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

March 17

WORKING DOCUMENT Updated 24/10/17

NoECCN Transfer Group
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<th><strong>Title</strong></th>
<th>Guidelines for the Safe Interhospital Transfer of the Adult Critical Care Patient</th>
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<tbody>
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<td><strong>Authors</strong></td>
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</tr>
<tr>
<td><strong>Version 2.2</strong></td>
<td>24th October, 2017</td>
</tr>
<tr>
<td><strong>Review date</strong></td>
<td>March 2018</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Working document</td>
</tr>
<tr>
<td><strong>Contact</strong></td>
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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:

- **Interhospital Transfer (2009)**. Association of Anaesthetists of Great Britain and Ireland.

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 ≤ 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 CCTSIX-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 contraindication 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 accessed 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

Decision made to transfer patient to another hospital

Commence Transfer Request Proforma (Appendix 2)

Use Inter-Hospital Transfer Chart (Appendix 9)

Find a bed at appropriate receiving Critical Care Unit
www.pathwaysdos.nhs.uk
Confirm bed at receiving unit
(Consultant to Consultant referral)

Move patient to critical care transfer trolley.
Stabilise patient: establish transfer monitoring and ventilation as appropriate

Request Ambulance
NEAS 0191 4143144

NB: All trolleys take up to 250kg (39stone)

Friarage Hospital
YAS 0300 33 00 266

West Cumberland Hospital and Cumberland Infirmary
NWas 0151 261 4301

Transfer patients to ambulance and inform receiving hospital of departure time

Ensure patient is effectively handed over to receiving unit.
All documentation is complete and filed appropriately.

Critical Care Handover SOP
Appendix 10

While in transit they will be available to respond to life threatening calls (C1 and C2)

Ambulance will transfer trolley and transfer team back to referring hospital.

Complete on line audit
NoECCN Transfer Audit Adults

NoECCN Critical Care Transfer Guidelines v 2.2 (October 2017)
### Adult Critical Care C2 Transfer Request Proforma

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Patient name</td>
<td></td>
</tr>
<tr>
<td>Patient Number</td>
<td></td>
</tr>
<tr>
<td>Consultant Requesting transfer</td>
<td></td>
</tr>
<tr>
<td><strong>Identify and confirm bed with receiving hospital and receiving Consultant</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital:</td>
<td></td>
</tr>
<tr>
<td>Unit:</td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
<tr>
<td>When the patient is stable on the transfer trolley inform NEAS that you need a Critical Care transfer:</td>
<td>0191 4143144</td>
</tr>
<tr>
<td>&quot;This is a Critical Care Transfer using the Transfer Trolley requiring a C2 response. A paramedic crew is not required&quot;</td>
<td></td>
</tr>
<tr>
<td>Dispatch NEAS job number:</td>
<td></td>
</tr>
<tr>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>Person Requesting Ambulance</td>
<td>Name:</td>
</tr>
<tr>
<td>Operator</td>
<td>Name:</td>
</tr>
<tr>
<td>Referring Department</td>
<td></td>
</tr>
<tr>
<td>Picking up point</td>
<td></td>
</tr>
<tr>
<td>Receiving Hospital</td>
<td></td>
</tr>
<tr>
<td>Receiving Department</td>
<td></td>
</tr>
<tr>
<td>Name of Patient</td>
<td></td>
</tr>
<tr>
<td>Principle diagnosis</td>
<td></td>
</tr>
<tr>
<td>Who is accompanying the patient.</td>
<td></td>
</tr>
<tr>
<td>How much Oxygen is required</td>
<td></td>
</tr>
<tr>
<td>Ambulance Arrived:</td>
<td>Time:</td>
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#### Ambulance Delayed – Follow-up Calls

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<tbody>
<tr>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>Person Requesting Ambulance</td>
<td>Name:</td>
</tr>
<tr>
<td>Speak to Duty Manager</td>
<td>Name:</td>
</tr>
<tr>
<td>Problem - EFA</td>
<td></td>
</tr>
</tbody>
</table>

**NoECCN Transfer Group 24/10/17**
Appendix 3 - Adult Critical Care Transfer for Independent Sector Flowchart

Decision made to transfer patient to another hospital

Find a bed at appropriate receiving Critical Care Unit.
www.pathwaysdos.nhs.uk
Confirm bed at receiving unit and Transfer Trolley is available

Request Ambulance
0191 4143144

Move patient to critical care transfer trolley.
Stabilise patient: establish transfer monitoring and ventilation as appropriate

Transfer patients to ambulance and inform receiving hospital of departure time

Ensure patient is effectively handed over to receiving unit.
All documentation is complete and filed appropriately.

