The Royal Wolverhampton NHS Trust

Policy Number CP05

Transfer of patients between wards, departments, specialist Units and Other Hospitals

Contents

Appendices

1.0 Policy Statement (Purpose / Objectives of the policy)

This policy identifies the Trust's expectations for the safe transfer of patients internally to other departments and externally to specialist units or other hospitals. It applies to all Royal Wolverhampton NHS Trust staff employed on a substantive or temporary contract, including Bank and Agency staff, who may be required at any time to undertake patient transfers internally and externally.

It also specifies how The Royal Wolverhampton NHS Trust will undertake these transfers. The principle of safe transfer relies upon high quality communication, therefore the tools used within this policy are SBARD based to standardise handover processes.

This policy covers the transfer of all patients across the Trust apart from those outlined below. Those not included have their own transfer form and standard operational policy relevant to their patients group's needs. This is provided as an appendix to this policy.

The movement of sick patients from Cannock Chase Hospital to another hospital is in Appendix 8

All areas use the Transfer SBART form (Appendix 2), apart from the areas listed below who have adopted a transfer form which meets the needs of their patient groups

Maternity

Antenatal Transfer Form Appendix 3.1
Post Natal Transfer Form Appendix 3.2

Neonatal Patients – Appendix 6

Paediatric Patients:
Paediatric patients who are being transferred to the Care of the Critical Care Repatriation Team (Appendix 6)

Critical Care Unit: (Appendix 4.1, 4.2, 4.3 & 4.4) Internal transfers to base medical/surgical wards
Internal transfers to Cardiothoracic ward
Level 3 Critical Care patients to another ICCU

Emergency Department

Adult Patients Appendix 5.0

Paediatric Patients Appendix 6.1

Theatres – Appendix 10 (this is an extract from a larger document)

1.1 Introduction

The Royal Wolverhampton NHS Trust is committed to providing high quality care to all patients. We have a duty to ensure that we secure safe transfer of patients between wards, departments, specialist units and other hospitals.

This will be undertaken safely and effectively with the minimum disruption to the patient and their family. An essential element of this is the communication within and between teams dealing with the transfer of patients and the coordination of various elements of care between professional staff, patients and relatives / carers and external care providers. Communication tools within the policy are SBARD based to ensure that communication is standardised and of the highest quality.

There are two categories of patient transfer within the Trust:

- Internal transfers: involve the movement of patients between departments and Trust sites which includes transfers to West Park Hospital and Cannock Chase Hospital.
- External transfers: involve patient movement to or from an external organisation.

Patients may move for a variety of reasons and they can be categorised as clinical or non-clinical.

Actions taken will depend on the level of care that the patient requires. Staff involved in all transfers will manage any risk to ensure patient safety, minimise personal disruption to the patient, and ensure the continuity of care.

The operational procedure for decision making and the process for transfer patients can be found in Appendix 1.and Appendix 8: **Outlier suitability matrix**.-

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Clinical Transfer

It may be necessary for patients to be transferred from one hospital to another or between wards / departments within The Royal Wolverhampton NHS Trust for a number of clinical reasons including the following.

- The patient needs to move due to a change in their clinical management.
- Clinical need due to an increase level of care requiring moving to a Critical Care area (ICU / HDU / CCU).
- Clinical need for rehabilitation services i.e. West Park Hospital or Cannock Chase Hospital.
- For initial assessment prior to placement on a dedicated speciality or consultant based area.
- When a 5 day ward closes at the weekend.
- When a single bed side room is required due to the patient's condition.
- For transfer to an in-patient area following a day case or routine procedure.
- External transfer due to repatriation.

Non- Clinical Transfer

It may be necessary at times to move patients to be out lied into another speciality ward to create capacity in their previous ward.

The medical team caring for any patient requiring transfer for non-clinical reasons must complete which will be filed in the patient's notes (Appendix 7). In times when capacity pressures are present Matron's or the specialty's registrars can assess patient suitability and complete the outlier form.

Discharge

Conclusion of a patient care spell (see CP04 Discharge Policy)

Escort Requirements

The need for an escort during the transfer of a patient to another ward/ department or another hospital will be assessed in line with Escort Policy OP 67. This will also guide the decision as to the most appropriate member of nursing or medical staff required as escort following assessment of the patient's clinical condition.

Intra-hospital transfer

Movement of patients between departments within the Trust site including transfer to other hospitals.

Inter-hospital transfer

Movement of patients to or from an external organisation.

Out of Hours Transfers

The transfer of patients between wards or other organisations (between 2000 and 0800) when the clinical need does not warrant a transfer between this time.

Twinned Ward

Identified non-medical wards are 'twinned' with a specified medical ward in order to have specific medical team cover.

SBARD

SBARD is an easy to remember communication tool utilizing the acronym:

S situation;

B background;

A assessment;

R recommendation;

D decision.

SBART

For the purposes of this policy the acronym **SBARD** has been modified to **SBART** indicate the decision to transfer.

S situation;

B background;

A assessment;

R recommendation;

T transfer.

3.0 Accountabilities

Chief Executive

The Chief Executive has overall responsibility for the implementation, monitoring and renewal of this policy. This responsibility is delegated to the Chief Nurse.

3.2 Chief Medical Officers

It is the responsibility of the Medical Directors to oversee the monitoring and application of this policy, and to report as necessary to Trust Board, via Trust Management Team Meeting.

3.3 Clinical Directors

Clinical Directors are responsible for ensuring that Consultants within their directorates understand the policy and ensure that it is applied within their practice.

3.4 Directorate Management Teams

The Directorate Management Teams are responsible for implementing and communicating the Patient Transfer Policy in their directorate areas.

3.5 Matrons

Matrons are responsible for ensuring that all nursing staff within their remit adhere to the Patient Transfer Policy. They are also responsible for ensuring that nursing staff are competent to undertake patient transfer, appropriate to their roles and responsibilities. Matrons may delegate day to day responsibility of competency assessment to the individual healthcare workers line manager.

3.6 Senior Sister / Charge Nurse

The Senior Sister/Charge Nurse of a ward/department is responsible for the following.

- Ensuring that the policy is understood and implemented by nursing staff in their area.
- Ensuring members of staff conducting transfers from their department are competent to do so.
- Ensuring the completion of outlier suitability matrix prior to transfer and the completion of the Safe Hands board to identify suitable outliers.
- Identifying appropriate training opportunities for staff to support the development of competence in relation to transfers.
- Ensuring that any temporary nursing staff, including bank and agency staff, are competent to undertake and respond appropriately during inter and intra hospital transfers.
- The auditing of practice and policy compliance within their own clinical area using the transfer checklist.
- Ensuring that appropriate processes are in place to ensure the safe and effective transfer of patients from the department/ward ensuring there is full communication with the receiving area.
- Ensuring the accurate completion of the SBART based transfer checklist at time of transfer.

3.7 Individual Responsibility

Nurses, Midwives, Doctors and Allied Health Professionals must follow the policy and report any incidents that occur where policy has not been followed.

4.0 Policy Detail

It is the policy of this Trust to ensure the safe transfer of patients between wards, departments, specialist units and other hospitals, to maintain patient safety and the quality of patient care.
The Operational Procedure for the Inter/Intra hospital transfer of a patient is in Appendix 1.
The unscheduled transfer of a sick person from Cannock chase Hospital to another hospital is in Appendix 8.

4.1 Decision to Transfer

- The decision to transfer a patient to another ward, unit, department or externally must be made considering the potential risks and benefits to the patient (see appendices, outlier matrix and transfer protocol).
- The decision to transfer to another hospital must be made by the Consultant in Charge, or, in their absence, the on call consultant for that speciality. The rationale for the transfer to another hospital must be documented in the patient's case notes.

4.2 Out of Hours Transfers

- Out of Hours transfers (between 2000 and 0800 hours) must be undertaken only when absolutely necessary to ensure sufficient capacity within the Trust or if required due to the patient's clinical condition. Out of hours transfers will be monitored via the Trust integrated health and social care team and this will be shared within the Trust via the night report.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

An initial equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

This policy will be the responsibility of the Matron lead for the safe admission, transfer, discharge creating best practice group and the Patient Safety Improvement Group. It will be reviewed in line with Trust Policy OP01 every 3 years or following any significant changes to the way patients are transferred.

8.0 Communication and Training

- An electronic copy of this policy will be available on the Trust intranet.
- Hyperlinks to the policy will be available on relevant intranet sites e.g. Nursing websites and Critical care.
- All staff will be notified of a new or renewed policy

The document will be included in The Royal Wolverhampton NHS Trust publication scheme in compliance with the Freedom of Information Act 2000.

