Assessment and Management of Interhospital Patient Transfers Policy

1. Purpose

The purpose of this policy is to establish minimum practice standards for the assessment, care and management of the patient requiring interhospital transfer from a WA Country Health Service (WACHS) facility.

This policy outlines the processes for standardised organisation of interhospital patient transfer (IHPT) from WACHS facilities, including the following:

- responsibilities of:
  - Acute Patient Transfer Coordination (APTC) Service
  - WACHS staff
  - Transport providers.
- required communication and documentation processes to ensure effective clinical handover for continuity of patient care.

2. Policy

WACHS is committed to ensuring interhospital patient transfers are equitable, clinically and culturally safe, responsive, efficient and effectively coordinated.

This policy applies to all WACHS staff who are involved in the clinical decision and care regarding patient transfer and those involved in the assessment and management of the patient requiring interhospital transfer.

Patient transfers to non-health sites such as independent nursing homes, patient outings, home visits and overnight/other leave is not within scope of this policy document.

There are a number of decisions which need to be made to ensure the patient transfer is safe and effectively coordinated. These decisions are the critical steps for a successful transfer.

The steps are:

- recognising the need to transfer the patient and determining the most appropriate facility to provide the definitive level of care required.
- discuss with and obtain consent of the patient and/or carers and document accordingly.
- determining the clinical transfer priority and the most appropriate mode of transport for the clinical condition and distances to be travelled.
- assessment and planning for appropriate patient escort as required.
- appropriate patient preparation for transfer.

2.1 Recognising the need to transfer the patient and determining the most appropriate facility to provide the level of care required

A guide for patient conditions that require transfer are outlined in Appendix A. Specific Indications for Transfer of the Neonate are outlined in Appendix B.

WACHS facilities provide clinical service at a variety of levels which are outlined in the WACHS Clinical Governance Framework and within the Emergency Care Capability Framework.

When definitive care cannot be provided at site, which includes lack of equipment and or appropriately skilled and available staff and/or services, referral is to be made to the aligned WACHS link hospital or appropriate state service i.e. State Trauma Unit, State Burns Unit. The patient's clinical condition is the major determinant in choosing a destination for transfer. The referring medical officer is to be guided by the facility's available resources to provide definitive care and recognise and respond to patient deterioration.

Appendix C provides clinicians with a detailed list of contact details to obtain specialist advice and assist in the decision making for determining the most appropriate destination for transfer.

The treating medical officer is to liaise with the nominated destination specialty team for acceptance of care and to provide clinical handover in accordance with the Clinical Handover Policy MP 0095/18. In the instance of Mental Health patient, this is to occur after a bed is identified, with the exception of ED to ED transfers. The rationale for transfer and the acceptance of the receiving medical practitioner and facility is to be clearly documented in the patient's healthcare record.

In instances of a complex transfer (or retrieval), a time critical transfer or where the referring clinician is unsure of the appropriate specialty due to an undifferentiated patient, the referring clinician is to contact APTC to facilitate a conference call with an appropriate receiving site.

Should the APTC Medical Coordinator (MC) determine an alternate accepting site more appropriate for the patient's ongoing management, either via an intermediate site with the ability to appropriately differentiate the patient condition or due to logistical implications requiring a staged transfer, the Medical Coordinator is to discuss with and coordinate the alternative accepting site with the referring site clinician.

The APTC MC will act as arbiter of any conflicting transfer decisions, with authority for final determination of a patient's destination within WACHS.

2.2 Patient and carer communication

It is always important to involve the patient and/or significant others early in the potential or actual decision to transfer, to create a shared understanding of the rationale for transfer and allow for consideration of the patient's wishes, goals and preferences. Ideally this conversation and shared understanding is to be documented by the treating clinician.

Where the potential for clinical deterioration is significant, a parent or significant other should be considered to accompany the patient (where possible). The ability to

accommodate companions/carers as an escort is dependent on the transport provider and is subject to weight restrictions and asset capacity. Aeromedical transport teams may need to offload a companion/carer at an intermediate destination to attend to another emergency patient. Noting all transfers of minors require a parent or guardian to accompany them, with the exception of primary retrievals or for IHPTs where consent has been received and documented in writing by a parent/ guardian or carer.

Where funding considerations and approvals surrounding companion/ carer escorts may impact a patient's decision to consent to a recommendation for transfer, sites should escalate to established escalation pathways.

2.3 Special considerations for patient transfer

Special considerations for the following groups of patients are required for the planning and management of the transfer:

Neonatal patient

The Newborn Emergency Transport Service (NETS) WA is responsible for retrieval of all sick newborn and young infants <44 weeks corrected age (<4 weeks if term baby). NETS is to provide clinical support and advice and is to organise the transfer in collaboration with transport providers and regional site clinicians as required. Regional paediatricians may be requested as an escort from remote regions to support time critical transfers.

All new NETS referrals should be directed without delay to NETS WA on 1300 638 792. Notification to NETS should be made as early as possible by either the clinician at the bedside or the Midwifery and Obstetrics Emergency Telehealth Service (MOETS) clinician involved in the patient care.

Please refer to Appendix B - Indications for Transfer for the Neonate. For more detailed information regarding stabilisation and initial management of common neonatal conditions, refer to the Child and Adolescent Health Service (CAHS) Newborn Emergency Transport Service WA (NETS WA) guidelines.

Primary contact information for all regions:

NETS 1300 638 792 (1300 NETS WA)

- General enquiries: 08 6456 3445
- Email: nets@health.wa.gov.au

Paediatric patient

Inter-hospital transfer from regional sites into Perth metropolitan of a child over the age of 28 days through to 16 years in the majority of cases will transfer to Perth Children's Hospital (PCH), with a small percentage being transferred to other metropolitan Paediatric services.

When requesting transfer for paediatric patients to PCH considerations should be given to service wait list times and if service could be more rapidly accessed closer to home for patients aged 15 years and nine months and above.

To facilitate the safe and timely transfer of children and adolescents whose medical condition requires care at a different level from that of the presenting regional WACHS site the treating clinician is to discuss the need for transfer with the parent/guardian and patient (age-appropriate). The plan for transfer should be discussed with the parent/guardian as part of the overall treatment plan for which informed consent was obtained, with consent of the child, where appropriate.

For WACHS paediatric patient transfers the MR184P Inter-hospital Transfer Neonatal & Paediatric Form is to be completed and sent to relevant nursing / midwifery personnel at the receiving hospital.

Special consideration should be made for the following when transferring paediatric patients:

- a supply of nappies, toiletries and food provisions for infants and toddlers during transfer
- appropriately credentialed clinical escorts of infants and children
- accommodation for parents and/or families at the receiving site. If a patient and escort are required to stay in the metropolitan area due to ongoing treatment or a delay in transport arrangements, they may require assistance in arranging accommodation with the Patient Assisted Travel Scheme. Inform the parents to contact Ronald McDonald House (RMD) on 9346 9000.

For paediatric patient transfers refer to:

- CAHS Admission and Age of Eligibility Policy
- CAHS Transfer by Road and Air of Stable Infants Guideline
- Paediatric Patient Assisted Travel Scheme

Pregnant or postnatal patient

There are to be no planned births at designated non-birthing sites. All pregnant women who live in communities with non-birthing hospitals are to be referred to an appropriate level maternity service for labour and birth care.

Imminent birth escalation processes should be followed to ensure the most senior available local medical, midwifery and / or nursing staff are present to assist with the care of mother and baby during the birth. Assistance should include clinical assessment as directed via the regional on call Obstetrician as per local escalation processes, or where not available, assistance should be sort from MOETS clinicians.