NEAS Crew will return to normal duties
Independent sector staff will arrange transport back to base

Complete on line audit
NoECCN Transfer Audit Adults

Commence Transfer Request Proforma for Independent Sector (Appendix 4)

Inform control where the CC Transfer Trolley with breathing circuit is to be collected from.
It is the hospitals responsibility to source an available trolley

Use Inter-Hospital Transfer Chart (Appendix 9)

Critical Care Handover SOP Appendix 10

NB: All trolleys take up to 250kg (39 stone)
### Appendix 4a - Adult Critical Care Transfer for Independent Sector Request Proforma

<table>
<thead>
<tr>
<th>Patient name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Number</td>
<td></td>
</tr>
<tr>
<td>Consultant Requesting transfer</td>
<td></td>
</tr>
</tbody>
</table>

**Identify and confirm bed and transfer trolley available with receiving hospital and receiving Consultant**

<table>
<thead>
<tr>
<th>Hospital:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit:</td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
</tbody>
</table>

“This is a Critical Care Transfer you will need to collect a Critical Care Transfer Trolley and Breathing Circuit from – identify hospital. A paramedic crew is not required”

0191 4143144

<table>
<thead>
<tr>
<th>Dispatch NEAS job number:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>Person Requesting Ambulance Name:</td>
<td></td>
</tr>
<tr>
<td>Operator Name:</td>
<td></td>
</tr>
<tr>
<td>Referring Department</td>
<td></td>
</tr>
<tr>
<td>Picking up point</td>
<td></td>
</tr>
<tr>
<td>Receiving Hospital</td>
<td></td>
</tr>
<tr>
<td>Receiving Department</td>
<td></td>
</tr>
<tr>
<td>Name of Patient</td>
<td></td>
</tr>
<tr>
<td>Principle diagnosis</td>
<td></td>
</tr>
<tr>
<td>Who is accompanying the patient.</td>
<td></td>
</tr>
<tr>
<td>How much Oxygen is required</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Trust &amp; Hospital</th>
<th>Unit Type</th>
<th>Direct Line</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Cumbria Acute Hospitals NHS Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>ICU/HDU</td>
<td>01946 523 443</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>ICU/HDU</td>
<td>01228 814 114</td>
</tr>
<tr>
<td><strong>Newcastle Upon Tyne Hospitals NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freeman Hospital</td>
<td>Ward 21 Cardio ICU</td>
<td>0191 223 1015</td>
</tr>
<tr>
<td></td>
<td>Wd 37 Combined ICU/HDU</td>
<td>0191 223 1176</td>
</tr>
<tr>
<td>Royal Victoria Infirmary</td>
<td>Ward 38 General ICU/HDU</td>
<td>0191 282 4616</td>
</tr>
<tr>
<td></td>
<td>Ward 18 Neuro ICU/HDU</td>
<td>0191 282 1788</td>
</tr>
<tr>
<td><strong>Northumbria Healthcare NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northumbria Specialist Emergency Care Hospital (NSECH)</td>
<td>Combined ICU/HDU</td>
<td>0191 6072513/ 0191 6072511</td>
</tr>
<tr>
<td><strong>South Tyneside NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Tyneside General Hospital</td>
<td>Combined ICU/HDU</td>
<td>0191 404 1030</td>
</tr>
<tr>
<td><strong>City Hospitals Sunderland NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunderland Royal Hospital</td>
<td>Combined ICU/HDU</td>
<td>0191 541 0238</td>
</tr>
<tr>
<td><strong>Gateshead Healthcare NHS Foundation Trust</strong></td>
<td></td>
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</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>Combined ICU/HDU</td>
<td>0191 445 2007</td>
</tr>
<tr>
<td><strong>County Durham &amp; Darlington NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Hospital of North Durham</td>
<td>Combined ICU/HDU</td>
<td>0191 333 2019</td>
</tr>
<tr>
<td>Darlington Memorial Hospital</td>
<td>Combined ICU/HDU</td>
<td>01325 743212</td>
</tr>
<tr>
<td><strong>North Tees &amp; Hartlepool NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Hospital of North Tees</td>
<td>Combined ICU/HDU</td>
<td>01642 624 562</td>
</tr>
<tr>
<td><strong>South Tees NHS Foundation Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Cook University Hospital</td>
<td>ICU2/3 General ICU</td>
<td>01642 282 680 / 01642 854 539</td>
</tr>
<tr>
<td></td>
<td>Cardio ICU</td>
<td>01642 282 676</td>
</tr>
<tr>
<td>Friarage Hospital, Northallerton</td>
<td>Combined ICU/HDU</td>
<td>01609 764 011</td>
</tr>
</tbody>
</table>
Appendix 5 - Paediatric Critical Care Transfers NECTAR

Paediatric Critical Care Transfers with NECTAR

**Contact NECTAR**

0191 2826699

- Discuss the need to transfer. Make an intermediate plan.

**TRANSFER NOT ACCEPTED**

- Advice given as appropriate. Call back if situation changes.

**TRANSFER ACCEPTED**

- Confirmation of transfer and ETA given
- Handover to NECTAR on their arrival
- Assist team with any further treatment
- Facilitate communication with family
- Organise transport to receiving hospital if required.

- Child is transferred to ambulance.

---

Unable to provide retrieval team and the transfer is TIME CRITICAL

Go to Appendix XX
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)

GUIDANCE FOR CRITICAL CARE TRANSFERRING OUT

All transfers Consultant-to-Consultant discussion

Need for transfer: Clinical Upgrade of Care?
- YES
- NO

Transfer to nearest appropriate unit (NOT affected by transfer group)
- NO

Appropriate bed and resources available within other critical care area in hospital
- YES
- NO

Apply local Critical Care Escalation Policy:
- Contact hospital bed manager if delayed discharge of a patient is an issue
- Review dependency of existing patients
- Could you accommodate safely another patient?
- Can additional bed be created in the short term (physical space in unit, extra staff, nurse bank, bed in theatre recovery)?
- Is the current bed situation likely to change within few hours (imminent deaths, potential for warding patients)?
- Can patient be held safely temporarily in other areas (AAU, A&E, theatre recovery)?