Staff will receive appropriate training and education on patient transfer as part of local induction. All internal training programmes will reflect the new policy.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee / Group
Handover requirements between all care settings, to include both giving and receiving of information	Matrons	Audit of checklist/patient case notes	Annual	Quality and Safety Intelligence Group
How handover is recorded	Matrons	Audit of checklist/patient case notes	Annual	Quality and Safety Intelligence Group
Out of hours handover process/ outlier matrix	Matrons	Audit of checklist/patient case notes	Annual	Quality and Safety Intelligence Group

10.0 References

Intensive Care Society (2002) Guidelines for the transport of the adult critically ill patient

Standards (Clinical Care Standards)

Intensive Care Standards (2001)

West Midlands Strategic Commissioning Group: Standards for Care of the Critically Ill and Critically Injured Child in the West Midlands (2004)

Policy number and Policy version: **CP05 Version 7**	**Policy Title** **Transfer of patients between wards, departments, specialist Units and Other Hospitals**	**Status:** **Final**		**Author: Matron Group** **Chief Officer Sponsor: Chief Nurse**
Version / Amendment History	Version	Date	Author	Reason
	7	August 2021	Matron Group	Full review of policy
	6.3	June 2021	Matron Group	Amendments to Appendix 5.1, 5.2, 5.3, 8,
	6.2	August 19	Matron group	Appendix 3 updated and replaced as well as Appendix 6.
	6.1	June 2019	Matron for respiratory and Diabetes	Adult In-patient SBART within Appendix 9 replaced
	6	July 2018	Matron for Respiratory, Sexual Health, Endoscopy and Dermatology	Full Review
	5.4	March 2018	Divisional Medical Director Div 1	Re-written Appendix 9 regarding RCA documented delays in transferring the critically ill patient.
	5.3	July 2017	Matron for Respiratory, Sexual Health, Endoscopy and Dermatology	Update of Appendix 2 to include information on falls and confusion, and format changed to bring in line with ED Transfer Checklist (Appendix 6.1)

	5.2	May 2017	CD Critical Care	Update of App 9 – (*Unscheduled transfer of the sick patient from CCH to another hospital)* regarding the final disaggregation of transition arrangement with UHNM.
	5.1	Oct 2016	Matron Respiratory & Sexual Health	Update of Adult In Patient SBART Transfer Checklist
	5.0	Jan 2015	Capacity Manager	Review
	4.2	Oct 2014	Capacity Manager	Cannock Addendum
	4.1	April & Sept 2013	Capacity Manager Capacity Manager	Review of content Review of content and reporting of audit updated
	4	Sept 2012	Capacity Manager	Review and update of checklist
	3	March 12	Capacity Manager	Review
	2	Sept 2009	Capacity Manager	Review
	1	May 96	Capacity Manager	Development

Intended Recipients: Consultants, Senior Registrars, Matrons, Ward Managers	
Consultation Group / Role Titles and Date: Heads of Nursing, Matrons, Safe & Effective Discharge Group –	
Name and date of Trust level group where reviewed	Trust Policy Group – October 2021
Name and date of final approval committee	Trust Management Committee – October 2021
Date of Policy issue	November 2021
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated	October 2024

Training and Dissemination: As and when required by staff involved in transfer of patients. This will be disseminated via Heads of Nursing, Matrons and All Users Bulletin
Publishing Requirements: Can this document be published on the Trust's public page: **Yes**
To be read in conjunction with: 1 Safeguarding Adults Strategy 2 Safeguarding Children CP41 3 Policy for the prevention and management of pressure ulcers OP96 4 Discharge Policy CP04 5 Booking non urgent patient transfers OP29 6 Patient Escort Policy OP67 7 Volunteer OP68 8 Health and Safety Section 9 Patient property OP18 10 Medicines Policies 11 Medical Devices HS11 12 Infection Prevention and Control Section 13 Birmingham and Black Country Critical Care Network Policy for Transfer of Level 3 Patients 14 Birmingham and Black Country Critical Care Network Policy for Repatriation of Level 2 Patients
Initial Equality Impact Assessment (all policies): Completed Yes **Full Equality impact assessment (as required): Completed NA** If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904

Monitoring arrangements and Committee	Section 9: Quality and Safety Intelligence Group

Document summary/key issues covered. **Inter hospital transfer of patients** **Intra hospital transfer of patients** **All referrals to West Park/ Cannock chase Hospital need to classified as transfers**

Key words for intranet searching purposes **Transfer, Inter hospital transfer, intra hospital transfers**	
High Risk Policy?	**No**

Part B **Ratification Assurance Statement**

Name of document: Transfer of patients between wards, departments, specialist Units and Other Hospitals

Name of author: Neil Jarvis Job Title: Matron for Gastroenterology and Endoscopy

I,the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: 

Date: 24/6/21

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version: **CP05 Version 7**	**Policy Title** **Transfer of patients between wards, departments, specialist Units and Other Hospitals Title of Policy**	
Reviewing Group		**Date reviewed:**
Implementation lead: Print name and contact details **Neil Jarvis Matron for Gastroenterology and Endoscopy 01902 86453**		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	Training will be provided by practice education facilitators in ITU.	3/12
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	Appendices attached to the policy, minor amendments made to ITU documents.	1/12
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	The policy changes will be disseminated to the wards managers and staff via staffing briefings.	1/12
Financial cost implementation Consider Business case development	No financial cost	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		

Appendix 1

Operational Procedure for the Inter /Intra Hospital Transfer of a patient

11.0 Decision to Transfer

- The decision to transfer a patient to another ward, unit, department or externally must be made considering the potential risks and benefits to the patient (see appendices and transfer protocol).
- There may be occasions where patients may have to be transferred (outlied) from one speciality to another to create capacity within a specific speciality. The identification of suitable patients to be outlied is to be made by the Consultant or Registrar in charge of the patient's care or the on-call Consultant or /Registrar for the speciality from which the patient is to be outlied

  Patients may also be identified by a designated senior nurse e.g.) Matron, Capacity Manager or Night Manager following a review of the patient's notes, nursing documentation and clinical observations. Criteria for suitability can be found in the outlier matrix (appendix 8) which should be completed prior to decision to transfer and filed in the patient's medical record. The suitability to outlie status will also be recorded on the safe hands board to aid a swift outlying process.

  Wherever possible medical patients should be transferred to their twinned ward.

  Patients are not to be outlied if it specifically states that they are not suitable to do so in their case notes.

- The decision to transfer to another hospital must be made by the Consultant in Charge, or in their absence the On-call Consultant. The rationale for the transfer to another hospital must be documented in the patient's case notes.

12.0 Informing the Receiving Ward/Department

Bed availability and arrangements, where appropriate, must be confirmed by both transferring and the receiving unit prior to transfer commencing so that the necessary equipment and resources can be put in place.

The Trust integrated health and social care team is best placed to liaise with other Trusts regarding bed availability for patient transfers.

13.0 Clinical Handover of patient

The verbal handover of the patient to the receiving ward/department will occur prior to the transfer utilising the SBART based transfer checklist as a communication tool. If the patient is escorted confirmation of the handover will be obtained by the escorting nurse and clarification provided if necessary.

This verbal handover must follow the SBART formats guided by the SBART based transfer checklist. This includes the following information:

- The recent diagnosis and medical history of the patient;
- Assessment of the patient including vital signs and VIEWS score;
- What safety risks are there for the patient (falls, allergies, psychological state, high risk medication, tissue viability, nutrition etc.?);
- If the patient needs isolation or has any infections that the receiving area needs to be made aware of;
- Carer and, or relatives have been informed of the transfer;
- The plan of care going forward, include any investigations outstanding;
- Confirm the destination is correct and they are expecting the patient;
- Confirm that the patient will have the required level of isolation if appropriate.

14.0 Patient Preparation for Transfer

14.1 The nurse must ensure that the patient is aware of the reason for transfer. The patient's next of kin and, or carer must be made aware of the transfer as soon as possible to avoid any distress.

14.2 The SBART based transfer checklist (Appendix 2) must be fully completed and attached to the front of the patient's case notes if the patient is to be transferred to a ward or department within the Trust or transferred to West Park Hospital or Cannock Chase Hospital. Ensure that all patient records are collected in preparation for the transfer.

14.3 If the patient is to be transferred to another Trust the case notes will not be sent with the patient. The Consultant or Registrar in charge of the patient's care must provide a letter to the receiving area providing a summary of the patient's condition, diagnosis, treatment plan and medications. It must be documented in the case notes that a letter has been sent with the patient. The nurse in charge of the patient transfer must complete the transfer checklist and a copy of this should be placed in a sealed envelope along with the doctors' letter in readiness for transfer.

14.4 Ensure that all of the necessary transportation equipment is present, in full working order, and with batteries fully charged. If the patient requires oxygen, ensure that the cylinder has enough supply to last during the transfer.

14.5 Intravenous fluids or infusions must not be discontinued or disconnected for the convenience of transfer.

14.6 Collect and check all of the patient's medications required for transfer. Ensure that the treatment sheet or a copy of the treatment summary is provided. All medications must be stored appropriately as per hospital policy.

14.7 Check that the patient is adequately dressed or covered prior to transfer and ensure that adequate warm cover is available.

14.8 Ensure that all of the patient's property is packed securely in hospital property bags or in the patient's own luggage. All valuables must be documented using the Trust property book and correctly signed for in line with the Patient's Property Policy OP18.

14.9 Document any care required during the transfer. Carry out any required observations.

15.0 Arranging transport for transfer

15.1 Internal transportation to other wards and departments can be arranged by requesting portering using the Trust 'Teletracking' system. The nurse in charge of the ward or department must decide on the required level of portering assistance and mode of transportation and ensure that they are informed if the patient requires oxygen.

15.2 Transfer to onsite departments which cannot be accessed using internal corridors must be done using the Trust Internal Ambulance - this request is to be made via the charge hand porter's mobile telephone (via Switchboard)

15.3 Transportation to Trust Departments which are based off site (e.g. West Park Hospital) will be provided by the Patient Transport Service. Requests are to be made by telephone to the booking office giving information regarding the patient's level of mobility and clinical needs to ensure that the correct level of support is provided by the service.

15.4 Transportation to other Trusts will depend on the clinical condition of the patient and the urgency of the transfer. Non urgent transfer transportation must be arranged via the Patient Transport Service. If the patient requires an urgent transfer to another hospital or Trust due to their clinical condition, transportation is to be requested via the Emergency Ambulance service stating the level of urgency and the level of support required for the transfer. For booking of transportation after 1700 hours contact switchboard to direct you to ambulance control for both non-urgent and urgent ambulance service

15.5 If the patient has a known infection and requires a level of isolation, this information must be provided at the time of request in accordance with the Trust Isolation Policy IP10

15.6 The Infection Prevention Team can be contacted for advice on the transport of patients with infectious conditions.

15.7 If the patient has a Do Not Attempt Resuscitation order or RESPECT document, a letter must be provided for the Ambulance crew upon collection stating this and the original document is to accompany the patient.

