413

NoECCN / SOP TCI / June 2013

Appendix 22 - Critical Care Transfer Critical Incident Form

<p>CRITICAL INCIDENT REPORT FORM INTERHOSPITAL TRANSFER OF CRITICALLY ILL PATIENT</p>	
DATE / TIME INCIDENT REPORTED	
PERSON REPORTING INCIDENT	Name
	Organisation
	Contact Phone
	Contact E-mail
CRITICAL INCIDENT NUMBER (OFFICE USE)	
CRITICAL INCIDENT DATE / TIME	
LOCATION OF INCIDENT	
NEAS (or equivalent) TRANSFER NUMBER (if available)	
INCIDENT TYPE	<input type="checkbox"/> Delayed Ambulance <input type="checkbox"/> Communication - Ambulance Staff (including ambulance control) <input type="checkbox"/> Communication - Referring Staff <input type="checkbox"/> Communication - Receiving Staff <input type="checkbox"/> Equipment problem – Critical Care Transfer Trolley <input type="checkbox"/> Equipment Problem – other <input type="checkbox"/> Traffic Accident <input type="checkbox"/> Out of “Transfer Group” transfer <input type="checkbox"/> Other – Please explain below
BRIEF DESCRIPTION OF INCIDENT	
STAFF INVOLVED WITH INCIDENT	

TRANSFER CRITICAL INCIDENT FORM / NoECCN / July 2012

 North of England Critical Care Network	
SEVERITY OF INCIDENT	<input type="checkbox"/> No obvious harm / Near miss / Insignificant <input type="checkbox"/> Low harm / Minor <input type="checkbox"/> Moderate harm / Temporary harm / Additional intervention required <input type="checkbox"/> Severe harm / Major permanent harm / Major intervention required <input type="checkbox"/> Death / Catastrophic
LIKELIHOOD OF RECURRENCE OF AN INCIDENT	<input type="checkbox"/> Almost certain <input type="checkbox"/> Likely <input type="checkbox"/> Possible <input type="checkbox"/> Likely <input type="checkbox"/> Rare
ACTUAL EFFECT ON PATIENT	<input type="checkbox"/> None <input type="checkbox"/> Other, please specify
ACTUAL EFFECT ON STAFF	<input type="checkbox"/> None <input type="checkbox"/> Other, please specify
CONTRIBUTING FACTORS	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Patient factors <input type="checkbox"/> Equipment factors <input type="checkbox"/> Team factors <input type="checkbox"/> Environmental factors </div> <div> <input type="checkbox"/> Individual (Staff) factors <input type="checkbox"/> Task factors <input type="checkbox"/> Organisational factors </div> </div> <p>Comments about contributing factors:</p>
OWN TRUST CRITICAL INCIDENT FORM COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO	
CONTACT DETAILS FOR FEEDBACK	NAME TITLE / ROLE ORGANISATION TELEPHONE NUMBER EMAIL ADDRESS

Please email within **48 hours** of incident to:
Jan.malone@nhct.nhs.uk and/or **Sarah.Tozer@nth.nhs.uk**

TRANSFER CRITICAL INCIDENT FORM / NoECCN / July 2012

(The critical incident form can be downloaded from www.noeccn.org.uk)

Appendix 23 - List of NHS and Independent Hospitals (NoECCN)

North East & Cumbria Critical Care Locality	
NHS	Independent Sector
<ul style="list-style-type: none"> • City Hospitals Sunderland • Cumberland Infirmary • Freeman Hospital • North Tyneside General Hospital • Northumbria Specialist Emergency Care Hospital • Queen Elizabeth Hospital, Gateshead • Royal Victoria Infirmary Hospital • South Tyneside General Hospital • Wansbeck General Hospital • West Cumberland Hospital 	<ul style="list-style-type: none"> • Abbey Caldwell, Cumbria • Cobalt NHS Treatment Centre, North Tyneside • Nuffield Health Newcastle-upon-Tyne Hospital • Spire Healthcare, Washington
Tees Valley & South Durham Critical Care Locality	
NHS	Independent Sector
<ul style="list-style-type: none"> • Darlington Memorial Hospital • Friarage Hospital, Northallerton • The James Cook University Hospital • University Hospital of Hartlepool • University Hospital of North Durham • University Hospital of North Tees 	<ul style="list-style-type: none"> • Cleveland Nuffield, Stockton • The Treatment Centre, Middlesbrough • Woodlands Hospital, Darlington

Appendix 24 - Example of SLA form for independent sector



Service Level Agreement for Transferring Critically Ill Patients from Independent to NHS Hospitals

*** Add Independent Hospital name***

This service level agreement is written to ensure that all transfers are performed in a safe and timely manner to the nearest, appropriate critical care bed within the NoECCN. All transfer of critically ill patients should be performed in accordance with the NoECCN Guidelines for the safe transport of the critical care patient (2016) and Independent Healthcare Advisory Service (2015).

