Navigating Transfer Challenges

MITCHELL COUNTY HOSPITAL HEALTH SYSTEMS
MARY GRAY ER MGR, TPM

THE GOAL

GETTING THE RIGHT PATIENT TO THE RIGHT FACILITY IN THE RIGHT TIME IS CRUCIAL!!!

INTER-HOSPITAL TRANSFER

An inter-hospital transfer (IHT), also known as interfacility or secondary transfer, is needed when the diagnostic and therapeutic facilities required for a patient are not available at the given hospital.

These may include: **Trauma**, **Burns**, **Cardiac**, **Neurology**, **etc.**

Optimal health and well-being of the patient is the underlying goal of IHT. The decision to transfer is patient-centered and is used when the benefits of the transfer outweigh the risks.

Level IV/ Rural communities

Most Level IV's are in rural communities. Inter-facility transfers will occur on a regular basis from these facilities.

Choice of a destination hospital should be based primarily on infrastructure, availability of specialized care and proximity to the referring hospital (nearest facility) that can provide the quality care needed.

Once the decision is made the transfer process must be initiated and completed as soon as possible.

TRANSFER AGREEMENTS

Developing **mutually agreed upon** written guidelines for the transfer of trauma patients between institutions is essential in the trauma system as they define which patients should be transferred and the process to do so.

Transfer agreements no longer ensure the acceptance of the trauma patient by the receiving facility as with current EMTALA laws, this purpose is moot as institutions with greater capabilities than the transferring hospital are required to accept the patient.

CAPABILITIES

Each hospital’s treatment capabilities as well as regional transportation options is the first step.

Develop guidelines for rapid resuscitation, and identify patients who require a higher level of care, transportation options, and two-way communication of performance improvement and patient safety issues between hospitals.

Ex: BURNS - Wichita Ascension Via Christi or KU Kansas City

Criteria for Consideration of transfer (level iv)

CRITICAL INJURIES SUCH AS:

1. Penetrating injury/open fracture
2. Spinal cord injury/cerebrospinal fluid leak
3. Widened mediastinum/signs of great vessel injury
4. Open pelvic injury/solid organ injury
5. GCS <14 or deterioration
6. Multiple system injury
7. Major extremity injuries
8. Pelvis/Abdomen injuries
9. Co-morbid Factors - age, diabetes, pregnancy. etc.

Transfer guidelines

1. **Identification of patient injuries** that require transfer
2. **Physician to Physician communication** between facilities
3. Discussion of patient injuries and current treatments
4. **Agreement on transportation mode** (ground vs air)and type of personnel recommended (BLS, ALS, RN)
5. **Documentation requirements** (transfer form) including contacts for identification and communication of patient safety and performance improvement issues (PIPS).
6. Consider early transfer for patients with critical injuries, limited resources or no surgical capabilities

TRANSFER MISSION

LIFESAVE

Mission Control Acquity Software(8 questions) + age, weight and gender

Helicopter available in Salina now

Data: just coming out

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Patient Transfer Form

PATIENT

Patient Consent to "Medically Indicated" or "Patient Requested" Transfer

☐ I hereby **CONSENT TO TRANSFER** to ______________________. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

☐ I hereby **REQUEST / REFUSE (circle one) TRANSFER** to ______________________. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital. The reason I request / refuse transfer is ______________

Signature of ☐ Patient ☐ Responsible person ______________________ Relationship______________

Witness ______________________ Date____________ Time ________

Relative/Guardian: ______________ Phone: ____________ Durable Power of Attorney: ______________ Phone: ____________

PHYSICIAN

Reason for Transfer

☐ Medically Indicated ☐ Patient Requested ☐ Other: ______________ Diagnosis: ______________

I have examined this patient and based upon the reasonable risks and benefits described below and upon the examination available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

Risks and Benefits for Transfer

Benefits
☐ There is a physician specialist at the receiving facility that has special training to treat your condition.
☐ There is a specific treatment program that is designed to treat the condition that you have.
☐ There is equipment available that will facilitate further evaluation / treatment of the condition you have.
☐ Other Benefits______________________

Risks
☐ Your condition may become worse while being transferred.
☐ There may be unforeseen delays, such as traffic or inclement weather.
☐ Other risks specific to this condition: ______________________

Transferring Physician's Name: Dr. K.G.Kimple

Transferring Physician Signature ______________________ Date____________ Time ____________

Acceptance

The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment). Date__________ Time__________

Transferring Physician (print name) ______________ spoke with **Receiving Physician** (print name) ______________

NURSE

Acceptance/Report

Person Arranging Acceptance ______________ **Person Accepting Transfer** ______________

to **Receiving Facility**______________ Room #__________ Date__________ Time__________

Transferring Nurse______________ gave report to **Receiving Nurse**______________ Date__________ Time__________