16.0 Patient Escort

16.1 The selection of the level of medical escort required must be made by the Consultant in charge, or in their absence, the Registrar. This selection may need to be discussed with the appropriate Matron, Head of Department or Duty Manager before a decision is made. The choice of escort is the Trust's decision and responsibility.

16.2 The selection of the level of nursing escort required must be made by the nurse in charge of the ward/department following assessment of the patient (refer to Patient Escort Policy OP67).

16.3 The identified escort needs to be aware of any action needed in the event of a change of condition of the patient during the transfer.

16.4 In the event that the ward does not have sufficient staffing resources to allow staff to be released for escort, the relevant manager during daytime hours or manager on-call during out of hours must be contacted and wherever possible, cover from another area provided.

16.5 In the event of accompanying patients for radioactive procedures, it must be ensured that the escort is not pregnant.

16.6 The escort nurse should contact the Directorate Management Team or On Call Manager to arrange a return journey following an external transfer if required.

17.0 The Transfer Checklist

All elements of the checklist must be completed. The checklist must be filed in the 'nursing process' section of the patients case notes following patient transfer.

18.0 Patient Information System

As soon as possible following the patient transfer the electronic patient information system e.g. PAS must be updated ensuring that the accurate time of the transfer and destination is entered.

19.0 Out of hours transfers

The procedure for the transfer of patients after 2000 hours will be the same apart from the following.

- The requesting of patient transport for transfers out of the hospital must be made directly to either the non-urgent or urgent ambulance service control depending on the patient's clinical need.
- In the event that the Ward does not have sufficient staffing resources to allow staff to be released for escort, the manager on-call during out of hours must be contacted and wherever possible, cover from another area provided.

Adult Inpatient SBART Transfer Checklist

The Royal Wolverhampton NHS Trust

To be completed by transferring ward/department and transferred on the front of the medical notes then filed.

S Situation

Date:..... Time of Transfer:.....

Speciality/Consultant:.....

Provisional diagnosis:.....

Transferring ward:.....

Registered nurse handing over: .....

Receiving ward:.....

Registered nurse receiving handover: .....

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

B Background

Relevant past medical history:.....

ID wristband in situ:.....

Safe hands Badge in situ Yes ☐ No ☐ DNACPR form completed Yes ☐ No ☐

Allergies:.....

A Assessment

Infection risk:

☐ None ☐ Flu ☐ Vomiting ☐ Diarrhoea

☐ Tuberculosis ☐ Known MRSA ☐ High risk CPE - healthcare abroad in the last 12 months

☐ Outstanding screens Details: .....

☐ Other .....

☐ Tracheostomy ☐ Laryngectomy ☐ Dysphagia ☐ NBM

☐ Urinary Catheter ☐ Chest drain ☐ Wound drain

☐ Peripheral venous catheter ☐ Central Venous Access Device ☐ Mid line

☐ IV Drugs / infusion / IV Insulin ☐ Diabetes Mellitus Capillary blood glucose .....

☐ NG / NJ tube insitu ☐ Tracheostomy Size: ..... ☐ Fenestrated/non-fenestrated

☐ CCOT aware Time: ..... ☐ Emergency box

Falls risk Yes ☐ No ☐ Fallen this admission Yes ☐ No ☐ Date of fall.....

Enhanced care required Yes ☐ No ☐ Pain score: .....

New Confusion/agitated Yes ☐ No ☐ If yes please give details .....

Wound pressure ulcer (please tick): ☐ None ☐ Yes (area): .....Category: .....

DATIX ref no: ..... Purpose T Assessment:..... Mattress:.....

Photograph of pressure ulcer taken Yes ☐ No ☐ N/A ☐

Observations must be taken and recorded within 30 minutes prior to transfer If not required please tick ☐

Current NEWS2 Score:..... Has NEWS2 escalation been followed Yes ☐ No ☐

Is sepsis suspected or confirmed Yes ☐ No ☐

Has the Sepsis Six been completed Yes ☐ No ☐ Time:.....

R Recommendation

Diagnosis still outstanding: .....

Management/discharge plan:.....

Special instructions (e.g. neuro obs, cardiac monitoring): .....

Referrals made (please tick) ☐ Safeguarding ☐ Domestic violence ☐ Alcohol
☐ Dementia ☐ Learning disabilities ☐ Social work
☐ Other:.....

T Transfer

Oxygen required (please tick) ☐ 2 litres ☐ 4 litres ☐ Other (detail): ..... Target Saturations: .....

☐ Oxygen cylinder sufficient for transfer ☐ Oxygen valve turned to on position

Property: ☐ No property ☐ Cash ☐ Valuables checked ☐ Disclaimer signed

☐ Relatives informed of transfer ☐ Medication with patient ☐ Locker emptied

☐ No medication ☐ Medication sent home ☐ Enteral feed in progress

☐ Escort required Level of escort: ..... ☐ Equipment checked

Signature: .....Designation: .....

Date:..... Time: .....Stamp:

Oxygen cylinder run times

Full Oxygen Cylinder Run Times (BOC)

Flow = litres/minute	Size / Flow	D (340 ltrs)	PD (300 ltrs)	CD/DD (460 ltrs)	E (680 ltrs)	F/AF (1360 ltrs)	HX (2300 ltrs)	ZX (3040 ltrs)	G (3400 ltrs)	J (6800 ltrs)
	0.25	22hrs 16min	20hrs	30hrs 36mins	45hrs 18mins	90hrs 36mins	153hrs 18mins	202hrs 36mins	226hrs 36mins	453hrs 18mins
	0.5	11hrs 18mins	10hrs	15hrs 18 mins	22hrs 36mins	45hrs 18mins	76hrs 36mins	101hrs 18mins	113hrs 18mins	226hrs 36mins
	0.75	7hrs 30mins	6hrs 36hrs	10hrs 12mins	15hrs 6mins	30hrs 12mins	51hrs 6mins	67hrs 30mins	75hrs 30mins	151hrs 6mins
	1	5hrs 36mins	5hrs	7hrs 36mins	11hrs 18mins	22hrs 36mins	38hrs 18mins	50hrs 36mins	56hrs 36mins	113hrs 18mins
	2	2hrs 48mins	2hrs 30mins	3hrs 48mins	5hrs 36mins	11hrs 18mins	19hrs 6mins	25hrs 18mins	28hrs 18mins	56hrs 36mins
	3	1hr 54mins	1hr 36mins	2hrs 30mins	3hrs 42mins	7hrs 30mins	12hrs 42mins	16hrs 48mins	18hrs 48mins	37hrs 42mins
	4	1hr 24mins	1hr 12mins	1hr 54mins	2hrs 48mins	5hrs 36mins	9hrs 30mins	12hrs 36mins	14hrs 6mins	28hrs 18mins
	5	1hr 6mins	1hr	1hr 30mins	2hrs 12mins	4hrs 30mins	7hrs 36mins	10hrs 6mins	11hrs 18mins	22hrs 36mins
	6	54mins	48mins	1hr 12mins	1hr 48mins	3hrs 42mins	6hrs 18mins	8hrs 24mins	9hrs 24mins	18hrs 48mins
	7	48mins	42mins	1hr	1hr 36mins	3hrs 12mins	5hrs 24mins	7hrs 12mins	8hrs	16hrs 6mins
	8	42mins	36mins	54mins	1hr 24mins	2hrs 48mins	4hrs 42mins	6hrs 18mins	7hrs	14hrs 6mins
	9	36mins	30mins	48mins	1hr 12mins	2hrs 30mins	4hrs 12mins	5hrs 36mins	6hrs 12mins	12hrs 30mins
	10	30mins	30mins	42mins	1hr 6mins	2hrs 12mins	3hrs 48mins	5hrs	5hrs 36mins	11hrs 18mins
	12	30mins	24mins	36mins	54mins	1hr 48mins	3hrs 6mins	4hrs 12mins	4hrs 42mins	9hrs 24mins
	15	24mins	18mins	30mins	42mins	1hr 30mins	2hrs 30mins	3hrs 18mins	3hrs 42mins	7hrs 30mins
Time = hours/minutes										

Cylinder size CD/DD is the most frequently used cylinder size.

SBART Handover Report for Antenatal Transfers

NHS
The Royal Wolverhampton
NHS Trust

Lead Professional .....

Date.....Time .....

Bed booked by .....RM

Call received by .....RM

Surname	Unit No
Forename	NHS N9
Address	DOB
Postcode	(or affix patient label)

Situation

G ..... P ..... Gestation..... EDD .....

Reason for Admission .....

Background

Date of Admission..... Time .....

The history is as follows .....

Relevant Medical History .....

Relevant Social History.....

Blood Group .....Rh factor.....

Assessment

PV loss ..... Pain ..... VE (if applicable).....

MEOWS (score) HII.....

Fetal well being Growth .....Placenta .....

CTG categorisation.....

Reviewed by ..... Grade.....

Investigations .....

CPE risk assessment completed Yes / No CPE result if known

Diagnosis .....

Recommendation

Management Plan.....

Decision

The plan has been agreed and ward able to admit Y / N Comments.....

Handover by .....RM

Care accepted by .....RM

File in Medical records

Name..... Unit No ..... NHS No .....

SBART

Post natal handover of care

Date & time of transfer:

Date & time of birth:

Type of birth:

EBL: .....

Last Hb and date taken: .....

Blood group: .....