All pregnant patients in labour who present to a non-birthing site should be discussed initially with MOETS, who will in turn liaise with APTC on behalf of the site to facilitate transfer. As soon as is it practicable and safe to do so, the mother and/or baby are to be transferred to the most appropriate maternity unit. For the transfer of a mother and/or baby from maternity sites the treating Obstetric/ Paediatric clinician should call APTC directly to facilitate transfer.

Where a metropolitan public maternity service is the closest available birthing unit, the on-call obstetric medical officer for that service will be the most appropriate point of consultation. Referrals regarding low risk women in labour at term, to King Edward Memorial Hospital (KEMH) may be directed to another metropolitan maternity hospital as the most appropriate receiving site for transfer. (See NETS above for relevant process).

For these transfers the MR184C Interhospital Transfer Maternal Form is to be completed and sent to relevant nursing / midwifery personnel at the receiving hospital. The MR184P Inter-hospital Transfer Neonatal & Paediatric Form will also be required for baby post birth.

The WACHS Maternity Care Clinical Escalation Pathway Policy is to be utilised when disagreement occurs between teams involved in the management and safe transfer of patient/s.

Special consideration should be made for the following when transferring pregnant or postnatal patients:

- provisions for breast feeding mothers
- for private transport, consideration must be given to, frequency and pain of contractions, labour is not established and/or the clinical needs of the newborn.

For pregnant or postnatal patient transfers refer to the WACHS:

- Maternal and Newborn Care Capability Framework Policy
- Imminent Unplanned Birth at a Non-Birthing Site Policy
- Midwifery and Obstetrics Emergency Telehealth Service.

Mental Health patient

All WACHS Mental Health IHPTs require consultation and assessment by a specialist mental health clinician, either Regional Psychiatric Services or the Mental Health ETS (MHETS) prior to arranging transfer.

Depending on the status of the mental health patient, special considerations need to be taken when preparing and planning for transport. For patients subject to referral or treatment under the *Mental Health Act 2014* the use of videoconferencing technology should also be considered as a less restrictive option to transfer. Sedation is only to be used where other psychological and behavioural approaches have failed to de-escalate any acute behavioural disturbance.

If an inpatient admission is required, WACHS Mental Health Patient Flow (MHPF) must be contacted to arrange coordination of an inpatient bed along with collation of required documentation/assessments:

- **MHPF Phone:** 0429 570 423
- **Email:** WACHSMHPF@health.wa.gov.au.

If escalation to an ED to ED transfer is required follow the WACHS Referral Pathway for ED to ED Transfer Mental Health Patients and the WACHS Mental Health Bed and Inter-hospital Patient Transfer Pathways.

Once all correctly completed mandatory referral documents have been received by MHPF, and an accepting site has been identified, WACHS MHPF is to refer the patient for transfer on behalf of the site/ referring clinician. At this point clinical transfer priority and transport planning is to be determined and coordinated in consultation with site by APTC.

The referring site will complete any documentation for the police escort booking (computer aided dispatch) CAD number and provide the CAD number to APTC. Arrangements of WA Police (WAPOL) or Transport Officer escorts in most instances can then be coordinated as required on behalf of site by the transport provider.

The referring mental health practitioner (regional or MHETS) must provide the following completed documentation to MHPF:

- history of presenting complaint
- past psychiatric and medical history
- current list of medications
- mental state examination including formulation and plan
- any physical problems that need follow up and monitoring within the first 24 hours of admission to a ward. (Use appropriate observation and response chart as relevant)
- any risks identified at the time (self, others, dependents or property etc.)
- a copy of the MHA forms that are in place
- SMHMR990 Mental Health Transport Risk Assessment Form. (Note: An Extreme risk rating will require a WA Police escort for transfer of a patient, impacting the ability to utilise a Mental Health Patient Transport Officer where possible.)
- any additional Mental Health forms required based on the patient's specific circumstances or as requested by MHPF.

For Mental Health Patient Transfers refer to:

- *Mental Health Act 2014* (WA)
- Mental Health Bed Access Capacity and Escalation State-wide Policy
- WACHS Mental Health Bed and Inter-hospital Patient Transfer Pathways
- WACHS Referral Pathway for ED to ED Transfer Mental Health Patients.

Trauma patient

Contact APTC directly and a conference call will be coordinated with the age-appropriate Trauma team to discuss management and transfer. Refer to the EMHS Guiding Principles for Major Trauma Interhospital Transfer.

For calls surrounding Trauma advice only, contact the relevant Trauma service as per Appendix C.

Stroke related transfers

Timely transfer of the acute stroke patent is crucial. Depending on the capability of the WACHS site to image or thrombolyse as clinically indicated, urgent transfer is to be requested of APTC who is to include the receiving site and/or Neurological Intervention and Imaging Service of WA (NIISWA) in the referral call as appropriate. The destination of transfer is dependent on the tertiary facility as outlined in the Acute Stoke Transfer Pathways.

Palliative care

Special consideration must be given for the critically ill who are unlikely to survive the transfer. Family members / carers must be consulted and given the opportunity to discuss options, which may include end of life care on site.

Patients should be supported to receive care in country and the setting of their choice wherever possible. The Palliative Care After Hours Telehealth Service (PalCATS) is available (1800 422 190) after-hours between 16:00 – 23:30 Monday to Friday, 08:00 – 23:30 on weekends and public holidays to provide specialist nursing consultancy support and care when sites are unable to access their regional Palliative Care teams.

The state-wide Palliative Care Outreach Service is available to provide 24-hour Palliative Care Consultant telephone advisory support for doctors and nurses (1300 558 655).

Heavier patient (bariatric)

The weight of the patient must be discussed when making initial contact with APTC to ensure the correct asset and equipment is deployed. In cases greater than 120 kg, a widest width measurement is to be requested. A useful tool to calculate this can be found here (St John Ambulance [SJA] Bariatric Patient Measurement Instructions Resource). Local procedures and use of equipment for the management of the bariatric patient are to be adhered to. Please refer to the WACHS Risk Assessment for Admission of the Heavier Patient Policy.

Culturally and linguistically diverse patient

It is the responsibility for all staff to deliver culturally safe and responsive patient care, ensuring the rights, views, values and expectations of all patient backgrounds are recognised and respected. The decision to transfer should include the identification of any cultural needs, factors, and considerations, such as 'being off Country'.

All transfers of Aboriginal patients/people should include discussions with the patient, family members/ carers, and hospital Aboriginal Liaison Officers. The impacts of cultural needs are to be considered when planning to transfer or the requirement of a companion, next of kin or carer as an escort.

If appropriate and available, language interpreting/ translation services should be utilised for support with linguistic barriers of non-English speaking and Aboriginal patients. The use of visual resources/information to support cross-cultural communication is recommended.

In the treatment and transfer of culturally diverse patients, gender matching of the health site and transfer staff inclusive of escorts should be considered and arranged where resourcing allows.

For culturally and linguistically diverse patient transfers refer to:

- Consent to Treatment Policy MP 0175/22
- Language Services Policy MP 0051/17
- Aboriginal Interpreting WA.

Repatriation of WACHS patients from metropolitan sites

Any patient requiring inpatient hospital care closer to their home should be referred to the 'WACHS Link' state service to ensure a standardised approach to planned WACHS patient flow. The purpose of the service is to provide a centralised point for communication and coordination for patients requiring transfer from any metropolitan site, including all tertiary, general and private hospitals to a WACHS country facility.

WACHS Link is a small team who are the central coordination and communication centre to assisting in the initial stage of securing an inpatient bed for safe and appropriate patient transfer planning.
Referring site clinicians and/or discharge planners at all metropolitan facilities are required to complete the relevant referral process and documentation as outlined on the WACHS

Patient Flow Hub (sharepoint.com) and liaise directly with the WACHS Link Patient Flow Coordinator via the following contact details:

- **Phone**: 1800 807 554
- **Email:** WACHSLink@health.wa.gov.au
- **Fax:** 08 9223 8599 (referral preference via email).