Introduction

On occasions unexpected complications occur and patients require critical care facilities and it is necessary to perform emergency transfers from Independent to NHS hospitals. This policy in conjunction with the Independent Healthcare Advisory Service (2015) and the NoECCN Guidelines for the safe transport of the critical care patient (2016) aims to ensure all transfers are performed in a safe and timely manner to the nearest appropriate speciality critical care bed within the NoECCN and enable repatriation of the patient when critical care is no longer required.

Transferring of the Patient

The nurse in charge should contact the nearest appropriate unit and enquire about bed availability. If no bed is available in the nearest hospital then the next appropriate bed can be identified by contacting the Directory of Services (DoS) on **0191 4309391**. Refer to Critical Care Transfer Independent Sector flow chart (Pages 18, 19 & 20) NoECCN Guidelines ([NoECCN](#)) for the safe transport of the critical care patient (2016).

The tertiary centres (James Cook University Hospital, South Tees NHS Foundation Trust and The Newcastle Hospitals NHS Foundation Trust) should only be used if there are no beds within the transfer group or if the required services can only be provided by these centres.

Each FERNO CCT SIX-P bariatric trolley is a fully equipped critical care transfer trolley. These are used to facilitate the safe transfer of critically ill patients within the NoECCN in compliance with the quality and safety standards set out by CEN and BS EN1789 BS EN 1865. These trollies will accommodate a patient weighing up to 39stone/250kg. The equipment list is clearly documented in the NoECCN Guidelines for the safe transport of the critical care patient (2016).

Roles & Responsibilities

The roles and responsibilities of the transferring team should follow the ICS recommendations (ICS, 2011) and are clearly set out in Appendix 7, NoECCN Guidelines for the safe transport of the critical care patient (2016).

Documentation & Audit

A standardised inter hospital transfer chart (Appendix 9) provides a contemporaneous record of the transfer and should form part of the patient notes. A photocopy should be taken at the receiving hospital for the transfer team to place in the host's notes. All untoward incidents that occur during critical care patient transfer should be reported to the relevant network locality office either by using the online audit system by email or by post in order that an investigation of the circumstances surrounding the incident can be undertaken (Appendix 22). NoECCN Guidelines for the safe transport of the critical care patient (2016).

The Audit link can be found on the website;

www.noeccn.org.uk

or by clicking the link below:

https://www.surveymonkey.com/s/NoECCN_Transfer_Audit_Adults

Password: north

Locality Addresses:

North East & Cumbria Locality
Critical Care Network
Emergency Care Centre
North Tyneside General Hospital
Rake Lane
North Shields
NE29 8NH
Tel/Fax: 0191 2934189
E-mail: Jan.malone@nhct.nhs.uk

Tees Valley & South Durham Locality
Critical Care Network
2nd Floor, Everley House,
University Hospital of North Tees
Hardwick
Stockton
TS19 8PE
Tel/Fax: 01642 624328
E-mail: sarah.gray@nth.nhs.uk

Agreed by:

Responsible Officer: (Job Title)	
Organisation:	
Date:	
Network Manager:	
NoECCN Locality:	
Date:	
On behalf of:	The NoECCN Transfer Group

References:

Independent Healthcare Advisory Services, Critical Care Transfer for Patients Treated in the Independent Sector (2015)

NoECCN Guidelines for the safe transport of the critical care patient (2016)

NoECCN Transfer Group – Terms of Reference and Membership (2011)

Guidelines for the Transport of the Critically Ill Patient

Intensive Care Society Standards and Guidelines (2011)

REFERENCES

- Guidelines for the Provision of Intensive Care Services, 1st ed, (2015). The Faculty of Intensive Care Medicine.
- Guidelines for the Transport of the Critically Ill Patient 3rd Ed, (2011). Intensive Care Society Standards and Guidelines.
- Head Injury: triage, assessment, investigation and early management of head injury in infants, children and adults (CG56 NICE, 2007).
- Independent Healthcare Advisory Services, Critical Care Transfer for Patients Treated in the Independent Sector (2009)
- Interhospital Transfer (2009). Association of Anaesthetists of Great Britain and Ireland.
- Recommendations for Standards of Monitoring during Anaesthesia and Recovery, (2015). Association of Anaesthetists of Great Britain and Ireland.