HDN Blood taken: Yes / No

Perineum:

Intact ☐ Episiotomy ☐ Ist degree tear ☐ 2nd degree tear ☐

3rd degree tear 3a ☐ 3b ☐ 3c ☐ 4th Degree tear ☐

Bladder catheter: YES / NO

Time of first void:..... Volume:.....

BOY / GIRL
ID bands x 2 correct YES / NO

Vitamin K: ORAL / I M / NOT GIVEN

Feeding:.....

Time of first feed:..... Duration or volume:.....

Passed meconium: YES / NO Urine: YES / NO

Safeguarding concerns: YES / NO

Risk Factors - Mother	
Mother	VTE assessment completed YES / NO Medication Prescribed YES / NO
Risk Factors - Baby	Weight..... Gestation..... Risk factors for neonatal hypoglycaemia Yes ☐ No ☐ Other ☐ .....
Maternal and neonatal plan for ward care	

Transferred to Ward by:..... Signature:.....

Accepted on Ward by: ..... Signature:.....

NHS
The Royal Wolverhampton
NHS Trust

Integrated Critical Care Unit

New Cross Hospital
Wolverhampton
West Midlands
WV10 0QP

Phone:
Side B Direct Line: 01902 695025
or 01902 307999 Ext 85025, 84264
Side A direct Line: 01902 695024
or 01902 307999 Ext 85024, 86654

Surname	Unit No
Forename	
Address	DOB
Postcode	(or affix patient label)

Discharge Summary

Date of admission ..... Age .....

Date of discharge .....

Re-admission date ..... Sex .....

Discharged to (ward, HDU, others) .....

Discharged under care of (Dr / Mr) ..... LOS Days (ICU) .....

Source and Type of Admission

A&E ..... Recovery .....

HDU ..... Ward or MAU .....

Operation theatre ..... Others .....

Elective or Emergency ..... Other Hospital ..... Source .....

Diagnoses

Summary

Latest blood results

WBC	Sodium	Glucose
Hb	Potassium	Albumin
Platelets	Creatinine	INR

Plan & drugs on discharge

Infection risk

☐ None ☐ Flu ☐ Vomiting ☐ Diarrhoea

☐ Tuberculosis ☐ Known MRSA ☐ High risk CPE - healthcare abroad in the last 12 months

☐ Outstanding screens Details: .....

☐ Other .....

Treatment and care since admission

Airway and breathing

pH (Latest) ..... Respiratory rate (Latest).....

P_aCO_2 (Latest)..... Date extubated.....

P_aO_2 (Latest)..... Ventilated Days.....

S_pO_2(%) ..... Tracheostomy in situ ..... **Y / N** Cuff ..... **Inflated / Deflated**

FiO_2..... Type of tracheostomy Percutaneous / Surgical .....

Circulation

Notes:

HR (Latest) ..... per minute

BP (Latest)..... mm Hg

Rhythm.....

Inotropic support .....

Antiarrhythmic (Review).....

Elimination

Notes:

Last 4 hrs Urine OUTPUT.....

Urinary catheter in situ.....

Renal Replacement Therapy (Type / No of days).....

Nutrition

Notes:

Enteral feeding tube in situ.....

Enteral feeding in progress .....

TPN in progress.....

Invasive Lines

Notes:

Type	**Date of insertion**
Central Venous	.....
Arterial	.....

AVPU score & pain control:

Notes:

Alert & orientated .....

Responding to **V**oice .....

Responding to **P**ain.....

Unconscious .....

Pain controlled with PCA / Epidural / IV Infusion / IM / PO

MEWS on discharge:	**Accepting Team informed:**	
Dr (print)	**Grade:**	**Bleep:**

Signature: ..... Designation:.....

Date: .....Time: ..... Stamp

Ortid Number:.....

Outreach Discharge date:.....

The Royal Wolverhampton NHS Trust

ICCU Patient Discharge Sheet

Date of Hospital Admission:.....

Date of Admission to ICCU:.....

Date of Discharge: .....

Time of Discharge: .....

Ward Discharged to:.....

VIEWS score on discharge: .....

Number of days ventilated:.....

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Summary of stay: (reason for admission to ICU / HDU, relevant PMH)

Blood	Results
Na	
K+	
Urea	
Creat	
Glucose	
HB	
WCC	
Platelets	
INR	

Relevant blood results / investigation

Equipment / care needed on receiving ward

Identified with ward staff Yes ☐ No ☐

Tracheostomy care bundle Yes ☐ No ☐

Waterlow score on discharge:.....

Mattress requirements Yes ☐ No ☐

Mattress score .....

Patient suitable for transfer: Bed ☐ Chair ☐

Oxygen needed for transfer Yes ☐ No ☐

Prescription chart IV - fluids prescribed Yes ☐ No ☐

Patients medication Yes ☐ No ☐

Patients own CD's Yes ☐ No ☐

Nursing documentation

Admission sheet / Care plans / Summary sheet Yes ☐ No ☐

Hospital notes

Diary of patient (if applicable) Yes ☐ No ☐

Have the receiving medical team been informed of the transfer Yes ☐ No ☐

Are the relatives aware of the transfer Yes ☐ No ☐

Ward information given to relatives Yes ☐ No ☐

Property from unit divider / safe Yes ☐ No ☐

Has a current property disclaimer been signed Yes ☐ No ☐

Porters booked Yes ☐ No ☐

Risk assessments Yes ☐ No ☐

Admission book Yes ☐ No ☐

Midnight bed return Yes ☐ No ☐

Appropriate specialist agencies contacted Yes ☐ No ☐

Name of transferring nurse:

Designation:

Time:

Stamp:

Name of receiving nurse:

Designation:

Time:

Stamp:

Infection risk:

☐ None ☐ Flu ☐ Vomiting

☐ Diarrhoea ☐ Tuberculosis ☐ Known MRSA

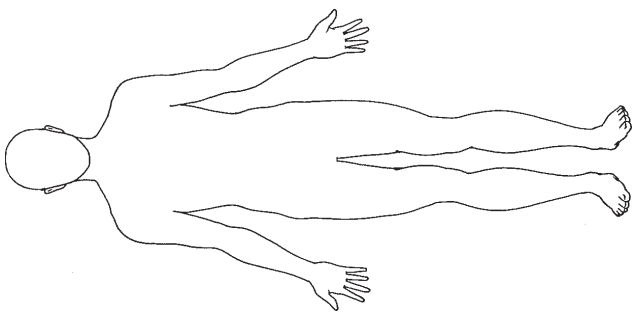
☐ High risk CPE - healthcare abroad in the last 12 months

☐ Outstanding screens

Details: .....

☐ Other .....

Position and date of lines



NHS
The Royal Wolverhampton
NHS Trust

Cardiothoracic Surgery

Nurse Transfer Sheet

Heart & Lung Centre

Surname	Unit No
Forename	
Address	DOB
Postcode	(or affix patient label)

Name of Referring Consultant	
	Date of transfer: Post Op Day: Operation: Complications following surgery:
☐ A-line removed ☐ Swan sheath removed ☐ Central line removed ☐ Pacing Wires: yes ☐ no ☐ ☐ Removed ☐ Chest Drains Removed ☐ CXR Completed ☐ Reviewed ☐ 12 lead ECG completed ☐ Todays blood results documented	Last ABG results: pH: pcO2: pO2: Hb: Ca+: Lactate: BE: HcO3: Na+: K+: Glucose: ☐ Insulin infusion Regime:
Checklist of Items to be transferred with patient	**Infection risk:**
☐ Current Drug Chart ☐ Integrated Care Pathway ☐ Medical Documentation ☐ Blood Results chart ☐ Microbiology chart ☐ Waterlow Score ☐ VIP score completed ☐ MUST score completed ☐ Risk of falls completed ☐ Manual Handling form completed ☐ Property and Clothing and own Drugs returned ☐ Surgical Site Surveillance MRSA Screen Result: ..... Last Screened:.....	☐ None ☐ Flu ☐ Vomiting ☐ Diarrhoea ☐ Tuberculosis ☐ Known MRSA ☐ High risk CPE - healthcare abroad in the last 12 months ☐ Outstanding screens Details: ..... ☐ Other

Activities of Living on Day of Transfer

Full wash / shave given Yes ☐ No ☐

Toiletries / Clothing / Footwear Yes ☐ No ☐

Dentures with patient Yes ☐ No ☐

Glasses Yes ☐ No ☐

Hearing aids Yes ☐ No ☐

Patient sat out in chair Yes ☐ No ☐

Time sat out:

TED Stockings applied Yes ☐ No ☐

If no please state reason

Physiotherapy assessment completed
Yes ☐ No ☐

Patient coughing and expectorating
Yes ☐ No ☐

Pain

Pain relief given Yes ☐ No ☐

Drug given: Time:

Pain Score on transfer:

Elimination

Urine output >1/2ml/kg Yes ☐ No ☐

Total output for last 4hours:

Bowels opened since surgery Yes ☐ No ☐

Wound intact Yes ☐ No ☐

If no please detail below wound care to be administered

Details:

Pressure areas intact Yes ☐ No ☐

Details:

Dressings to wounds intact / redressed
Yes ☐ No ☐

Infusions

Infusions in situ

1. Rate:

2. Rate:

3. Rate:

Cardiovascular/Respiratory State

HR..... BP .....

Rhythm..... Sao_2 .....

Temp ..... CVP.....

FiO_2..... Route .....

Details of nurse completing form

Nurse completing form and transferring pt:

Name:

Designation:

Time ready for transfer:

Transferred at:

Stamp:

Nurse receiving pt and handover:

Name:

Designation:

Time:

Stamp:

Number: 04237

BBCCCN/CNet/NWMCCN Transfer Form

NHS Walsall

Patients Name
Postcode
DOB/age
Hospital No
Referring Hospital
Receiving Hospital
Date of Admission to Hospital
Date of Transfer Time

Transfer from

ICU	
A&E	
Ward	
Theatre	
Other	

clinical or non clinical transfer?	
Reason for transfer?	