Available Monday to Friday 7:30am - 4:30pm.

Once the receiving site has reviewed and ensured the patient care requirements can be appropriately and safety managed, WACHS Link will advise the referring site of the accepting medical governance contact details followed by a date for transfer.

WACHS Link can also assist with advice and identification of barriers regarding transport planning, coordination of complex patient care processes and provide advice related to IHPT requirements or local discharge services for patient care needs.

2.4 Arranging transfers

All WACHS IHPTs completed by transport providers are to be requested through and coordinated by the APTC **by calling 1800 951 211**. Notification to APTC of the potential for transfer is to occur as early as possible.

To enable timely referral for transfer of medium to low acuity patient transfers only, the patient's completed MR184 WACHS Inter-hospital Clinical Handover Form can be faxed to APTC (1300 018 391) prior to referral, followed up by phone within 30 minutes by the referring site.

The APTC Medical Coordinator is responsible for determining the patient's clinical transfer priority (Appendix D and Figure 1 below), the mode of transport and most appropriate clinical escort required for the transfer based on the information provided of the patient's clinical condition at the point of referral.

Figure 1: APTC Clinical Transfer Priority:

- ITB = Ideal time to bedside - the time the main transport crew is beside to the patient.
- ITDC = Ideal time to definitive care - this may include bringing the intervention and clinician to the patient (i.e. intubation, critical drugs such as blood, antidotes etc) or the patient to a higher level of care. This time is the escalation marker for any delays to transfer.

P1 – Immediate	P2 – Emergency	P3 – Urgent	P4 – Semi-Urgent	P5 – Non-Urgent
ITB= ASAP	ITB = 2-6hr	ITB = 6-12hr	ITB = 12-24hr	ITB = 24-48hr
ITDC =6hr	**ITDC = 12hr**	**ITDC = 24hr**	**ITDC = 48hr**	**ITDC = 72hr**

The APTC Medical Coordinator is guided by the following influencing factors:

- patient's clinical condition
- local site capabilities and capacity to provide ongoing care
- availability and skill set of personnel required for the transfer
- location of destination and distances involved
- road transport times and road conditions
- availability, range and speed of vehicles
- patient comfort
- patient and escort safety / fatigue /stress

- time of day
- weather conditions and aviation restrictions
- aircraft landing facilities
- other patient transfer referrals and competing priorities for available assets.

The referrer may be requested by APTC, to arrange alternative modes of transfer for appropriately identified patients, which may include:

- private transport
- commercial or non-Government organisation transport e.g. bus, train, air, taxi, and community bus
- health service vehicles
- clinic transfer service
- commercial airline – Refer to Considerations for Patient Transfer by Commercial Airlines (Appendix E) and for more specific medical exclusions and timeframes for commercial travel, please refer to the airline's website
- some regional areas have private aeromedical evacuation options for employees of mining companies.

Should all transfer options be exhausted through APTC with contracted providers or the APTC Medical Coordinator determines an alternate medicalised transport option is required, (such as alternate road or air private charter for medical evacuation), this coordination and approval is to be arranged by APTC in accordance with the WA Country Health Service Authorisation Schedule.

2.5 Escalation

The APTC is to be contacted by the treating clinician if:

- the patient's clinical condition deteriorates or significantly changes
- the site feels unable to safely provide ongoing management
- a time critical inpatient bed or receiving facility it is unable to be sourced
- there is concern about a delay in or lack of a transport plan within the timeframe for the clinical transfer priority assigned
- if there needs to be a re-evaluation of the clinical transfer priority, including a need for transfer.

The APTC is to work with all parties to understand the patient's needs, any referring sites' concerns to explore a change to the transfer plan if determined necessary.

The APTC Medical Coordinator will act as arbiter of any conflicting transfer decisions, with authority for final decision on all WACHS IHPTs, escalating to the Chief Operating Officer (COO) or Executive on Call when required.

2.6 Clinical escorts

Consideration of the following is to be used to inform the APTC in conjunction with the referring clinician in determining the minimum clinical escort requirements, and their anticipated skill set to accompany and care for the patient during transfer, in accordance with the available transport provider escort's scope of practice:

- the patient's condition including behavioural considerations
- the potential for procedural intervention
- medication and fluid requirements

- the distance to be travelled
- the mode of transport
- consideration of gender matching of staff and patients where appropriate and required.

If the APTC determines that the skill mix of the clinical escort is beyond that available by the identified transport provider, the referring site may be asked to provide an escort for transfer.

Consideration is to be given for continuity of clinician care for the patient transfer and site staffing levels as well as the ongoing implications on patient care if they remain at the referring site to await transport alternatives.

Any concerns around the request for site to provide an escort should initially be discussed with APTC for a suitable alternative to be explored. A conference call with rostered regional escalation contacts can be facilitated as required.

In instances where a healthcare worker escort is required and the APTC or treating clinician anticipates potential patient instability or deterioration on route, and/or there is potential need to provide patient treatment on route, or at the request of the person performing the escort, a "Transfer Team Timeout" should be considered as per Appendix F. This ensures a shared mental model prior to being an escort to allow appropriate preparations and risk mitigation. The scope of practice for SJA Paramedics is available here St John W.A. Paramedic Scope of Practice.

Table 1: Common Examples of Patient Care Frequently Requiring a Nurse Escort

When transferred with a Paramedic	When transferred with a Volunteer
• Infusion pumps • IV with infusion drivers that cannot be stopped without detriment to patient • IV with additives outside the normal scope of a paramedic • IV with blood infusion • Ventilators • AirvoTM • Negative pressure chest drain's that can't be clamped • Bladder washout devices • Transcutaneous pacing.	As per paramedic plus: • All patients requiring advanced life support intervention • All IV with all additives • Patients with known serious clinical urgency at risk of acute deterioration • Patients requiring narcotic analgesia • Patients requiring ECG interpretation above telemetry viewing • Obstetrics • Paediatrics of clinical concern.

Due to distances travelled between health facilities across WA fatigue management is to be considered when requesting a healthcare worker escort. The WACHS Safe Driving Policy and supporting documents are to be adhered to.

Dependent on clinical or behavioural assessment additional people may be required to accompany the patient including:

- family members/carers
- health care workers and/or clinicians
- police or correctional services
- patient transport officer.

The WACHS Operations Hub Duty Operations Manager is to support the facilitation of the return of healthcare worker escorts to the referring hospital as required, in consultation with the local regional process. This may be inclusive of any potential temporary accommodation arrangements needed.

Where practicable the IHPT provider may return the escorting staff to the referring hospital, however, should not be relied upon or expected. In addition, the IHPT provider may be required to attend to another emergency delaying the return of the escort.

For personal safety and security all WACHS healthcare worker escorts should ensure they take with them an appropriate phone (mobile / satellite) for direct access to both clinical and non-clinical support during transfer. Consideration is also recommended to include a site grab bag with commonly required equipment and taxi vouchers (where appropriate) in unexpected instances where the IHPT provider is unable to return the escort.

2.7 Patient preparation for transfer

Patient preparation for the different modes of transport may have specific needs and are the responsibility of the referring site to organise prior to the transport crew's arrival. Patient preparation requirements for the designated transport platform is to be communicated to the referring site by APTC. Specific patient preparations include:

- Royal Flying Doctor Service (RFDS) Clinical Manuals - Endorsed for Use in Clinical Practice
- Considerations for Patient Transfer by Commercial Airlines Appendix E
- Transfer Team Timeout Appendix F
- Patient Transfer Checklist Appendix G.

Luggage

There is limited space on board both aeromedical and road assets and no dedicated luggage areas. Only minimal personal belongings can be carried, a small overnight bag is the usual maximum, please ensure patients only pack essentials.