Still no bed available?
- Identify the most appropriate patient for transfer
- Contact CMS (www.cms.nhs.uk)

Capacity Transfer (no resource available)
- NO

Bed available within Transfer Group?
- NO

Transfer patient following NoECCN Transfer Guidelines
- YES

Ensure Critical Care and Specialty Consultant handover

Transfer of patient outside Transfer Group:
- Check CMS (www.cms.nhs.uk)
- Shortest transfer distance outside Transfer Group
- Destination Unit has appropriate clinical facilities

Clinical Director, Chief Executive and NoECCN Co-ordinator to be informed within 24 hours

These transfers will be investigated and must followed up by local risk reporting for critical incidents

CLINICAL NEED ALWAYS TAKE PRIORITY
Appendix 8 - Guidance for transferring in (RECEIVING UNIT)

**GUIDANCE FOR CRITICAL CARE TRANSFERRING IN**

All transfers Consultant-to-Consultant discussion

Request for bed from outside hospital
Consultant to Consultant discussions between all involved specialties for the patient care

Bed available

Inform referring hospital

Referring hospital within Transfer Group

Case discussed by Critical Care Consultants and Speciality Consultant from referring and accepting hospitals

Advice referring hospital that transfer would be outside the Transfer Group

Clinical Director, Chief Executive and NoECCN Co-ordinator to be informed within 24 hours (These transfers will be investigated and must followed up by local risk reporting for critical incidents)

Appropriate transfer and resources available at accepting hospital

Accept patient following NoECCN Transfer Guidelines
Ensure Critical Care and Speciality Consultant handover

**CLINICAL NEED ALWAYS TAKE PRIORITY**
## Appendix 9 - Interhospital and Intrahospital Transfer Chart

### 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>ID Number</td>
</tr>
<tr>
<td>TRANSFER TEAM STAFF</td>
<td></td>
<td></td>
<td>S ex M / F</td>
</tr>
</tbody>
</table>

### PRE-TRANSFER ASSESSMENT

<table>
<thead>
<tr>
<th>History / Examination</th>
<th>Admission date</th>
<th>INVESTIGATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>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: ICU Ward A&amp;E Theatre Other……………………………… Reason for transfer: Upgrade care Repatriation No bed available unstaffed No bed available full</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hb WCC Platelets PT APTT Fib Na Ur K Cr pH PaO2 PaCO2 HCO3 BXS Lactate ECG C-spine XR CXR Pelvis XR Special investigations</td>
</tr>
</tbody>
</table>

### CURRENT MEDICATIONS

### ALLERGIES

### PRE-TRANSFER CHECKLIST

**Airway / Breathing**
- Airway safe or secured by intubation
- Tracheal tube position confirmed on chest X-ray
- Work of breathing acceptable
- Patient improving or stable and not tiring
- Adequate gas exchange confirmed on arterial blood gas
- Head up tilt 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
- Haemoglobin 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

**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

**Monitoring**
- ECG, Blood pressure (IABP gold standard), SpO2
- EtCO2
- Temperature
- Oxygen calculation – twice anticipated need!
- Infusions calculation – twice anticipated need!

**Metabolic**
- Blood glucose > 4mmol/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
**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

**MONITORS**
- ECG
- IABP
- SpO₂
- ECO₂
- Temperature
- Urinary Catheter
- NIBP
- Vent Alarm
- CVP

**VASCULAR ACCESS**
- Right
- Arterial
- Left
- CVP

**PERIPHERAL INVASIVE**
- Oxyllog 3000
- Other
- IPPV SIMV BIPAP +/- ASB........cmH₂O
- V₁.........mls  F........min  F₂O₅
- P₅₀........cmH₂O  PEEP / CPAP........cmH₂O

**ABDOMINAL / CHEST DRAINS**

<table>
<thead>
<tr>
<th>SpO₂</th>
<th>ECO₂</th>
<th>FIO₂</th>
<th>Temp</th>
<th>Pupillary changes</th>
<th>CVP</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>180</td>
<td>160</td>
<td>140</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>200</td>
<td>180</td>
<td>160</td>
<td>140</td>
<td>60</td>
<td>40</td>
</tr>
</tbody>
</table>

**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/nurse................................. GMC/NMC number..................

Signature of receiving doctor/nurse................................. GMC/NMC number..................