Brief Clinical History

Clinical Incident: Y / N See over

Pre-sedation GCS .....

Time decision for transfer made	
Time of departure from referring hospital	
Time of arrival at Receiving	
Time of transfer team leaving receiving hospital	
Time of transferring team arriving at base	
Incident number	
Ambulance or helicopter	
Type of crew	

Intensivist or anaesthetist managing patient for transfer

Name: .....
Grade: .....
Speciality: .....

Staff accompanying patient

Name: .....
Grade: .....
Speciality & Contact No: .....
Transfer training? Y / N

Name: .....
Grade: .....
Speciality & Contact No: .....
Transfer training? Y / N

At receiving hospital

Name: .....
Speciality & Grade: .....
Contact No: .....

At receiving unit

Name: .....
Grade & Contact No: .....

Monitoring *(circle)*

Breathing	Spont	Mech	Ambu bag	ECG	
Trachy/ET	Site		Size	NIPB	
Vent Type				SaO2	
TV				Temp	
Peak Pres				ETCO2	
PEEP				CVP	
FiO2				Others state	
RR				No of pumps	
Number of lines	Arterial Venous		Sites		

Start Time:									
Drugs & fluids (mis/hr)									
SaO2									
ETCO2									
Pulse									
BP									
Monitoring	CVP (mmHg)									
Pupil size	GCS. Eyes									
1mm 5mm	Motor									
2mm 6mm	Verbal									
3mm 7mm	220									
4mm 8mm	200									
	180									
	160									
	140									
	120									
	100									
	80									
	60									

Transfer comments (including any adverse events).

Top copy: File on Transfering Unit for Collection by Network, Blue copy: File in Patient Notes, Yellow copy: File on Recieving Unit

Signature of Dr or Nurse

BBCCCN/CNet/NWMCCN Check List for Patient Transfers

A - Assessment
C - Control
C - Communication
E - Evaluation
P - Preparation & Packaging
T - Transportation

Assessment

Airway/Respiration

- ☐ Airway safe
- ☐ Sedation, analgesia, paralysis adequate
- ☐ PaO2>8KPa or SpO2>92%
- ☐ PaCO2 4.0 - 5.5 KPa

If unable to achieve please give reason.

- ☐ Pneumothorax
- ☐ If yes - **Chest Drain**

Circulation

- ☐ Circulating volume adequate
- ☐ Perfusion adequate
- ☐ IV access adequate
- ☐ Bleeding - intrathoracic ☐
  - abdominal ☐
  - pelvic ☐
  - long bone ☐

Additional Monitoring Required Prior to Transfer

- ☐ CVP ICP ☐
- ☐ Direct BP

Neurological/Spinal

- ☐ GCS and pupil response documented
- ☐ Cervical spine immobilised
- ☐ C spine immobilised not indicated
- ☐ Other spinal injury if yes, adequate immobilisation

Necessary investigations Completed

- ☐ Haematology
- ☐ Biochemistry
- ☐ ABG's
- ☐ X rays
- ☐ CT scans
- ☐ Peritoneal lavage/laporotomy
- ☐ X match blood/blood products

Control

- ☐ Team leader identified
- ☐ Tasks allocated to individuals

Communication

- ☐ Admitting consultant responsible for patient
- ☐ ICU consultant
- ☐ Clinical team at receiving hospital
- ☐ Destination and bed availability confirmed
  - Paramedic/non paramedic crew ☐
  - Falcon or york 4 trolley base ☐
- ☐ Relatives informed

Evaluation

- ☐ Transfer appropriate to proceed at this time
- ☐ Record urgency on front of form

Preparation & Packaging

Equipment

- ☐ Transfer pack checked
- ☐ Appropriate drugs prepared
- ☐ Transfer trolley
- ☐ Transport ventilator & oxygen
- ☐ Reserve oxygen & key
- ☐ Monitoring devises, batteries & power supply
- ☐ Necessary infusion devises

Patient and Documentation

- ☐ Patient 'mummy wrap'
- ☐ Case notes
- ☐ Investigation results
- ☐ X rays & scans

Transfer Personel

- ☐ **P** - Phone
- ☐ **E** - enquiry number & name
- ☐ **R** - revenue
- ☐ **S** - safe clothing
- ☐ **O** - organised route
- ☐ **N** - nutrition
- ☐ **A** - A-Z map
- ☐ **L** - lift home

Confirm Telephone Number of Recieving Unit

_____

Transportation

Begin transfer.

Complete handover on arrival.

Ensure documentation completed and filed/sent on when returned to base.

Transfer Definitions

Emergency - 'blue light response to requesting unit.
Immediate - within 1 hour of requesting.
Urgent - 2-4 hour response to requesting unit.
Routine - over 4 hours or following day.

Obtain ambulance incident number.

In the event of an untoward incident

Clinical Non Clinical

How preventable was the incident?

1. Probably preventable within current resources.
2. Probably prevent with reasonable extra resources.
3. Possibly preventable within current resources.
4. Possibly prevent with reasonable extra resources.
5. Not obviously preventable by any change in practice.

Critical/Clinical Incident

What effect did it have on the patient?

1. No effect on anybody.
2. Transient abnormality not noticed by pt.
3. Transient abnormality with full recovery.
4. Potential permanent but not disabling harm.
5. Potential permanent disabling harm.
6. Death

The Royal Wolverhampton NHS Trust

SBART Checklist Emergency Department (Paediatric)

S – Situation

Speciality / Named Consultant:

.....

Provisional Diagnosis:

.....

Accompanying Adult Name:

.....

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

B – Background

P.M.H .....

Allergies .....

A – Assessment

Time Obs taken: ..... Weight: ..... BP: ..... Temp: .....

HR:..... Temp:..... RR:..... GCS:.....

BM: ..... O_2 sats .....% O_2 Therapy.....%

Infection risk (please circle) None Vomiting Diarrhoea Previous MRSA Other.....

CRT..... Safeguarding concern Yes ☐ No ☐

If any element is not applicable please write N/A

R – Recommendation

Diagnostics complete: .....

Treatment Given.....

Any Special Instructions e.g. Cardiac Monitoring, Neuro Obs etc,. .....

Referrals made Safeguarding ☐ Other.....

Referral Date: ..... Time: ..... Receiving ward / unit: .....

Referred By: ..... Stamp

Accepted By: .....

T – Transfer - Observations to be recorded only if due according to views 'track and trigger' protocol

Pews Score: .....Not required ☐ BP: ..... HR ..... Temp .

RR: ..... GCS: ..... O_2 Sats: ..... % O_2 Therapy:.....%

Oxygen required 2 litres 4 litres other none

Oxygen cylinder sufficient for duration of transfer o

(Please circle)

MRSA screen Yes ☐ NO ☐ N/A/G Wounds Sputum Urine Tracheostomy IV Cannula / lNotes

scanned ☐ Property checked / disclaimer signed ☐ Wrist band in-situ ☐

Relatives informed of transfer ☐ Medication with patient ☐ Medication sent home ☐

No medication ☐ Escort required Yes ☐ No ☐ Type of escort: Trained Nurse ☐ Untrained nurse ☐

Name of person completing:.....

Signature:	Designation:	Time:	Stamp:

Oxygen cylinder run times

Full Oxygen Cylinder Run Times (BOC)

Flow = litres/minute	Size / Flow	D (340 ltrs)	PD (300 ltrs)	CD/DD (460 ltrs)	E (680 ltrs)	F/AF (1360 ltrs)	HX (2300 ltrs)	ZX (3040 ltrs)	G (3400 ltrs)	J (6800 ltrs)
	0.25	22hrs 16min	20hrs	30hrs 36mins	45hrs 18mins	90hrs 36mins	153hrs 18mins	202hrs 36mins	226hrs 36mins	453hrs 18mins
	0.5	11hrs 18mins	10hrs	15hrs 18 mins	22hrs 36mins	45hrs 18mins	76hrs 36mins	101hrs 18mins	113hrs 18mins	226hrs 36mins
	0.75	7hrs 30mins	6hrs 36hrs	10hrs 12mins	15hrs 6mins	30hrs 12mins	51hrs 6mins	67hrs 30mins	75hrs 30mins	151hrs 6mins
	1	5hrs 36mins	5hrs	7hrs 36mins	11hrs 18mins	22hrs 36mins	38hrs 18mins	50hrs 36mins	56hrs 36mins	113hrs 18mins
	2	2hrs 48mins	2hrs 30mins	3hrs 48mins	5hrs 36mins	11hrs 18mins	19hrs 6mins	25hrs 18mins	28hrs 18mins	56hrs 36mins
	3	1hr 54mins	1hr 36mins	2hrs 30mins	3hrs 42mins	7hrs 30mins	12hrs 42mins	16hrs 48mins	18hrs 48mins	37hrs 42mins
	4	1hr 24mins	1hr 12mins	1hr 54mins	2hrs 48mins	5hrs 36mins	9hrs 30mins	12hrs 36mins	14hrs 6mins	28hrs 18mins
	5	1hr 6mins	1hr	1hr 30mins	2hrs 12mins	4hrs 30mins	7hrs 36mins	10hrs 6mins	11hrs 18mins	22hrs 36mins
	6	54mins	48mins	1hr 12mins	1hr 48mins	3hrs 42mins	6hrs 18mins	8hrs 24mins	9hrs 24mins	18hrs 48mins
	7	48mins	42mins	1hr	1hr 36mins	3hrs 12mins	5hrs 24mins	7hrs 12mins	8hrs	16hrs 6mins
	8	42mins	36mins	54mins	1hr 24mins	2hrs 48mins	4hrs 42mins	6hrs 18mins	7hrs	14hrs 6mins
	9	36mins	30mins	48mins	1hr 12mins	2hrs 30mins	4hrs 12mins	5hrs 36mins	6hrs 12mins	12hrs 30mins
	10	30mins	30mins	42mins	1hr 6mins	2hrs 12mins	3hrs 48mins	5hrs	5hrs 36mins	11hrs 18mins
	12	30mins	24mins	36mins	54mins	1hr 48mins	3hrs 6mins	4hrs 12mins	4hrs 42mins	9hrs 24mins
	15	24mins	18mins	30mins	42mins	1hr 30mins	2hrs 30mins	3hrs 18mins	3hrs 42mins	7hrs 30mins
Time = hours/minutes										

Cylinder size CD/DD is the most frequently used cylinder size.