Dangerous Goods

When preparing patients for transport the normal restrictions which apply to the carriage of dangerous goods on airlines, also applies to aeromedical flights. Dangerous goods such as matches, lighters, gas cylinders or other flammable liquids and weapons are not permitted on all flights. Pilots are entitled to search patient baggage.

Biological Specimens

Likewise, specimens and biological substances (with the exception of blood products for transfusion) must be safely packaged to prevent spillage and contamination.

Service Animals

On occasion patients may present with and request to transfer with their service, assistance or companion animal, including guide dogs, hearing dogs and service animals for support with disability or physical and mental illness. Every effort should be made to accommodate service/ companion animals where practicable, however is dependent on the transport provider and is subject to weight restrictions, asset capacity and the animal's

behavioural management. For best outcomes, communication of this requirement should occur early in the referral to APTC to be managed on a case-by-case basis.

2.8 Ongoing care, documentation during transfer, and clinical handover

If a WACHS healthcare worker is escorting a patient either to another facility or to the location of the transport platform, they remain responsible for ongoing patient care until clinical handover and formal acceptance of care has occurred. During this time the healthcare worker must continue to document ongoing care provided. Retrieval clinicians may contact the treating clinician directly before departure for a final clinical update and to communicate patient preparation requests for transfer.

The MR184 Inter-hospital Clinical Handover Form (or MR184C Inter-hospital Transfer Maternal Form, MR184P Inter-hospital Transfer Neonatal & Paediatric Form as appropriate) is to be completed and sent to relevant nursing / midwifery personnel at the receiving hospital, filed into the patient's medical record and a copy is to accompany the patient. The process to record, observations, medications or fluids delivered, or any change in clinical condition during the transfer is to be continued on the appropriate WACHS documentation accompanying the patient. If the WACHS healthcare worker is expecting to take ongoing observations during transfer a new observation chart should be commenced at the beginning of the transfer following discharge from the referring site.

Any documentation completed by a WACHS escort during transfer is to be photocopied, with the original provided to the receiving clinician during handover. The photocopied documentation is to return to the referring site with the WACHS healthcare worker escort in a sealed envelope for addition to the patient's healthcare record. Documentation should be filed on the top of the patient file in reverse chronological order ensuring a seamless record for the transfer of care.

At any point during transfer of care, clinical handover is to occur as per the Clinical Handover Policy MP 0095/18. For patients experiencing acute deterioration refer to the Recognising and Responding to Acute Deterioration Policy MP 0171/22 for clinical handover.

3. Roles and Responsibilities

The **APTC Service:**

- will be:
  - available to respond 24 hours a day seven days a week
  - the point of escalation regarding WACHS IHPT issues.
- determines the clinical transfer priority (to be formulated in consultation with the referring clinician and relevant specialist expertise as required, including consideration of the site's capabilities and capacity to provide ongoing care).
- assesses the patient's clinical needs and potential for deterioration during transfer.
- determines the:
  - minimum clinical escort requirements
  - most appropriate means of transferring the patient.
- books the transport provider
- provides clinical advice to the referring clinician on the preparation of the patient for transfer as required
- ensures a Transfer Team Timeout is completed if required

- advises and updates the referring hospital of transfer plan including clinical transfer priority and a provisional Expected Time of Arrival (ETA) when known
- maintains accuracy of patient transfer plans via the APTC Clinician dashboard
- notifies the receiving facility via the APTC Clinician dashboard the patient's provisional ETA when known.

The **Referring Site (Medical Officer and/or Nurse/Midwife):**

- obtains receiving site and bed acceptance as appropriate with support of APTC where required.
- contacts APTC to refer the patient for transfer.
- provides:
  - all requested information to enable appropriate and timely transfer coordination
  - an appropriate clinical escort in the absence of an available suitable clinical escort by the transport provider, as determined by APTC
  - appropriate clinical equipment (within local capacity), in the absence of provision of suitable clinical equipment by the transport provider
  - medications to treat the patient during transfer where the transport provider cannot provide them as per transport provider guidelines.
- ensures:
  - awareness of the patient transport plan via the APTC Clinician dashboard
  - the patient has an identification band in situ as per the WACHS Patient Identification Policy, and that patient identification using three (3) core identifiers occurs at each point of care transfer.
  - clinical handover is completed in accordance with the Clinical Handover Policy MP 0095/18
- informs APTC as soon as possible if a patient departs site either against medical advice, via alternate transport or if there has been a change in need for transfer to enable existing transport arrangements to be cancelled.

The **Receiving Hospital:**

- provides:
  - appropriate care of the accepted patient
  - clinical advice for the interim management of the patient, as required.
- on transfer of care, signs the MR184 Inter-hospital Clinical Handover Form (or MR184C Inter-hospital Transfer Maternal Form, MR184P Inter-hospital Transfer Neonatal & Paediatric Form as appropriate).
- liaises with the APTC as required to enable safe and timely patient transfer coordination.

The **Referring Medical Officer**:

- is responsible for assessment and medical management (including stabilisation) of the patient
- determines the need for initiating the transfer
- advises APTC if the patient's clinical condition changes whilst awaiting transfer, as clinical changes may require alteration in the transfer arrangements, such as the requirement for a higher level of clinical escort or additional monitoring equipment
- ensures that the patient and the patient's nominated next of kin are informed of the requirement of transfer and that this is documented in the health record, including the risks to the patient during transfer
- prepares the patient for transfer, including completing all relevant documentation

- provides iSoBAR handover to the clinical team transferring the patient and the receiving hospital
- ensures required transfer documentation in relation to the mental health patient is completed by an authorised role, including:
  - Form 1A – Referral for examination by a psychiatrist
  - Form 4A – Transport Order
  - Mental Health Transport Risk Assessment Form.

The **Referring Site Registered Nurse / Midwife:**

- prepares the patient for transfer, including coordinating all relevant documentation, patient transfer checklist items (Appendix G), medications and clinical equipment required for transfer, ensuring that if a WACHS clinical escort is accompanying the patient, there is sufficient space on documentation accompanying the patient for the recording of observations, progress notes and medications
- ensures the MR184 Inter-hospital Clinical Handover Form (or MR184C Inter-hospital Transfer Maternal Form, MR184P Inter-hospital Transfer Neonatal & Paediatric Form as appropriate) is completed as per WACHS Interhospital Clinical Handover Form Procedure and provided to the referral hospital and transport agencies
- arranges for any logistical requirements for the transfer, such as meals for staff / patient
- confirms that the patient's nominated next of kin are informed of the impending transfer
- provides a verbal handover with the patient escort (or transport provider clinician) on patient's condition utilising the iSoBAR format.

Note: In the absence of access to a medical officer (on-site, via telephone or emergency telehealth), the senior nurse/midwife on duty is to assume responsibility for the medical officer's responsibilities within their level of registration, and scope of practice.

The **Transport provider:**

- ensures arrangements of any necessary pick-up of the transferring team are coordinated, such as arranging for staff to be transferred from the airport to the hospital.
- liaises with and coordinating additional escorts following the completion of required paperwork by WACHS, i.e. WAPOL.
- contacts the referring site for a final clinical update and providing a firm ETA prior to departure in instances of all modes of aeromedical transfer.
- takes a face to face clinical handover of the patient from the referring site/ previous provider.
- ensures adequate knowledge of any equipment supplied by the site prior to accepting care of the patient
- responsible for clinical management of the patient during transfer and handover to the receiving site (except in instances when a WACHS escort is present).
- informs APTC of any delays or impacts to patient transfer arrangements

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

4. Monitoring and Evaluation

4.1 Monitoring

Monitoring of compliance with this procedure is to occur via WACHS clinical incident monitoring process or feedback received relating to interhospital transfers of patients for the identified retrieval site.