Please photocopy form and give to transferring team for their records.
Standard Operating Procedure – Critical Care Handover

1. **Prepare for transfer**
   Use transfer checklist handover

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, pat-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
## Transfer Checklist Handover

<table>
<thead>
<tr>
<th>Airway</th>
<th>Date of admission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETT</td>
<td>Date of transfer:</td>
</tr>
<tr>
<td>Intubation grade</td>
<td></td>
</tr>
<tr>
<td>Indication for intubation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breathing</th>
<th>Patient details</th>
</tr>
</thead>
<tbody>
<tr>
<td>FiO2</td>
<td>Affix sticker</td>
</tr>
<tr>
<td>Ventilator settings</td>
<td></td>
</tr>
<tr>
<td>CXR</td>
<td></td>
</tr>
<tr>
<td>ABG</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circulation</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>PC / HPC</td>
</tr>
<tr>
<td>Fluids / output</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>CV support / inotropes</td>
<td>Examination / key findings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability / drugs</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS and pupils</td>
<td>Surgical</td>
</tr>
<tr>
<td>Glucose / temperature</td>
<td>LMWH / UFH</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Antibiotics</td>
</tr>
<tr>
<td>Insulin / infusions</td>
<td>Drains</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exposure / equipment</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusions labelled</td>
<td>MAP</td>
</tr>
<tr>
<td>Log roll</td>
<td>UO</td>
</tr>
<tr>
<td>Drains</td>
<td>PaO2</td>
</tr>
<tr>
<td>Other</td>
<td>PaCO2</td>
</tr>
</tbody>
</table>

Consultant critical care ___________________________ Parent specialty consultant ___________________________

---

NoECCN / SOP Handover Checklist
Appendix 11 - Management of Trauma Patients with GCS≤13 (RVI)

Management of Trauma Patients with GCS≤13

The care of patients on this pathway should be directed by a senior doctor.
All patient transfers must be approved by an EM Consultant.
Management of any extra-cranial injuries should be as per existing protocols.
Deviations from the pathway should be approved by a Consultant.
Further detail and supporting documentation is available at:
www.noeccn.org.uk

Primary Survey (including GCS, blood glucose and examination of pupils)
Assess whether pathway is appropriate
Yes
Management as per local guidelines

Contact anaesthetics / intensive care team if potential need for intubation.
Intubation not required
Intubation required

Emergency Department Doctor
- Arrange for immediate CT
- Ensure coagulation screen, U&E, FBC sent
- Begin documentation

Emergency Department Nurse
- Ensure monitoring is attached
- Arrange porter
- Contact NEAS and state: “This is a warning that we may require a priority Red 2 transfer within the next hour” (tel. 0191 4143144)

Emergency Department Doctor
- Arrange for immediate CT
- Ensure coagulation screen, U&E, FBC sent
- Begin documentation

Emergency Department Nurse
- Ensure monitoring is attached
- Arrange porter
- Insert a urinary catheter only if doing so will not delay CT

Critical Care Doctor
- Intubate and ventilate
- Optimise physiological parameters
- Insert an arterial line only if doing so will not delay CT

**Ensure any life-threatening respiratory or circulatory issues have been managed appropriately**

Transfer for CT Head +/- Neck (NICE Protocol)
Images to be sent to RVI PACS

Acute, traumatic, time-critical lesion
or
Meets other criteria for transfer to Major Trauma Centre?

Yes
No

Management as per local guidelines
Contact neurosurgical registrar if the patient may require non-urgent transfer

Emergency Department Doctor
- Inform RVI Emergency Department Registrar (tel. 0191 2823994) of transfer
- Inform Neurosurgical Registrar of transfer (tel. 0191 2823720). If not available within a reasonable timeframe do not delay transfer.
- Complete required documentation
- Discuss with the patient’s family
- Complete emergency department notes
- Allocate suitably skilled staff to accompany patient

Emergency Department Nurse
- Complete required documentation
- Insert a urinary catheter if not in-situ and patient is anaesthetised

Critical Care Doctor
- If patient anaesthetised
- Insert an arterial line if not in-situ and take arterial blood gas measurement
- Insert a central line only if requiring an infusion of vasoactive drugs or inotropes
- Insert an oesogastric tube
- Prepare drugs, equipment and personnel for transfer
- Begin transfer documentation
- Inform RVI Critical Care Registrar of transfer (tel. 0191 2829999). If not immediately available do not delay transfer

(This chart can be downloaded from www.noeccn.org.uk as pdf)
Appendix 12 - Management of Trauma Patients with GCS≤13 (JCUH)

Management of Trauma Patients with GCS≤13

Primary Survey (including GCS, blood glucose and examination of pupils)

Assess whether pathway is appropriate

- Yes
  - Contact anaesthetics / intensive care team if potential need for intubation.

- No
  - Intubation not required
  - Management as per local guidelines

<table>
<thead>
<tr>
<th>Emergency Department Doctor</th>
<th>Emergency Department Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arrange for immediate CT</td>
<td>• Ensure monitoring is attached</td>
</tr>
<tr>
<td>• Ensure coagulation screen, U&amp;E, FBC sent</td>
<td>• Arrange porter</td>
</tr>
<tr>
<td>• Begin documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Department Doctor</th>
<th>Emergency Department Nurse</th>
<th>Critical Care Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arrange for immediate CT</td>
<td>• Ensure monitoring is attached</td>
<td>• Intubate and ventilate</td>
</tr>
<tr>
<td>• Ensure coagulation screen, U&amp;E, FBC sent</td>
<td>• Arrange porter</td>
<td>• Optimise physiological parameters</td>
</tr>
<tr>
<td>• Begin documentation</td>
<td>• Insert a urinary catheter only if doing so will not delay CT</td>
<td>• Insert an arterial line only if doing so will not delay CT</td>
</tr>
</tbody>
</table>

**Ensure any life-threatening respiratory or circulatory issues have been managed appropriately**

Transfer for CT Head +/- Neck (NICE Protocol)
Images to be sent to JCUH PACS

Acute, traumatic, time-critical lesion or Meets other criteria for transfer to Major Trauma Centre?