Mi_2050614_05.09.16_V_1

The Royal Wolverhampton NHS Trust

Adult SBART Transfer Checklist (Emergency Department)

S – Situation

Speciality.....

Provisional Diagnosis .....

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

B – Background

Past Medical History.....

Allergies .....

DNACPR form completed Yes ☐ No ☐

CPE Risk assessment completed Yes ☐ No ☐

A – Assessment

Time Obs taken..... if any element is not applicable please write 'N/A'

BP ..... HR ..... Temp..... RR..... GCS.....

BM..... O_2 sats..... % O_2 Therapy..... % NEWS 2.....

Infection Risk (Please circle) None Vomiting Diarrhoea Previous MRSA Other.....

Pressure Injury (Please circle) Yes (Area).....Datix ref no.....

Photo Taken: Yes ☐ No ☐ Falls risk Yes ☐ No ☐ Fallen this admission Yes ☐ No ☐

Confusion Yes ☐ No ☐

R – Recommendation

Diagnostics completed.....

Treatment Given.....

Any Special Instructions e.g. Cardiac Monitoring, Neuro Obs etc,. .....

Referrals made (Please circle) Safeguarding / Domestic Violence / Alcohol / Dementia / L/D / S/W / Other.....

Referral Date ..... Time ..... Receiving Ward / Unit .....

Referred by..... Stamp

Accepted by.....

T – Transfer

Observations to be recorded only if due according to NEWS 2 'track and trigger' protocol (see over) NEWS 2 Score..... Not required ☐

BP ..... HR ..... Temp..... RR..... GCS.....

BM..... O_2 sats..... % O_2 Therapy..... % NEWS 2.....

Oxygen required 2 litres 4 litres other none

O2 cylinder sufficient for duration of transfer ☐

(Please circle)

MRSA Screen N/A/G Wounds Sputum Urine Tracheostomy IV Cannula/Lines

(Please circle)

Notes scanned ☐ Property checked / disclaimer signed ☐

Wrist Band in-situ ☐ Relatives informed of transfer ☐

Medication with patient ☐ Medication sent home ☐ No Medication ☐

Name of person completing: Consider escort required

Safe Hands Badge: Yes ☐ No ☐ Not required ☐

Stamp Signature.....

Designation ..... Date ..... Time .....

Emergency Department Track & Trigger

NEW score	Frequency of monitoring	Clinical Response
0	Minimum 4 hourly	• Repeat Obs prior to discharge
1 - 4	Repeat Obs within 1hour	• RN to decide whether increased frequency of monitoring and / or escalation of care is required
3 in a single parameter	At least 1 hourly	• RN to inform senior clinician who will review and decide whether escalation is necessary. • Consider sepsis screen • Plan documented
Total 5 or more Urgent response threshold	½ hourly Obs unless clinically indicated	• RN to immediately inform senior clinician who will review and decide whether escalation is necessary. • Patient to be moved into resus or an observable majors cubicle. • Perform sepsis screen • Plan documented
Total 7 or more Emergency response threshold	Continuous monitoring in resus or a visible cubicle	• RN to immediately inform the ED consultant (*Reg between 2am – 8am*) who will review and decide whether escalation is necessary. • Patient to be moved to resus or an observable majors cubicle • Perform sepsis screen • Plan documented
Visible Cubicle:- A13, A14,or RAT1		**Observable Cubicle:-** A7, A8, A9, A10, A11, A18 & A19

NEWS 2 Scoring

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

The Royal Wolverhampton NHS Trust

Patients Suitability to Outlie in next 24 hours - suitability should be made by: Consultant, Registrar or Matron

Signature: .....

Designation: .....

Stamp:

Date: .....Time: .....

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Suitable

- Confirmed EDD on Safe Hands
- Patient has a confirmed discharge plan
- Patient awaiting DST assessment, who are Medically Fit
- Medically fit for discharge awaiting social care package
- Views of 4 or less, stable for past 48 hours
- Clinically stable patient awaiting INR stabilisation
- Patients receiving long term IV Therapy awaiting capacity availability by OPAT / Hospital at Home to continue therapy in the Community
- D2A Completed

Unsuitable

- 2 or more moves of ward (excluding AMU / SEU)
- Dementia
- Pts undergoing assisted withdrawal from alcohol
- High risk of suicide / Adult Mental health
- Acute Confused State ECS >7
- Unstable fractures
- Spinal injuries
- Requires specialist care in own specialty unless agreed by Consultant
- Intercostal chest drain (other than to CTW, or resp ward)
- DKA acute phase
- Ongoing major complaint
- Major abdominal wounds
- In need of specialist airway management
- Views score of greater than 4 (other than COPD patients)
- Patient with infectious symptoms of unknown origin
- Patients receiving EOL care
- Patients with a transmissible infection in the red sections on the IP Isolation Matrix

Checklist:

Consultant Aware of Transfer o

Patient Aware of Transfer o

Relatives / Carers Aware of Transfer o

Recorded on Safe Hands o

Suitable to outlie to: - see admission criteria on the back

C39 o Surgical Ward o Gynaecology Ward o Heart & Lung Centre o Other Base Ward o

Final nurse check immediately prior to outlying transfer that the above has been completed

Signature: ..... Designation: ..... Stamp: Date: ..... Time:.....

Ward Admission Criteria

C39	A12 & A14
• Discharge planned for next 48 hours and plans in place • Mobile patients only (no hoist available) • No patients diagnosed with dementia or confusion (particularly due to the fire exits which go on a walkway outside) • No patients with a history of alcohol / drug dependencies or recovering on reducing regimes • No end of life patients • No infected patients as there are no side rooms on the ward • No outlier patient directly from ED without a direct plan from their speciality and is deemed suitable for C39	• Discharge planned for next 48 hours and plans in place • End of life patients • Drug / alcohol dependent patients in withdrawal • Patients experiencing cardiac events • Avoid immobile patients - limited access to physiotherapy • No outlier patient directly from ED without a direct plan from their speciality and is deemed suitable for A12 & A14
D7	
• No patients that need log rolling • No bariatric hoisting • They need to be fit and stable with date of discharge • Can transfer with walking aid • No patients with a history of alcohol / drug dependencies or recovering on reducing regimes • Patients experiencing cardiac events • No outlier patient directly from ED without a direct plan from their speciality and is deemed suitable for D7 • No high risk of falls / confused patients as we do not have a tagged bay in visual site due to the layout of the ward	

Procedure to CP05: **Unscheduled Transfer of a Patient from Cannock Chase Hospital (CCH) to another Hospital.**	**Version:** **2.3 May 2021**	**Status:** **FINAL**	**Author:** Clinical Director, Critical Care Services Directorate Division 1 **Director Sponsor: Chief Nurse**

Version / Amendment History	Version	Date	Author	Reason
	1.0	Oct 2014	CD Critical Care Services Directorate Division 1	Clarification of procedure to be followed in the event of a person becomes acutely unwell whilst at Cannock Chase Hospital.
	2.0	May 2017	CD Critical Care Services Directorate, Division 1	To amend in light of final disaggregation of transition arrangement with UHNM.
	2.1	March 2018	Divisional Medical Director Div. 1	Rewritten regarding RCA documented delays in transferring critically ill patient
	2.2	June 2019	Clinical Director, CriticalCare Services Directorate Division 1	Adult In-patient SBARTupdated (Form 1)
	2.3	May 2021	Divisional Medical Director, Div. 1	Updated re discretionary transfer to a non-New Cross Hospital site.

Intended Recipients: Nursing & Medical Staff. The document applies to all patients, both inpatients & outpatients, visitors to and staff workingon site at CCH.	
Consultation Group / Role Titles and Date:	
Name and date of Trust level committee where reviewed	Trust Policy Group Virtual approval May 2021 – V2.3
Name and date of final approval committee	Trust Management Committee – October 2014

Date of Policy issue	May 2021
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]	May 2020 (as situation with respect to Cannock Chase Hospital is likely to have changed at this time) *After this 1st review every 3 years.*
Training and Dissemination: This policy will need wide dissemination to all CCH staff. Staff at New Cross Hospital ED will need to be aware of the implications of this policy as will thestaff of the Acute Cardiology service.	
To be read in conjunction with: CP05	
Initial Equality Impact Assessment [all policies]: **Completed Yes / No / N/A** **Full Equality Impact assessment [as required]:** **Completed Yes / No/ N/A** If you require this document in an alternative format e.g., larger printplease contact Central Governance Department on Ext 5114.	
Contact for Review	Clinical Director, Critical Care Services Directorate, Division 1
Implementation plan / arrangements [Dr Simon Fenner]	Clinical Director, Critical Care Services Directorate, Division 1
Monitoring arrangements and Committee	An annual review/ audit of all admissions and transfers from CCH will be untaken. The results of this will be presented to and reviewed by the Critical Care Services Directorate Governance committee and will be shared with RWT QSAG.
Document summary / key issues covered: Urgent admission/ Transfer of Patients from CCH to New Cross Hospital or another NHS hospital	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

Contents

Unscheduled Transfer of a Patient from Cannock Chase Hospital

1.0 Procedure Statement

This document details the processes that must be followed to ensure the prompt and safe transfer of any patient at Cannock Chase Hospital (CCH) who requires admission to an acute hospital for care that cannot be provided at CCH.