4.2 Evaluation

This policy will be formally reviewed every two years (or as required) by the WACHS Command Centre Director for correct content and articulation of processes. Continuous evaluation will occur alongside the monitoring program through trends identified in incidents and feedback received.

5. Compliance

This policy is a mandatory requirement under Section 26 of the *Health Services Act 2016*.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

6. References

Government of Western Australia: Child and Adolescent Health Service [Internet]: Newborn Emergency Transport Service WA (NETS WA) guidelines. [Accessed 28 September 2023].

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St John Ambulance W.A. [Internet]: St John W.A. Paramedic Scope of Practice [Accessed 28 September 2023].

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7. Definitions

Term	Definition
Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.
Accepting Site / Destination	The Regional or Metropolitan health facility accepting and taking carriage of the patient care requirements.
Acute Patient Transfer Coordination (APTC) Service	A centralised service, providing front-line country clinicians with advice and support in transferring their patients, to an appropriate level of care.
Clinical Escort	A clinician from either a health facility or transport provider with the appropriate level of clinical scope for the patient care needs.
Clinical Handover	A structured and standardised communication method for the transfer of information surrounding patient care between healthcare providers or locations.
Clinical Transfer Priority	The APTC allocated transfer priority, which takes into account site's capability and capacity, time to definitive care as well as the patient's clinical condition and requirements, to determine the patient's transfer timeframe.
Carer	An individual 18 years or over, who provides care and assistance to another person, usually in a regular and sustained manner, to someone with an illness or disability.
Deterioration	A dynamic state experienced by a patient compromising hemodynamic stability, marked by physiological

	decompensation accompanied by subjective or objective findings.
Emergency Telehealth Service	A *telemedicine* service provided by Emergency Medicine Specialists using high-definition video-conferencing equipment that is installed in participating Emergency Departments.
Healthcare Record	A documented record of the clinical/ physical care provided, decisions made and communication surrounding the patient care provided by site clinicians either at site or during transfer.
Interhospital Patient Transfer (IHPT)	A patient transfer occurring between a Hospital, Health Facility or Site, not inclusive of nursing homes, community clinics or residential facilities.
Minor	A patient under 16 years of age.
Paediatric Acute Recognition and Response Observation Tool (PARROT)	A statewide initiative and will replace the P-ORC charts to align with the rest of WA Health in a unified approach to Paediatric Escalation Systems and Recognising and Responding to Acute Deterioration in our infants and children.
Preparation for Transfer	Ensuring a patient is clinically stable for transport, including any additional lines, fluids etc and all paperwork requirements are complete and prepared in the appropriate order.
Referring Clinician	The clinician directly responsible for the care of the patient, this maybe an onsite clinician or a remote clinician providing support to the site via ETS, ITS, etc.
Referring Site	The site currently providing care for the patient and completing the referral for transfer via the APTC service.
Retrieval	Medicalised collection of a patient with the ability to provide a level of care during transport, and an appropriate level of clinical escort scope for the patient needs.
Shared Mental Model	Sharing an understanding of individually held knowledge that helps team members function collaboratively in their environments, ensuring everyone has a shared understanding of what's going on and what needs to happen next.
Tertiary Facility	A healthcare facility that provides specialised care for patients with serious or complex medical conditions.
Transfer Team Timeout	A structured team approach to ensure a minimum safety check is conducted and ensuring a shared mental model and understanding.
Transport Platform/ Mode	The asset type used to transfer the patient, i.e. Ambulance, Fixed Wing, Helicopter etc.
Transport Providers	Medicalised transport providers that may or may not have a DoH or WACHS contract. i.e. RFDS, SJA etc.

8. Document Summary

Coverage	WACHS wide
Audience	All WACHS Clinicians who are involved in the assessment and management of the patient requiring interhospital transfer.
Records Management	Non Clinical: Corporate Recordkeeping Compliance Policy Clinical: Health Record Management Policy
Related Legislation	Civil Aviation Safety Regulations 1998 (Commonwealth) *Work Health and Safety Act 2020* (WA) *Mental Health Act 2014* (WA)
Related Mandatory Policies / Frameworks	• Clinical Handover Policy MP 0095/18 • Consent to Treatment Policy MP 0175/22 • Language Services Policy MP 0051/17 • Recognising and Responding to Acute Deterioration Policy MP 0171/22 • Clinical Governance, Safety and Quality Framework
Related WACHS Policy Documents	• Inter-hospital Clinical Handover Form Procedure Patient Assisted Travel Scheme Guideline • Recognition and Response to Acute Deterioration (RRAD) in the Newborn Policy • Recognising and Responding to Acute Deterioration Procedure • Risk Assessment for Admission of the Heavier Patient Policy • Royal Flying Doctor Service (RFDS) Clinical Manuals - Endorsed for Use in Clinical Practice • Safe Driving Policy • Imminent Unplanned Birth at a Non-Birthing Site Policy • Maternity Care Clinical Escalation Pathway Policy • Snakebite Management Guideline • Fiona Stanley Hospital (FSH) Burns Management Resources - Endorsed for Use in Clinical Practice (EUCP) Policy
Other Related Documents	• ACEM/ANZCA/CICM Guidelines for Transport of Critically Ill Patients 2015 [PG52(G)] • CAHS Admission and Age of Eligibility Policy • CAHS Newborn Emergency Transport Service WA (NETS WA) guidelines • CAHS Transfer by Road and Air of Stable Infants Guideline • EMHS Guiding Principles for Major Trauma Interhospital Transfer • FSH Burn Service Admission Guidelines • WACHS Authorisation Schedule • WACHS Emergency Care Capability Framework • WACHS Clinical Governance Framework

	• WA Health Mental Health Bed Access Capacity and Escalation State-wide Policy • WA Health Department of Veteran Affairs (DVA) arrangements • Paediatric Patient Assisted Travel Scheme
Related Forms	• MR184 WACHS Inter-hospital Clinical Handover Form • MR184C WACHS Inter-hospital Transfer Maternal Form • MR184H WACHS Rural Hip Fracture Aeromedical Retrieval Form • MR184P WACHS Inter-hospital transfer form Neonatal & Paediatric • SMHMR990 Mental Health Transport Risk Assessment
Related Training Packages	Nil
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2383
National Safety and Quality Health Service (NSQHS) Standards	5.01- 5.36, 6.04, 6.07, 6.08, 8.06, 8.10
Aged Care Quality Standards	Nil
National Standards for Mental Health Services	Nil

9. Document Control

Version	Published date	Current from	Summary of changes
5.00	2 November 2023	2 November 2023	Full policy review and alignment to new WACHS APTC service

10. Approval

Policy Owner	Executive Director Operations Hub
Co-approver	Executive Director Clinical Excellence Executive Director Nursing and Midwifery Services
Contact	Director Command Centre
Business Unit	Command Centre
EDRMS #	ED-CO-14-26112

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This document can be made available in alternative formats on request.

Appendix A: Indications for Transfer

While the need for transfer is dependent upon the patient's condition and the resources of the referring hospital, transfer should be considered for the conditions described in Table below. Please note this is not an exhaustive list.