- Yes
  - Management as per local guidelines
  - Contact Neurosurgical registrar if the patient may require non-urgent transfer

<table>
<thead>
<tr>
<th>Emergency Department Doctor</th>
<th>Emergency Department Nurse</th>
<th>Critical Care Doctor (if patient anaesthetised)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inform JCUH Emergency Department Registrar (tel. 01642 854226) of transfer</td>
<td>• Complete required documentation</td>
<td>• Insert an arterial line if not in-situ and take arterial blood gas measurement</td>
</tr>
<tr>
<td>• Inform Neurosurgical Registrar of transfer (via JCUH switchboard tel. 01642 850850). If not available within a reasonable timeframe do not delay transfer</td>
<td>• Insert a urinary catheter if not in-situ and patient is anaesthetised</td>
<td>• Insert a central line only if requiring an infusion of vasoactive drugs or inotropes</td>
</tr>
<tr>
<td>• Complete required documentation</td>
<td>• Once on the Critical Care Transfer Trolley &amp; ready for departure contact NEAS 0191 4143144</td>
<td>• Insert an orogastric tube</td>
</tr>
<tr>
<td>• Discuss with the patient’s family</td>
<td><em>This is a Critical Care Transfer using the Critical Care Transfer Trolley requiring a R1 response. A paramedic crew is not required.</em> to JCUH Emergency Department.</td>
<td>• Prepare drugs, equipment and personnel for transfer</td>
</tr>
<tr>
<td>• Complete Emergency Department notes</td>
<td><a href="https://www.noeccn.org.uk">Adult Critical Care R1 Transfer Request Forms are available in NECTC Website</a></td>
<td>• Begin transfer documentation</td>
</tr>
<tr>
<td>• Allocate suitably skilled staff to accompany patient</td>
<td></td>
<td>• Inform JCUH Critical Care Registrar of transfer (via JCUH switchboard tel. 01642 850850, bleep 1005) If not immediately available do not delay transfer</td>
</tr>
</tbody>
</table>

(This chart can be downloaded from [www.noeccn.org.uk](http://www.noeccn.org.uk) as pdf)
## Appendix 13 - NEAS category of transfers

### National Ambulance Response Programme

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Average response time</th>
<th>Access by calling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
<td>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.</td>
<td>7 minutes</td>
<td>999</td>
</tr>
<tr>
<td><strong>Category 2</strong></td>
<td>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.</td>
<td>18 minutes</td>
<td>999</td>
</tr>
<tr>
<td><strong>Category 3</strong></td>
<td>Is for urgent problems, for example uncomplicated diabetic that needs treatment and transport to an acute setting. Mortality rates are very low or zero; the is evidence to support alternative pathways of care.</td>
<td>At least 9 out of 10 times within 120 minutes</td>
<td>999</td>
</tr>
<tr>
<td><strong>Category 4</strong></td>
<td>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).</td>
<td>At least 9 out of 10 times within 180 minutes</td>
<td>999</td>
</tr>
</tbody>
</table>
## Appendix 14 - Transfer Groups and contact information (NHS)

<table>
<thead>
<tr>
<th>Transferring Hospital</th>
<th>Receiving Hospital</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>NE1 4LP</td>
<td>0191 2824616</td>
</tr>
<tr>
<td>Freeman Hospital</td>
<td>NE1 7TD</td>
<td>0191 2231014</td>
</tr>
<tr>
<td>Sunderland Royal Hospital</td>
<td>SR6 7PA</td>
<td>0191 5699745</td>
</tr>
<tr>
<td>Freeman Hospital</td>
<td>NE7 7DN</td>
<td>0191 4041030</td>
</tr>
<tr>
<td>South Tyneside General Hospital</td>
<td>NE3 6YJ</td>
<td>0191 4452007</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>0191 4452007</td>
<td></td>
</tr>
<tr>
<td>Northumbria Specialist Emergency Care Hospital (NSECH)</td>
<td>NE23 6NZ</td>
<td>0191 6072011</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>01228 814114</td>
<td>01342 624562</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>01946 523443</td>
<td>01325 743212</td>
</tr>
<tr>
<td>University Hospital of North Durham</td>
<td>NE19 332019</td>
<td>01642 202680</td>
</tr>
<tr>
<td>University Hospital of North Tees</td>
<td>01342 624562</td>
<td>01609 764011</td>
</tr>
</tbody>
</table>

### NON CLINICAL TRANSFER GROUPS

- **Friarage Hospital**
  - Harrogate District General = 37 miles
  - York District Hospital = 35 miles

- **Cumberland Infirmary**
  - Dunfries and Galloway = 34 miles

- **West Cumberland**
  - Dunfries and Galloway = 72 miles
  - Furness General Hospital = 49 miles

---

NoECCN Critical Care Transfer Guidelines v 2.2 (October 2017)
## Appendix 15 - Transfer Groups and contact information (Independent Sector)