2.0 Accountabilities

The Clinical Directors (CD's) of all services that are provided at CCH and the CD for the Critical Care Services Directorate must ensure that the processes described in this document are followed by all staff in their directorates.

The CD for the Emergency Department (ED) is responsible for disseminating the contents of this Procedure to all relevant staff.

Clinical staff at CCH and New Cross Hospital must comply with these processes.

3.0 Procedure Detail / Actions

CCH provides limited services for inpatients and outpatients, and any patient may require urgent transfer elsewhere due to the severity and, or nature of their clinical problem. The expected destination of these patients is New Cross Hospital.

This SOP specifies:

a) Transfer destination;
b) Need for escort for transfer;
c) Essential communication with the destination site;
d) Transportation of patients;
e) Completion of a Transfer Check List;
f) Return of staff and equipment after transfer.

The diagnostic and therapeutic facilities at CCH are limited. Any inpatient whose condition deteriorates such that they need immediate investigation (beyond plain radiology (in working hours) or simple blood tests) or acute medical or surgical care or any level of care greater than level zero must be transferred promptly to New Cross Hospital.

a) Transfer Destination

i) In-patients

If the urgent transfer of an in-patient is required, it is of paramount importance that the transfer is undertaken as soon as possible.

If the patient requires direct admission to the Critical Care Unit at New Cross Hospital, the transfer mustbe discussed with the Consultant on duty for the Critical Care Unit by the Consultant responsible for the patient at CCH – this may be the patient's own Consultant (during normal working hours) or the Consultant on-call for the relevant specialty. If there is no Critical Care bed available at New Cross Hospital, then the Critical Care Unit Consultant will engage with the Black Country Intensive Care Unit Network to identify the nearest available bed. This process must not delay the transfer of the patient from CCH. The patient should go to the New Cross Hospital ED while a Critical Care Unit bed is identified in another hospital. The ED department staff will arrange the onward transfer of the patient from ED once a Critical Care Unit bed is identified.

In all other than except exceptional perioperative circumstances (*see below), the patient will be taken by ambulance to the ED. The transfer must be discussed with and approved by the Consultant responsible for the patient at CCH, but transfer must not be delayed by making attempts to refer the patient to an in-patient specialty at New Cross Hospital. The only measures that are needed at this point are those required to secure the patient's clinical condition – there must not be a delay transfer while awaiting investigations that will have no immediate bearing on the patient's condition.

*In exceptional circumstances, there may be a surgery specific complication which requires urgent management that cannot be delivered at New Cross Hospital. In such cases, after discussion with the responsible consultant, it may be decided that transfer to another NHS hospital would be appropriate, the senior decision maker (this must be Consultant level and not the resident doctor[s] at CCH), must arrange acceptance by the clinical team at the other NHS hospital prior to arranging ambulance transfer.

ii) Outpatients

If an outpatient requires immediate admission to New Cross Hospital, they will go to the ED. The mode of transportation will depend on the patient's condition and circumstances. If it is safe andthe facility exists, they can be taken to New Cross Hospital by private transport; otherwise, they will needto be taken by ambulance.

b) Need for Escort for Urgent Transfer

The need for a doctor to escort a patient will be determined by the medical team at CCHin discussion with the on-call middle-grade Anaesthetist and, or Consultant Anaesthetist.A doctor must accompany any patient who is being transferred for level 3 care. Other patients requiring transfer to New Cross Hospital (or another NHS Hospital – see 1 a) i) * above) will usually be escorted by CCH nursing and, or ambulance staff.

c) Essential Communication

If a patient is being transferred to the Critical Care Unit, there must be a Consultant to Consultant referral (as described above) before the transfer can be made. In all other circumstances (See 1 a) i) * above) the patient will go to ED. The medical staff caring for the patient at CCH must telephone ED to inform them of the transfer.

When a decision to transfer the patient to New Cross Hospital has been made, it may be obvious which specialty will need to take over the care of the patient at New Cross Hospital. The medical staff at CCH must make contact with the on-call registrar or consultant for that specialty: if an empty bed is available for the patient, the medical staff at CCH should contact ED again so that the patient can be transferred there directly, and the medical staff accepting the patient should contact the destination ward to inform them of the transfer. The nursing staff on the ward at CCH should do a telephone handover to the nursing staff on the destination ward at New Cross Hospital if not accompanying the patient to New Cross Hospital. If there is no bed available, the medical staff at CCH should contact ED to tell them which medical team has accepted the patient.

It may be that the cause for the patient's condition is not known at this stage, so no specialty referral can be made. This must be told to the staff at ED, and they will then undertake essential diagnostic work and make an appropriate referral.

The patient's next of kin should be informed about the transfer (patient's consent should be

obtained if they have capacity).

(See 1 a) i) * above) – If the patient is being transferred to another NHS Trust, the patient's responsible consultant or the senior decision maker should speak directly with the accepting team at the other hospital. If the patient is NOT being accompanied by nursing staff from CCH, nursing staff should speak with staff on the receiving area of the hospital that has accepted the patient as well as providing appropriate documentation e.g. copy of clinical notes, referral letter and SBART.

d) Transportation of Patients

If an ambulance is needed to transport the inpatient from CCH to New Cross Hospital ED or to the Critical Care Unit at New Cross Hospital or to another NHS hospital, staff at CCH must contact West Midlands Ambulance Service Control (WMASC) though for transfer of Level 3 patients, it would be quicker to ring 999. WMASC will need to know relevant information about the patient's requirements i.e. oxygen, ventilation requirements, monitoring, infusion requirements and escorting personnel and the receiving area.

All urgent inpatient transfers will be undertaken in a paramedic crewed ambulance.
Level 2 urgent transfers must have a minimum of a qualified nurse escort.
All Level 3 transfers must be accompanied by a doctor with the necessary transfer (resuscitation/ airway) skills.

A referral letter must be written by medical staff at CCH, using the SBART form (see Form1), for the clinicians at the receiving hospital: it will be taken with the patient to the receiving hospital. All current in-patient notes and charts must also accompany the patient.

e) Transfer Check List to be completed

A Transfer Checklist (see Form 2) must be completed before the ambulance leaves.

f) Return of Staff and Equipment after Transfer

Accompanying staff will arrange a taxi (through New Cross Hospital switchboard) to return them and anyequipment to CCH.

4.0 Equipment Required

Patients requiring Level 2 transfer or those requiring lesser degrees of care would normally use monitoring equipment supplied by West Midland Ambulance Service in their paramedic ambulances. Equipment for the transfer of Level 3 patients and for the monitoring or support of vital organ functions from CCH is found on Hilton Main SECU (Surgical Enhanced Care Unit) or in Theatre Recovery and may be used instead of or in addition to equipment supplied by West Midland Ambulance Service.

5.0 Training

The synoptic Action Cards for each of the three identified areas will be laminated and held on file in and openly displayed by the relevant clinical areas near to the usual main phone access point, the nursing station and the office.

All staff at CCH will be informed of the new transfer and admission arrangements by their line managers.

6.0 References

a) AAGBI SAFETY GUIDELINE - Interhospital Transfer. (2009). AAGBI, London.

b) Guidance On: The Transfer Of The Critically Ill Adult. (May 2019). Faculty of Intensive Care Medicine & Intensive Care Society. London.

Form 1

ADULT In-patient SBART Transfer Checklist From WPH / CCH to New Cross

The Royal Wolverhampton NHS Trust

S – Situation

Speciality / Named Consultant ……

Provisional diagnosis ……

Transferring ward ……

Receiving ward ……

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Clinical reason for transfer:……

……

……

……

B – Background

P.M.H ……

……

……

……

Allergies ……

DNACPR form completed (please tick) Yes o No o CPE screening required Yes o No o

If Yes date screen completed:…… Results of screen: ……

A – Assessment

Breathing: Self ventilating o Ventilated / intubated o

ETT Size_____ secured at_____cm at lips O_2 Therapy: -_____% or_____lt/min

If applicable, AGB's: Time of ABG:___:___ pH:_____$PaCO_2$ PaO_2 HCO_3

Physiological Observations: -

BP =___/___ HR =_____RR =_____SpO_2 =_____%

Temp_____°C GCS = E @____/4 V @_____/5 M @_____/6 = Blood sugar_____mmol/l

R – Clinical management plan for transfer

…… ……

…… ……

…… ……

T

Transfer (Tick appropriate checkbox and if any **not** ticked, conduct further review/ action)

Identification Band in-situ o Property checked / disclaimer signed o

Notes accompanying patient o Relatives informed of transfer: Yes o No o If no give detail

Electronic Notes printed out o

Sufficient Transfer drugs available (if applicable):- Sedative o Analgesia o Muscle Relaxant o
Vasopressors o Resuscitation Drugs/ Box o

Airway and Breathing (If any 'NO" boxes ticked, conduct a further review):-	Yes	No
Capnography available and connected (mandatory for all ventilated patients)?		
Portable aspirator + suction catheters available?		
Portable monitor battery charged?		
Sufficient O_2 supply for transfer?		
Circulation: iv ACCESS (≥ 18G) X 2 secure and accessible:-		
Sufficient IV Fluids and any X-matched blood:		

Transport Team / Organisation
A minimum of 2 escorts available (including one experienced doctor for level 3 patient)?