AIRWAY
• Intubated emergency patients. • Patients potentially requiring airway intervention outside local capacity or clinical skill, such as threatened airway obstruction, altered or decreasing conscious state, head/neck trauma, head/neck burns.
BREATHING
• Significant respiratory distress or compromise after treatment. • RR < 8 or >30, SaO2 ≤ 90% on 15L oxygen -adult – (Utilise PARROT chart for children according to age). • Any patient dependent on hospital applied CPAP (i.e. excludes domestic devices) or BiPAP. • Drowning / immersion.
CIRCULATION
• Circulatory shock of any cause. • Hypotension: SBP ≤100mmHg -adult – (Utilise PARROT chart for children according to age). • Complex or recurrent arrhythmias (e.g. Recurrent VF, sustained VT, Complete Heart Block (CHB)). • Ongoing significant bleeding.
DISABILITY
• Significant altered consciousness (Glasgow Coma Score (GCS) ≤13). • Significant head injury, such as loss of consciousness at the time of and since injury, any focal neurological deficitsince injury, GCS ≤13 at any time since injury, persistent headache since injury. • Acute spinal cord injuries. • Recurrent or prolonged seizures. • Intracerebral bleeding.
TRAUMA
• EMHS Guiding Principles for Major Trauma Interhospital Transfer. • WACHS Fiona Stanley Hospital (FSH) Burns Management Resources - Endorsed for Use in Clinical Practice (EUCP) Policy. • FSH Burn Service Admission Guidelines.
HIGH RISK MECHANISM OF INJURY
• Vehicle rollover. • With other occupants in a vehicle, in which one or more were fatally injured. • Patient who was ejected from a vehicle. • Motor Vehicle Collision >75kph. • Motor Vehicle Collision with intrusion > 35cm. • Cyclist or pedestrian hit by a motor vehicle. • Fall > 3m. • EMHS Guiding Principles for Major Trauma Interhospital Transfer.
MISCELLANEOUS
• Severe Sepsis / Septic Shock. - Recognising and Responding to Acute Deterioration (Sepsis Pathway) • Significant electrolyte, acid-base or fluid status abnormality. • Decompression illness. • Significant poisoning / snakebite / envenomation. WACHS Snakebite Management Guideline • Serious complications of pregnancy.- Midwifery and Obstetrics Emergency Telehealth Service & Maternal and Newborn Care Capability Framework Policy. • Paediatric patients requiring advanced care. CAHS Paediatric Critical Care Admission and Discharge Guideline • Neonatal retrieval. (refer Appendix B below Indicative Clinical Conditions for Transfer of the Neonate) • Clients requiring assessment and care by Psychiatrist or specialist Mental Health Team

Appendix B - Indications for Transfer for the Neonate

While the need for transfer is dependent upon the patient's condition and the resources of the referring hospital, transfer should be considered but not limited to the conditions described in Table below.

Reference should be made to the following policy document: WACHS
Recognition and Response to Acute Deterioration (RRAD) in the Newborn Policy

Condition	Neonatal Indicative Clinical Indicators
Respiratory Distress	• Oxygen therapy required for more than four hours after birth at a site without a licensed Special Care Nursery. • More than 40-50% oxygen required to maintain SaO_2 above 90%. • Apnoeic episodes requiring bag and mask ventilation. • Suspected pneumonia with signs of systemic infection.
Low BirthWeight	• Babies 34 - 37 weeks gestation and 2000- 2500g require at least Level4 or above nursery care (at Clinical Service Level 3 or above as per WACHS Maternity and Newborn Services policy). • The decision to keep neonates in the above groups in WACHS SCN units is at the discretion of the unit manager and the local consultant paediatrician advice. • All premature live born babies < 32 weeks are to be discussed with NETS regarding transfer and management.

Circulation	• Any neonate with:
	  ○ weak palpable peripheral pulses
	  ○ severe bradycardia
	  ○ tachyarrhythmia
	  ○ persistent cyanosis with minimal distress, but poor perfusion.
	May or may not be associated with poor respiratory function, intubation should be considered and discussed with NETS medical officer.

Neonatal surgical emergencies	Includes abdominal pathology such as: • bowel obstruction • necrotising enterocolitis • congenital diaphragmatic hernia • gastroschisis • airway obstruction related to Pierre Robin or Macroglossia and Choanal Atresia.
Other neonatal conditions	• Seizure activity – must be discussed with NETS • Sepsis (with signs of systemic infection). • Persistent hypoglycaemia at a site without a licensed Special Care Nursery. • Cardiac conditions. • Bleeding from any site. • Severe or multiple congenital abnormalities. • Congenital Heart Disease (suspected or known).

Appendix C - Interhospital Transfer Destinations

TABLE 2: SPECIALISED SERVICES REFERRAL CENTRES	
Adults Requiring Transfer to Tertiary Hospital(Perth) Unplanned IHPT WACHS LINK	**GOLDFIELDS** Fiona Stanley Hospital contact **1800 659 475** **GREAT SOUTHERN** Fiona Stanley Hospital contact **1800 659 475** **KIMBERLEY** Royal Perth Hospital contact **9224 2244** **MIDWEST** Sir Charles Gairdner Hospital **6457 3333** **PILBARA** Royal Perth Hospital contact **9224 2244** **SOUTH WEST** Fiona Stanley Hospital contact **1800 659 475** **WHEATBELT** **Eastern Wheatbelt** - Royal Perth Hospital contact **9224 2244** **Coastal Wheatbelt** - Sir Charles Gairdner Hospital contact **6457 3333** **Western Wheatbelt** - Royal Perth Hospital contact **9224 2244** **Southern Wheatbelt** -Fiona Stanley Hospital contact **1800 659 475**
Acute Stroke As per WA Acute Stoke transfer pathways	**Statewide Telestroke Service - 1800 770 880** **GOLDFIELDS** Fiona Stanley Hospital contact **1800 659 475** **GREAT SOUTHERN** Fiona Stanley Hospital contact **1800 659 475** **KIMBERLEY** Royal Perth Hospital contact **9224 2244** **MIDWEST** Sir Charles Gairdner Hospital contact **6457 3333** **PILBARA** Royal Perth Hospital contact **9224 2244** **SOUTH WEST** Fiona Stanley Hospital contact **1800 659 475** **WHEATBELT** **Eastern Wheatbelt** - Royal Perth Hospital contact **9224 2244** **Coastal Wheatbelt** - Sir Charles Gairdner Hospital contact **6457 3333** **Western Wheatbelt** - Royal Perth Hospital contact **9224 2244** **Southern Wheatbelt** - Fiona Stanley Hospital contact **1800 659 475**

Trauma - Adult	State Trauma Service (Royal Perth Hospital) contact **0404 894 277 or RPH Switch 9224 2244**
Trauma - Paediatric	Perth Children's Hospital (PCH) • Duty ED Consultant: 6456 0010 • Switch: 6456 2222
Burns	**Adult** Burns Unit Fiona Stanley Hospital contact **1800 659 475** **Paediatric** Burns Unit PCH contact **Switch 6456 2222**
Hyperbaric	Fiona Stanley Hospital • Switch: 1800 659 475 • Hyperbaric Medicine Unit (HMU): 08 6152 5222
Donate life	**On-call Donor Coordinator** (24/7) via SCGH switchboard**: (08) 6457 3333** Donate Life WA Office **- 1800 950155**
Spinal Trauma	Royal Perth Hospital contact **9224 2244**
Intensive Care Units within WACHS	**SOUTH WEST REGION** 24/7 Referrals: **0477 802 828** Or Contact Switch for ICU Consultant on Call: **97221000** • A combined 8 bed ICU/HDU functioning as a level 2 (CICM) ICU • Capacity for: Ventilated, trachy, bedside dialysis patients. • Note: Transfer to tertiary sites for specialty reason needs.
High Dependency Units within WACHS The level of service varies between units and may change dependent on the local staffing arrangements and availability of clinical equipment**.**	**GOLDFIELDS REGION** Kalgoorlie Health Campus contact **9347 6600** **GREAT SOUTHERN REGION** Albany Hospital contact **9892 2222** **KIMBERLEY REGION** Broome Hospital contact **9194 2222** NOTE: East Kimberley Transfers from Kununurra, Halls Creek and Wyndham Hospital patients may be transferred to Royal Darwin Hospital (NT) on a case by case negotiated transfer through the Acute Patient Transfer Coordination service (APTC) **MIDWEST REGION** Geraldton Hospital contact **9956 2222** **PILBARA REGION** Hedland Health Campus contact **9174 1410** **SOUTH WEST REGION** Bunbury Hospital contact **97221000** **WHEATBELT** Referral to Perth metropolitan is usual for Wheatbelt as per WACHS Link