<table>
<thead>
<tr>
<th>Receiving Hospital</th>
<th>Royal Infirmary - Newcastle (NGS)</th>
<th>Freeman Hospital - Newcastle (NGS)</th>
<th>Sunderland Royal Hospital - Newcastle (NGS)</th>
<th>South Tyneside General Hospital (NEG)</th>
<th>Queen Elizabeth Hospital - Gateshead (NEG)</th>
<th>Northern General Hospital - Newcastle (NEG)</th>
<th>Cumberland Infirmary (NEG)</th>
<th>West Cumberland Hospital - Maryport (NEG)</th>
<th>University Hospital of North Durham - Darlington (NEG)</th>
<th>Durham County Hospital (NEG)</th>
<th>James Cook University Hospital (NEG)</th>
<th>Pringle Hospital - North Tees (NEG)</th>
<th>University Hospital of North Tees - Stockton (NEG)</th>
</tr>
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<tbody>
<tr>
<td>Royal Victoria Infirmary (0191 282 6516)</td>
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<td>Freeman Hospital (0191 221 1014)</td>
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<td>University Hospital of North Durham (0191 335 019)</td>
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<td>100</td>
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<td>32</td>
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<td>22</td>
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<tr>
<td>Darlington Memorial Hospital (01325 452 122)</td>
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<td>James Cook University Hospital (01642 202 600)</td>
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<td>Ramsey Healthcare - Middlesbrough (01642 726 855)</td>
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<td>Friarage Hospital (01609 764 011)</td>
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<td>17</td>
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</tr>
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<td>The Hawthorns, Peterlee (0191 581 251)</td>
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</tr>
<tr>
<td>Overland Hillsfield - Stockton (01642 360 100)</td>
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<td>52</td>
</tr>
<tr>
<td>University Hospital of North Tees (01324 624 562)</td>
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<td>32</td>
<td>51</td>
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<td>22</td>
<td>14</td>
<td>11</td>
<td>26</td>
<td>11</td>
</tr>
</tbody>
</table>

**INDEPENDENT SECTOR TRANSFER GROUPS**

- Friarage Hospital - 37 miles
- Ryhope District General - 39 miles
- York District General - 49 miles
- Dunfermline and Galloway - 72 miles
- Penrith General Hospital - 49 miles
- West Cumberland - 49 miles
- West Durham - 49 miles
Appendix 16 - Critical Care Transfer: Adult Critical Care Escalation chart

ADULT CRITICAL CARE ESCALATION PLAN (ACCEP)
CRITICAL CARE TRANSFER FLOW CHART
North of England

Decision made by a consultant to transfer patient to another hospital

Find and confirm bed at appropriate receiving hospital (Live bed register or direct contact).

Pre alert NEAS that a critical care transfer is necessary: 0191 4143144. Speak to Duty Manager; give 30 minutes notice if possible.

ADVISER WHICH CATEGORY
1. EMERGENCY Critical Care Transfer – 20 mins
2. URGENT Critical Care Transfer – 2 to 4 hours
3. STANDARD Critical Care Transfer – 4 hours+

EMERGENCY CC TRANSFER
When patient is stable and checklist completed, inform NEAS that the patient is now ready for transfer: 0191 4143144. Speak to operator; give as much information as possible.

Information Required:
- Caller name
- Pick up point
- Referring Department
- Who is accompanying patient?
- Patient Name
- Receiving Hospital and department
- How much oxygen required?
- Is there a balloon pump?
- Is a bariatric trolley required?

URGENT & STANDARD CC TRANSFER
NEAS will provide a 30 minute pre-warning that they can move the patient. Confirm transfer to go ahead and provide as much information as possible.

At this time the patient can be moved to the critical care transfer trolley; stabilise patient; establish transfer monitoring and ventilation as appropriate.

Re confirm appropriate bed available at receiving hospital and that all relevant staff are aware of the imminent transfer.

Transfer patient to ambulance and inform receiving hospital of departure time.

Ensure patient effectively handed over to receiving unit; all documentation is complete and filed appropriately.

Ambulance Control will make every effort to transfer the trolley and team back to the referring hospital.

ADULT
Refer to NoECCN Network Transfer Guidelines; Transfers out – page 17

PAEDIATRIC
Refer to NoECCN Network Transfer Guidelines; Transfers out – pages 12-14
### Appendix 17 - Suggested contents of transfer bag