Critical Values/Procedures

____

Output

☐ Cath/Urine ________ ☐ NG ________
☐ Emesis ________ ☐ Stool ________

Immobilizations

______________________ ☐ N/A

Respiratory Status

☐ Room air ☐ Oxygen: ____L cannula / mask ☐ ET/Trach

Oral Diet/Restrictions

☐ NPO ☐ Feeds Self ☐ Needs Assistance ☐ Type of Diet ______

Impairments/Sensory Status

☐None ☐Vision ☐Hearing ☐Speech ☐Amputation ☐Paralysis

Transportation Requirements

☐ Private transportation ☐ Ambulance ALS/BLS ☐ Helicopter

Belongings

☐ Sent with patient ☐ Sent with family

Name/relationship:______________________

List:______________________

Discharge Vital Signs Time:________

Height________ Weight (kg)________ Temp______

B/P______ Pulse______ Resp______ SpO2______

FHT______ GCS______

☐ **Copy of demographics/insurance information included**

☐ **Transfer form complete-original in chart/copy with patient**

☐ ______________________

Signature of verification

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ALLERGIES

MEDICATIONS/FLUIDS GIVEN IN ER

Medication/IVF	Route	Dose	Rate	Time

HOME MEDICATIONS

☐ **No home medications**

☐ **See attached medication list**

MODES OF TRANSFER

AMBULANCE – GROUND OR AIR

BLS: Basic Life Support – EMT

AEMT: Advanced Emergency Medical Technician

ALS: Advanced Life Support – Paramedic

Miscellaneous – Doctor, RN, RT, OB nurse

HELICOPTER

FIXED WING

POV

Transport Delays

Ambulance issues:

No Paramedic available – EMT's only or volunteers

One ambulance already out of the county – if you have more

Only available Ambulance on another call in the county

Making arrangements with other counties ambulance to take transfer (Jewell Co. EMS, Cloud Co. EMS) – locate staff

Weather Issues – Wind, Snow, Fog, Ice, etc.

TRANSPORT DELAYS CONTD.

Equipment not available – OB patient – FHM

Aggressive/uncooperative patient – unable to load till stable

Patient contaminated with a chemical or noxious agent

TRANSport DELAYS CONTINUED:

HELICOPTER ISSUES:

Weather - rain, snow, fog, wind, etc.

Pilot issues - too many flying hours

Already on a transfer - not available

Patient size (Bariatric) - patient too heavy

Patient injuries - Clinical instability - position (frogleg)

Inadequate communication with facility or vice a versa

Transport delays continued

Change in destination - weather related/specialty requests

Adverse events - Multiple patients d/t Disaster event

Nearest Helicopter or ambulance not available

HOSPITAL DELAYS

A. **DIVERSION**
B. NO AVAILABLE BEDS - OVERCROWDED
C. SPECIALTY SERVICE NEEDED NOT AVAILABLE (Neuro-surgeon)
D. EMERGENCY EVENT INVOLVING THE FACILITY

(INTERNAL DISASTER/EQUIPMENT FAILURE) examples include: Fire, Bomb threat, hostage situation, power outage, flood, etc.)

COMPARISON OF GROUND AND AIR TRANSPORT

	ADVANTAGES	DISADVANTAGES
MODE: **GROUND**	LOWER COST	LONGER TRANSPORT TIME
	RAPID MOBILIZATION	DEPENDENT ON ROAD CONDITIONS
	LESS WEATHER DEPENDENT	
	EASIER PATIENT MONITORING	
MODE: **AIR**	SHORTER TRANSPORT TIME	LANDING SITE NEEDED
	FAST RESPONSE TIME	NEEDS ADDITIONAL GROUND TRANSPORT
	CAN ACCESS PTS. HARD TO REACH AREAS	MORE EXPENSIVE
		SLOW TO MOBILIZE

Level IV hospital delays

Delay of transfer to perform tests

Doing CT scans in hospitals with no surgical capability only delays definitive care and should be avoided.

No Blood Bank available

PEDS – No Pediatrician available or equipment

BURNS –

MULTI-TRAUMA

RESOURCES

RURAL TRAUMA TEAM DEVELOPMENT COURSE

GUIDELINES FOR RURAL COMMUNITIES ON GUIDANCE TO TRANSFER TO A HIGHER LEVEL CAN BE FOUND AT:

www.facs.org/quality-programs/trauma/vrc/resources

EMTALA

1987 - The “anti-dumping” law was designed to prevent the transfer of patients based solely on the patient’s ability to pay.

WHEN IN DOUBT - FILL IT OUT

Page 32 of the Orange book includes additional elements relative to the obligations that are expected.

TRANSFER CHECKLIST (REAL TIME AUDIT)

1. **Provider to Provider acceptance** obtained prior to transfer and documented
2. **Healthcare Facility to Healthcare Facility acceptance** obtained prior to transfer and documented.
3. **Phone report to receiving nurse** done and documented
4. **Written orders obtained for further care en-route** if needed
5. **Appropriate meds and equipment sent with patient** as needed.
6. **Copies of records including Nurses Notes and Doctors H & P** in envelope and transferred with patient or faxed within 60 minutes of patient discharge.

Transfer Checklist contd:

7. **Transportation arrangements made** and documented

8. **Doctor signature obtained on all appropriate risk, benefit or refusal of transfer forms.**

9. **Patient signature or next of kin signature obtained for transfer,** request for transfer or refusal.

10. **Belongings secured, listed and sent with whom documented.**

 Transfer Check List Real Time Audit	Orig. unk. Rvsd. 3-1-17
	Public/flowsheets/er/er policies
	Pg. 1

Patient Name:________________________________ Date:____________________Time:__________

____1. Provider to Provider acceptance obtained prior to transfer and documented

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____9. Patient signature obtained for transfer, request for transfer or refusal

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RN Signature_____________________________