Obstetrics **Obstetric Consultant Services within WACHS** **Please contact the on-call Obstetrician** The level of service varies between units and may change dependent on the local staffing arrangements and availability of clinical equipment.	King Edward Memorial Hospital **Switch 6458 2222** **GOLDFIELDS REGION** Kalgoorlie Health Campus contact **9347 6600** **GREAT SOUTHERN REGION** Albany Hospital contact **9892 2222** **KIMBERLEY REGION** Broome Hospital contact **9194 2222** **MIDWEST REGION** Geraldton Hospital contact **9956 2222** **PILBARA REGION** Hedland Health Campus contact **9174 1000** **SOUTH WEST REGION** Bunbury Hospital contact **9722 1000** **WHEATBELT** Referral to Perth metropolitan is usual for Wheatbelt **–** King Edward Memorial Hospital **9430 2222**
Neonates	Perth Children's Hospital **Switch 6456 2222** King Edward Memorial Hospital **Switch 6458 2222** **NETS 1300 638 792 (1300 NETS WA)** • General enquiries: 6456 3445
Special Care Nurseries within WACHS **Please contact the on call Paediatrician** The level of service varies between units and may change dependent on the local staffing arrangements and availability of clinical equipment**.**	**GREAT SOUTHERN** Albany Health Campus contact **9892 2222** **GOLDFIELDS REGION** Kalgoorlie Health Campus contact **9347 6600** **KIMBERLEY REGION** Broome Hospital contact **9194 2222** **MIDWEST REGION** Geraldton Hospital contact **9956 2222** **PILBARA REGION** Hedland Health Campus contact **9174 1000** **SOUTH WEST REGION** Bunbury Hospital contact **9722 1000** **WHEATBELT** Referral to Perth metropolitan is usual for Wheatbelt – **PCH 6456 2222**

Neurosurgery	Sir Charles Gairdner Hospital • On call Neurosurgical Registrar via switchboard **6457 3333**
Paediatrics	Perth Children's Hospital **Switch 6456 2222**
Mental Health Inpatient Unit Mental Health Patient Flow (sharepoint.com) **Referral centres**	Refer all patients to Mental Health Patient Flow for bed finding 7:00 am to 5:00 pm - 7 days a week: • Phone: 0429 570 423 • Email: WACHSMHPF@health.wa.gov.au • Out of Hours: ○ clinical support contact MH ETS 1800 422 190 - select option 2 and then 2 again. ○ patient transport enquiries contact APTC 1800 951 211 - select option 2. **GOLDFIELDS** Goldfield Mental Health Inpatient Unit contact **9080 5888** **GREAT SOUTHERN** Albany Mental Health Inpatient Unit contact **9892 2222** **KIMBERLEY** Broome Mental Health Inpatient Unit contact **9194 2222** **MIDWEST** Graylands Mental Health Inpatient Unit contact **9347 6600** **PILBARA** Broome Mental Health Inpatient Unit contact **9194 2222** **SOUTH WEST** Bunbury Mental Health Inpatient Unit contact **9722 1000** **WHEATBELT** Graylands Mental Health Inpatient Unit contact **9347 6600**

Appendix D – APTC Clinical Transfer Priority

1. Immediate (red):

- Conditions that are imminently life or limb threatening.
- The patient's condition is serious enough or deteriorating so rapidly that there is there is a threat to life, limb, or organ system failure, if the patient does not receive definitive care immediately.
- The site is unable to deliver ongoing definitive potentially lifesaving treatment.
- The ideal time to definitive care is “as soon as possible” and the threshold for continuing to hold the patient at the referring site is low.

2. Emergency (yellow):

- Conditions that are potentially life or limb threatening.
- The patient's condition may progress to life or limb threatening or may lead to significant morbidity or adverse events if the patient does not receive definitive care in the required time frame.
- The site is unable to provide the potentially lifesaving or definitive treatment required.
- There is a high risk of clinical deterioration as time progresses.
- The ideal time to definitive care may be considered as ranging from “as early as possible”, up to 12 hours.
- The “ideal time to bedside” can be from 2 up to 6 hours, this may require adequate support (i.e. ETS) for interim care be provided to the patient while awaiting transfer.

3. Urgent (green):

- The patient’s condition is serious and requires a higher level of care to manage.
- The site can initiate treatment to safely stabilise the patient.
- The patient requires ongoing care that cannot be provided onsite.
- Further deterioration is possible, and / or the site would be unable to provide the required level of care.
- The ideal time to definitive care may be considered as ranging from “as early as possible”, up to 24 hours.
- The “ideal time to bedside” can be from 6 up to 12 hours.

4. Semi-urgent (blue):

- The patient’s outcome may be comprised without further treatment which is unable to be provided on site.
- Further deterioration may occur, and the site may be unable to provide the required level of care.
- The patient requires ongoing care that cannot be provided onsite.
- The ideal time to definitive care may be considered as ranging from “as early as possible”, up to 48 hours.
- The “ideal time to bedside” can be from 12 up to 24 hours. this may require adequate interim care be provided to the patient while awaiting transfer.

5. Non-Urgent or repatriation (white):

- The patient’s clinical outcome requires a higher level of care than the site is able to provide and is not time critical.
- This includes repatriation cases who require medicalised transfer.
- The patient requires a transfer by stretcher and no other transport options are available.
- Ideal time to bed side can be from 24 up to 72 hours but requires regular reassessment if beyond this.

Appendix E - Considerations for Patient Transfer by Commercial Airlines

The APTC in conjunction with the referring medical officer is responsible for determining that commercial air travel is a safe mode of IHPT, including the level of escort required for the patient.

Where a patient is to travel via a commercial IHPT, the referring medical officer is to:

- authorise the mode of travel by commercial air travel
- authorise the level of escort for the patient
- complete the relevant airlines Travel Clearance Form 1 certifying that the patient is fit to travel. This is to be documented in the patient's health record. A copy of this is to be retained by the patient and carried when travelling.
- coordinate the booking of the commercial travel with the assistance of local site staff.

It is mandatory for health services to make their domestic air travel bookings through Carlson Wagonlit Travel (CWL) unless WACHS hospitals can purchase travel reservation services through a local travel agent in accordance with the Government's Buy Local Policy.

Arranging for transfer by a chartered aircraft requires clinical approval and is to be coordinated by the APTC with the appropriate WACHS officer's authority according to the WA Country Health Service Authorities Schedule.

Table 2. Conditions that Usually Prevent Commercial Airline Travel

Condition	Conditions that may be imposed on travel
Abdominal surgery	Within 10 days of travel.
Anaemia	Haemoglobin < 7. 5 g/L.
Angioplasty (with or without stent)	Within two days of travel.
Assisted Breathing During Travel / Supplemental Oxygen	While the aircraft may be at 40,000 feet, cabin altitude is generally maintained at 6,000 to 8,000 feet. This results in an oxygen level equivalent to an atmosphere with 15% oxygen content. Because of the nature of the oxygen dissociation curve most passengers can tolerate this partial pressure without detriment. However, passengers with pre- existing respiratory or cardiac conditions may need supplementary oxygen. If the patient requires supplemental oxygen during travel aTravel Clearance Form must be submitted to the airline. For some airlines, supplemental oxygen must be pre- ordered (2-5 days) and there is an additional charge, while other airlines require the oxygen cylinder to be supplied by the health service or patient with appropriate travel packs and restraints.
Asthma	Recent deterioration within 48 hours of travel.
Cardiac events	Within seven days of intended travel.
Cerebral VascularAccident/ Transient Ischemic Attack	Within three (3) days of intended travel.