<table>
<thead>
<tr>
<th>Advanced Airway</th>
<th>Breathing Pocket</th>
<th>Circulation Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x ETT 6</td>
<td>1 x LMA/Igel size 3</td>
<td>2 x IV cannula size 14G</td>
</tr>
<tr>
<td>1 x ETT 7</td>
<td>1 x LMA/Igel size 4</td>
<td>2 x IV cannula size 16G</td>
</tr>
<tr>
<td>1 x ETT 8</td>
<td>1 x LMA/Igel size 5</td>
<td>2 x IV cannula size 18G</td>
</tr>
<tr>
<td>2 x Laryngoscopes handles and batteries</td>
<td>1 x HME filter</td>
<td>2 x IV cannula size 20G</td>
</tr>
<tr>
<td>1 x Laryngoscope Blades 3</td>
<td>1 x Catheter Mount</td>
<td>2 x IV cannula size 22G</td>
</tr>
<tr>
<td>1 x Laryngoscope Blades 4</td>
<td>1 x C-circuit</td>
<td>5 x non sterile gloves</td>
</tr>
<tr>
<td>1 x Elastoplast</td>
<td>1 x Stethoscope</td>
<td>4 x 20 ml syringes</td>
</tr>
<tr>
<td>1 x Magill Forceps</td>
<td>1 x Wave form Capnography line</td>
<td>4 x 50 ml syringes</td>
</tr>
<tr>
<td>2 x Lubricating gels</td>
<td>1 x Green anaesthetic Face mask</td>
<td>4 x 10ml syringe</td>
</tr>
<tr>
<td>1 x Gum elastic bougie</td>
<td>1 x Orange anaesthetic Face mask</td>
<td>10 x chloraprep skin wipes</td>
</tr>
<tr>
<td>1 x Scalpel size</td>
<td>1 x colorimetric CO2</td>
<td>1 x infusion giving set</td>
</tr>
<tr>
<td>1 x 10 ml syringe</td>
<td>Suction Pocket</td>
<td>1 x micropore tape</td>
</tr>
<tr>
<td>1 x FONA pack</td>
<td>2 x Yankauer suckers</td>
<td>4 x gauze</td>
</tr>
<tr>
<td>1 x Scissors</td>
<td>2 x 14F suction catheters</td>
<td>4 x cannula dressings</td>
</tr>
<tr>
<td>Self ventilating pocket</td>
<td>2 x 12F suction catheters</td>
<td>12 x ECG electrodes</td>
</tr>
<tr>
<td>1 x Guedel Green</td>
<td>External Pocket</td>
<td>10 x Sodium chloride flushes</td>
</tr>
<tr>
<td>1 x Guedel Red</td>
<td>1 x Self inflating Ambu bag and mask</td>
<td>5 x Obturators</td>
</tr>
<tr>
<td>1 x NP airway size 6</td>
<td>Inside pouch on side of bag</td>
<td>4 x Drug labels</td>
</tr>
<tr>
<td>1 x NP airway size 7</td>
<td>Interventional circulation</td>
<td>5 x Green/drawing up needles</td>
</tr>
<tr>
<td>1 x Non rebreathe mask size 5</td>
<td></td>
<td>2 x Tourniquets</td>
</tr>
<tr>
<td>1 x Oxygen Tubing</td>
<td></td>
<td></td>
</tr>
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</table>
## Appendix 18 - Critical Care Transfer Trolley Checklist

### Critical Care Transfer Trolley and After Use Check List

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transfer trolley plugged into mains, all leads plugged into extension cable.</td>
</tr>
<tr>
<td>2</td>
<td>Oxylog 3000, Leardal suction unit, Mindray 1PM monitor and 4 x syringe drivers all on charge.</td>
</tr>
<tr>
<td>3</td>
<td>Oxylog 3000 device check passed. Correctly assembled hoses with HME, capnograph and test lung fitted.</td>
</tr>
<tr>
<td>4</td>
<td>Mindray: NIBP hose and cuff, IBP leads and transducers, ECG lead, capnography and Oximetry leads all fitted.</td>
</tr>
<tr>
<td>5</td>
<td>All brakes operation, back rest, leg elevation, side support and head rest mechanisms all functioning correctly.</td>
</tr>
<tr>
<td>6</td>
<td>Vac mat operational and free from punctures.</td>
</tr>
<tr>
<td>7</td>
<td>2 x C/D Oxygen cylinders full and correctly secured.</td>
</tr>
<tr>
<td>8</td>
<td>Transfer bag present and correctly stocked according to checklist.</td>
</tr>
<tr>
<td>9</td>
<td>Leardal suction unit operational and has: Tubing, Trachea –care and Yankeur sucker attached. Suction liner unused/empty.</td>
</tr>
<tr>
<td>10</td>
<td>All straps on trolley present, undamaged and clasps operational.</td>
</tr>
<tr>
<td>11</td>
<td>Trolley clean and free from bloodstains / soiling. Clean patient surfaces with neutral detergent (Use Chlor-clean if the patient has gastroenteritis of Clostridium difficile).</td>
</tr>
<tr>
<td>12</td>
<td>Check all items/devices remain securely mounted.</td>
</tr>
<tr>
<td>13</td>
<td>Ensure sufficient disposables are available: 10 x disposable ventilator circuits 10 x capnograph hoses 10 x suction lines Either order of leave note for designated person if restocking required.</td>
</tr>
</tbody>
</table>

**Any fault to be reported to Malcolm Wood (NEAS) 0191 566 4326 Out of hours: 0191 430 2210**
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

**When to request air support**

1. **Will the transfer take more than 1 hour by ground?**
   - Yes
   - No

2. **Is the patient stable enough to transfer by air?**
   - Yes
   - No

3. **Does the patient have any contraindications to flying?**
   - Yes
     - Stabilise for transport then reconsider; and/or consider ground transfer
   - No

4. **Is there a specific reason why air transfer is required?**
   - Yes
   - No

5. **Speak to air support to discuss availability and means of travel**
   - Consider ground transfer or contact air support to discuss
   - Consider ground transfer

---

eg: imminent parturient; uncontrolled epilepsy
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.