Clinical Stability of Patient	Yes	No
Is the airway clinically secure?		
Is ventilation appropriate to clinical condition?		
Have haemodynamics been optimized?		
Has haemostasis been achieved?		
Adequate Sedation / Analgesia / Neuromuscular blockade (if applicable)		
Hypothermia: prevention and anticipation		
Patient monitored: ECG / BP / SpO_2 / $ETCO_2$ (if applicable)		

Nurse handed over to .....
Name of person completing form

Signature: ..... Designation:.....

Date:..... Time:..... Stamp:

Form 2 – Transfer Check List

T	**Transfer** (Tick appropriate checkbox) (If any 'NO' boxes ticked, conduct a further review) Identification Band in-situ Property checked / disclaimer signed Notes accompanying patient Relatives informed of transfer Notes scanned Electronic Notes Printed out Sufficient Transfer drugs available (if applicable): - Sedative Analgesia Muscle Relaxant Vasopressors Resuscitation Drugs/ Box **AIRWAY & BREATHING** (If any 'NO' boxes ticked, conduct a further review):- **YES** **NO** Intubation equipment, bag, valve and mask available? Capnography available and connected (mandatory for all ventilated patients)? Portable aspirator + suction catheters available? Portable monitor battery charged? Sufficient O_2 supply for transfer? **CIRCULATION:** IV access (≥ 18G) x 2 secure and accessible: - Sufficient IV Fluids and any X-matched blood: - **TRANSPORT TEAM/ ORGANISATION** A minimum of 2 escorts available (including one experienced doctor for level 3 patient)? Timetable for transfer discussed and confirmed? **Clinical Stability of Patient** Is the airway clinically secure? Is ventilation appropriate to clinical condition? Have haemodynamics been optimized? Has haemostasis been achieved? Adequate Sedation/ Analgesia/ Neuromuscular blockade (if applicable) Hypothermia: prevention and anticipation Patient monitored: ECG / BP / SpO_2 / $ETCO_2$ (if applicable)

TRANSFER NOTES or SUPPORTING INFORMATION: -

ACTION CARD 1 for RESIDENT MEDICAL STAFF AT CCH		
Title	**URGENT TRANSFER OF AN INPATIENT AT CCH (see CP05 Appendix 9)**	
Purpose	To provide clear instructions on how to transfer an inpatient to an acute NHS hospital.	
Definitions	CCH	Cannock Chase Hospital
	RWT	Royal Wolverhampton NHS Trust
	WMAS	West Midlands Ambulance Service
	ED	The Emergency Department
	RMO	The non-consultant doctor at CCH on duty to cover the inpatients at CCH.
	RC	**Responsible Consultant** is the consultant responsible for the patient's care at CCH or the on-call consultant for that specialty or the on-call consultant anaesthetist depending on circumstances.
	To ensure a seamless process of care is understood and followed by medical staff responsible for providing care for inpatients at CCH, and in accordance with RWT Policy relating to the Unscheduled Transfer of the Sick Person from CCH to another Hospital (RWT).	
Rationale	To ensure a seamless process of care is understood and followed by medical staff responsible for providing care for inpatients at CCH, and in accordance with RWT Policy relating to the Unscheduled Transfer of the Sick Person from CCH to another Hospital (RWT).	

Immediate Management

If an inpatient at CCH needs to be transferred to New Cross Hospital (or another acute NHS hospital), the medical staff must communicate with the RC (responsible consultant) and contact the on-call middle grade anaesthetist to do all thatthey can to optimize the condition of the patient. The priority is to transfer the patient safely and quickly.

Transfer Destination

If the transfer is to the Critical Care Unit, the RC must refer the patient to the New Cross Hospital Critical Care Unit consultantpersonally. If no Critical Care Unit bed is available at New Cross Hospital, the transfer must be to ED in the first instance and the CCH RMO must contact ED to inform them of the transfer.
If the transfer is not to Critical Care, the patient will go to New Cross Hospital ED: the RMO must contact ED to inform them of the transfer.
If transfer is required to a hospital other than New Cross Hospital for a specific perioperative surgical complication, the senior responsible clinician, usually a consultant, will liaise directly with the receiving clinical team at the other hospital.
West Midlands Ambulance Service Control (WMASC) will then be contacted to arrange the transfer without any further delay.
If it is obvious which specialty will need to take over the care of the patient when they reach New Cross Hospital, the CCH RMOmust first contact the on-call registrar or consultant for that specialty and then the ED to tell them which specialtyhas agreed to admit the patient. If an empty bed can be identified for the patient, the CCH RMO must tell the ED so the patient can be moved there promptly.

Essential Communication

The CCH RMO must inform the RC of a planned transfer. The RC may need to refer the patient to Critical Care or a hospital other than New Cross Hospital.The CCH RMO must inform ED of the transfer if the patient is not going directly to Critical Care.
The nursing staff must phone West Midlands Ambulance Service Control to provide an ambulance to take the patient to New Cross Hospital or a hospital other than New Cross Hospital though for Level 3 transfer it would be quicker to ring 999.
The CCH RMO must inform ED if the patient has been accepted by a specialty team at New Cross Hospital (and if there is an available ward bed).
The CCH ward nurses must do a telephone handover to the receiving ward at New Cross Hospital if known or the receiving team of the hospital other than New Cross Hospital.
The patient's next of kin should be informed of the transfer – if the patient has capacity, their consent should be obtained.

ACTION CARD 2 for RESIDENT MEDICAL STAFF AT CCH		
Title	**URGENT TRANSFER OF AN OUTPATIENT AT CCH (see CP05 Appendix 9)**	
Purpose	To provide clear instructions on how to transfer an outpatient from CCH to an acute hospital (NXH).	
Definitions	CCH	Cannock Chase Hospital
	RWT	Royal Wolverhampton NHS Trust
	WMAS	West Midlands Ambulance Service
	ED	The Emergency Department
	RMO	The non-consultant doctor at CCH on duty to cover the inpatients at CCH.
	RC	**Responsible Consultant** is the consultant responsible for the patient's care at CCH or the on-call consultant for that specialty or the on-call consultant anaesthetist depending on circumstances
	To ensure a seamless process of care is understood and followed by staff responsible for providingcare for outpatients at CCH.	
Rationale	To ensure a seamless process of care is understood and followed by staff responsible for providing care for outpatients at CCH.	

Immediate Management

If an outpatient at CCH needs to be admitted to New Cross Hospital (or another acute hospital), the clinic staff must ensuremedical input from clinic staff or from the RMO to try to optimize the condition of the patient. The priority is totransfer the patient safely and quickly.

Transfer Destination

All transfers will be to New Cross Hospital ED unless the patient has suffered a cardiac arrest and needs transfer to the Critical Care Unit (in which case there must be a consultant to consultant Critical Care Unit doctor referral; if no Critical Care Unit bed is available, the transfer must be to ED in the first instance – see Action card 1 URGENT TRANSFER OFAN INPATIENT AT CCH).
The mode of transportation will depend on the patient's condition and circumstances – if private transport is not appropriate or available, transfer will be by ambulance. If transfer to level 3 care is needed, a paramedic ambulance willbe needed.
If it is obvious which specialty will need to take over the care of the patient when they reach New Cross Hospital, the most senior clinician in the clinic must contact the on-call registrar or consultant for that specialty to get their agreement to admit the patient.

Essential Communication

The most senior clinician in the clinic must inform the consultant responsible for the clinic of the transfer (if the transfer is to Critical Care, there must be a consultant referral to the Critical Care Unit consultant).
The most senior clinician in the clinic must inform ED of the transfer if the patient is not going directly to Critical Care.
The clinic nursing staff must phone West Midlands Ambulance Service Control (or 999 for Level 3 transfers) to provide an ambulance to take the patient to New Cross Hospital if necessary.
The most senior clinician in the clinic must inform ED if the patient has been accepted by a specialty team at New Cross Hospital (and if there is an available ward bed).
The patient's next of kin should be informed of the transfer – if the patient has capacity, their consent should be obtained.

WCA_2369_01.09.17_V4

Discharge Summary

Airway	
Self maintaining	
Ventilated	
Breathing	
Rate	
O2	
Air	
Circulation	
Pulse	
Bp	
Arterial Line	
Central Line	
Dressing (Mapped)	
Drains	
Urine Output	
Disability	
AVPU	
Blood glucose	
Exposure	
Waterlow / Braden Q (Paed)	
Marks (Mapped)	
Stoma (Mapped)	

Theatre recoverypatient handover document

Date:..... Time:.....

Surname	Unit No
Forename	
Address	DOB
Postcode	(or affix patient label)

ISBAR - Recovery Communication Tool

Standardised ISBAR Handover Recovery staff to receiving ward staff

Identify	• Give patient's name, DOB, Hospital number. • Check patient's wristband with receiving nurse.
Situation	• Give name of procedure / operation performed.
Background	• State any relevant history to surgery performed. • State any allergy. • Was procedure performed under GA, LA, Regional block or IV sedation? • Anything to report during the procedure? e.g. Blood loss, difficult intubation, laryngospasm
Assessment	• Give latest clinical assessment of observations. • Start from head to toe with O2 requirements, IV lines and fluids, dressings urinary catheter, drains, VTE prophylaxis. • Pain score and analgesia given. • Any tests performed e.g. X-ray, ECG? • Has surgeon / anaesthetist reviewed patient in recovery?
Recommendations	• Any post op instruction including routine care following surgery? • IV fluids prescribed, medication prescribed, follow up tests, positioning of patient, use of O2 adjuncts, care and removal of drains / catheters, wound care and mobilisation post op. • Assign responsibility for any tasks that require undertaking. • Ensure receiving staff understand everything discussed.