Condition	Conditions that may be imposed on travel
Chest surgery	Within 9 days of travel.
Contagious or infectious disease	If it imposes a direct risk of infection to passengers or crew.
Decompression sickness	Is likely to require clearance from a specialist in hyperbaric medicine.
Ear and/or Sinus Pathology	Within 48 hours of travel.
Fractured jaw which has been wired	Must carry wire cutters on board. Must travel with an escort capable of cutting the wires if necessary. Suitable documentation must be carried because of the security issues.
Head Injury	Within two weeks of travel or where there is air in the cranium.
Inability to sit upright	Passengers are required to sit upright for take-off and landing.
Inability to toilet, eat or administer own medication	Subject to the length of flight, a competent escort (arranged by the health service) must be available to travel with the patient. The escort must sit in an adjacent seat.
Infants - newborn babies	Within seven (7) days of birth.
Intravenous Access Devices	PICC lines.
Penetrating Eye Injury	While there is air in the eye or a vitreous leak, or within 6 days of travel.
Phobias	If doubt about ability to cope with air travel.
Plaster casts	Plaster cast **must** be split if the injury is < 48 hours old.
Plug in electrical equipment	To prevent interference with aircraft electrical systems, all plug-in equipment must be approved, and pre-approval is required by the airline.
Pneumothorax	Within 14 days of resolution.
Pregnancy	Multiple pregnancy after 36th week. Flights > 4 hours – single pregnancy after 36th week.
Psychiatric Disorder	Acute or uncontrolled.
Psychiatric disorder that may deteriorate during flight	Must travel with medical escort.Escort must sit in adjacent seat.
Requirement for Stretcher / Humidicrib	Must travel with medical escort.Escort must sit in adjacent seat.
Significant cardiac arrhythmia	No medical clearance is required for patients with a pacemaker who are otherwise in good health.
Stroke	Within three (3) days of intended travel.

For more detailed conditions proposed on travel please see the commercial airline company's Medical Travel Clearance Guidelines

Appendix F – Transfer Team Timeout

A simple check contributing to the safety of patients and staff performing an escort. The Transfer Team Timeout is designed to strengthen communication by guiding and supporting conversations, bringing together the WACHS and transport provider staff involved in each patient transfer and ensuring a shared mental model and understanding of potential patient deterioration along with actions and/or equipment that may be required.

Designed to improve safety by enhancing active verbal communication and ensuring consistency through a structured team approach to ensure a minimum safety check is conducted. Discussion is to be led by the treating clinician (on site or via ETS/ITS) directly with the escort/s. All concerns and/or questions are to be clarified prior to departure.

The checklist process should take no longer than a few minutes to complete and is not designed for planning or documenting treatment or care, or supplementing other documentation, processes or procedures.

The Transfer Team Timeout should be considered for all transfers where:

- a WACHS Healthcare Worker is performing the role of a clinical escort
- there is a requirement or potential for the escort to provide patient treatment on route
- the treating clinician anticipates potential patient instability or deterioration on route
- a transport provider requests a timeout prior to transfer.

Process:

1. It is identified a timeout should be performed by a member of the treating team, transport team or APTC team.
2. The treating clinician is to conduct a timeout with the person/s performing the escort, with specific consideration to the below items:
    a. **Logistics**
        i. **Patient transfer plan is clear** – Destination Site and Location; ED/ Direct Admit
        ii. **Escort return method confirmed?** – Returning with Provider, Taxi, Bus etc or if unconfirmed contact the WACHS Operation Hub (1800 975 225) to support logistics coordination.
    b. **Patient preparation requirements for transfer**
    c. **Treatment required during transfer**
    d. **Medications and equipment requirements**
        i. Analgesia / GTN
        ii. Antiemetic
        iii. Fluids
        iv. Oxygen
        v. Equipment
        vi. Medication order required and supplied?
    e. **Possible complications/ deterioration and actions required**
        i. Infection Control Precautions
        ii. Allergies
        iii. Behavioural Concerns
        iv. GoPC relevant?
    f. **Escort/s provided the opportunity to have any questions or concerns clarified?**

Appendix G – Patient Transfer Checklist

WACHS **Patient Transfer Checklist**	**Patient Details**		
	Surname	UMRN/MRN	
	Given Name	DOB	Gender

Referring Doctor / Team	Referring Hospital	Referring Ward/ Dept
Receiving Doctor / Team: Receiving doctor aware ☐	Receiving Hospital: Patient accepted ☐	Receiving Ward/ Dept

ALL PATIENTS

Patient's consent to transfer (And/or Parent/carer/guardian if applicable)	☐	Identifying name band on patient	☐
APTC referral complete and notified of all transfer requirements	☒	**Patient Property:** valuables secured and documented. Luggage no greater than 5kg.	☐
Patient and nominated next of kin informed of transfer plan • Receiving hospital • accepting doctor / team / ward • contact details	☐ ☐	**Bladder:** Toileted prior to departure or indwelling catheter. **Nutrition:** Food, drink prior to departure. Nutrition arranged for patient during travel	☐ ☐
Escort Confirmed (if applicable)	☐	Transfer Team Timeout Considered	☐
Medications: • Anti-emetic, analgesia, and/or sedation pre-transport? • Reconciliation-compare discharge/transfer orders to medication history	☐ ☐	**Secure Intravenous (IV/IO) access** (needle-free injection port) Required for all mental health patients and critically ill/ ventilated patients.	☐

DOCUMENTATION

Ensure photocopies of the following health records, relevant to this episode of care are ready for transfer
(Tick boxes once completed, or Cross boxes if not applicable)

Relevant MR184 Patient Transfer Form Copy (original in integrated notes) (e.g. Adult/child, Neonatal, Maternal, Residential Care)	☐	Observation Charts (e.g. neurological observations, neurovascular observations, rhythm strips)	☐
If transferring via air also include RFDS transfer form	☐	Medication Chart / Intravenous Fluid Therapy Chart	☐
MR1 Emergency Department Notes	☐	Recent pathology results/ samples	☐
MR111 Nursing Admission, Screening & Assessment Tool	☐	Goals of Patient Care / Advanced Health Directive	☐
Copy of Notes	☐	Allied health summary report and care plan	☐
Investigations • such as x-rays, CT Scan, MRI, Ultrasound, ECG • Hard Copy (Y/N) (copied if original must remain at the transferring hospital)	☐ ☐	Images transmitted to (Destination) Confirmed by (MIT) **PATS Transfer** - Clerk Notified Original medical officer's transfer letter (copy filed in patient's record)	☐ ☐ ☐ ☐

SPECIFIC PATIENTS

The following checklist will aid in the preparation of patients with specific injury or illness for transfer

Bariatric • APTC advised of Bariatric Risk > 120 kg • Hover mat in place (if available)	☐ ☐	**Ventilated** • Endo tracheal tube secured • Eyes taped • Nasogastric tube and indwelling catheter secured and insitu	☐ ☐ ☐
Chest Trauma • Intercostal catheter taped and secured (Heimlich valve for pneumothorax)	☐	**Fractures** • Adequate immobilisation Splinting of limb • Analgesia: Arranged for transfer/pre-transfer	☐ ☐
Mental Health • Sedation: Arranged for transfer • Copy of Mental Health Forms • A hard copy Transport Order **4A/B** and **Transport Risk Ax** Form provided to Police Officer (must NOT be provided with a copy of the Form 1A/B, due to confidentiality)	☐ ☐ ☐	**Spinal** • C spine immobilisation insitu • Scoop stretcher or vacuum mattress	☐ ☐
Checklist Completed: Name: _____ Date/ Time: _____ Designation: _____	☐	**Eye Injury** • Anti-emetic pre-transport • Eye/s Shielded **Additional Precautions** • Appropriate PPE (i.e. mask, gown etc)	☐ ☐ ☐