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

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)

*Transfer Incidents Form Codes

- Management of Transfer-related critical incidents SOP
- Excel Critical Incident Database (TCIF log)
- Transfer Clinical Incident Form (TCIF 1)
- Standard response email – incident received (TCIF 2)
- NoECCN Concise Investigation Report Form (TCIF 3)
- NoECCN Comprehensive RCA Report Form (TCIF 4)
- Standard response email closure of incidents (TCIF 5)

**Example of Incident numbering log

Incident Log no:
- CI (month)/(year)/(number), e.g. CI0413/01
- Date of Incident: 240413

NoECCN / SOP TCI / June 2013
### Appendix 22 - Critical Care Transfer Critical Incident Form

#### CRITICAL INCIDENT REPORT FORM

**INTERHOSPITAL TRANSFER OF CRITICALLY ILL PATIENT**

<table>
<thead>
<tr>
<th>DATE / TIME INCIDENT REPORTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Organisation</td>
</tr>
<tr>
<td>Contact Phone</td>
</tr>
<tr>
<td>Contact E-mail</td>
</tr>
</tbody>
</table>

#### CRITICAL INCIDENT NUMBER (OFFICE USE)

#### CRITICAL INCIDENT DATE / TIME

#### LOCATION OF INCIDENT

#### NEAS (or equivalent) TRANSFER NUMBER (if available)

#### INCIDENT TYPE

- [ ] Delayed Ambulance
- [ ] Communication - Ambulance Staff (including ambulance control)
- [ ] Communication - Referring Staff
- [ ] Communication - Receiving Staff
- [ ] Equipment problem – Critical Care Transfer Trolley
- [ ] Equipment Problem – other
- [ ] Traffic Accident
- [ ] Out of “Transfer Group” transfer
- [ ] Other – Please explain below

#### BRIEF DESCRIPTION OF INCIDENT

#### STAFF INVOLVED WITH INCIDENT

**TRANSFER CRITICAL INCIDENT FORM / NoECCN / July 2012**
| SEVERITY OF INCIDENT | ☐ No obvious harm / Near miss / Insignificant  
|                      | ☐ Low harm / Minor  
|                      | ☐ Moderate harm / Temporary harm / Additional intervention required  
|                      | ☐ Severe harm / Major permanent harm / Major intervention required  
|                      | ☐ Death / Catastrophic  
| LIKELIHOOD OF RECURRENCE OF AN INCIDENT | ☐ Almost certain  
|                              | ☐ Likely  
|                              | ☐ Possible  
|                              | ☐ Likely  
|                              | ☐ Rare  
| ACTUAL EFFECT ON PATIENT | ☐ None  
|                              | ☐ Other, please specify  
| ACTUAL EFFECT ON STAFF | ☐ None  
|                              | ☐ Other, please specify  
| CONTRIBUTING FACTORS | ☐ Patient factors  
|                          | ☐ Individual (Staff) factors  
|                          | ☐ Equipment factors  
|                          | ☐ Task factors  
|                          | ☐ Team factors  
|                          | ☐ Organisational factors  
|                          | ☐ Environmental factors  
|                          | Comments about contributing factors:  
| OWN TRUST CRITICAL INCIDENT FORM COMPLETED | ☐ YES ☐ 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)*
### North East & Cumbria Critical Care Locality

<table>
<thead>
<tr>
<th>NHS</th>
<th>Independent Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Hospitals Sunderland</td>
<td>Abbey Caldew, Cumbria</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>Cobalt NHS Treatment Centre, North Tyneside</td>
</tr>
<tr>
<td>Freeman Hospital</td>
<td>Nuffield Health Newcastle-upon-Tyne Hospital</td>
</tr>
<tr>
<td>North Tyneside General Hospital</td>
<td>Spire Healthcare, Washington</td>
</tr>
<tr>
<td>Northumbria Specialist Emergency Care Hospital</td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital, Gateshead</td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Infirmary Hospital</td>
<td></td>
</tr>
<tr>
<td>South Tyneside General Hospital</td>
<td></td>
</tr>
<tr>
<td>Wansbeck General Hospital</td>
<td></td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td></td>
</tr>
</tbody>
</table>

### Tees Valley & South Durham Critical Care Locality

<table>
<thead>
<tr>
<th>NHS</th>
<th>Independent Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darlington Memorial Hospital</td>
<td>Cleveland Nuffield, Stockton</td>
</tr>
<tr>
<td>Friarage Hospital, Northallerton</td>
<td>The Treatment Centre, Middlesbrough</td>
</tr>
<tr>
<td>The James Cook University Hospital</td>
<td>Woodlands Hospital, Darlington</td>
</tr>
<tr>
<td>University Hospital of Hartlepool</td>
<td></td>
</tr>
<tr>
<td>University Hospital of North Durham</td>
<td></td>
</tr>
<tr>
<td>University Hospital of North Tees</td>
<td></td>
</tr>
</tbody>
</table>
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

- Independent Healthcare Advisory Services, Critical Care Transfer for Patients Treated in the Independent Sector (2009)