The Newcastle upon Tyne Hospitals NHS Foundation Trust

Transfer of Patients Policy

<table>
<thead>
<tr>
<th>Version No.:</th>
<th>6.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective From:</td>
<td>05 July 2018</td>
</tr>
<tr>
<td>Expiry Date:</td>
<td>05 July 2021</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>02 January 2018</td>
</tr>
<tr>
<td>Ratified By:</td>
<td>Discharge Review Group</td>
</tr>
</tbody>
</table>

1 Introduction

This policy is written to clarify the requirements of patients who are transferring between wards or departments on Trust sites, and the role and responsibilities of Trust staff in this respect. Patients who are transferring out of the Trust, whether to their permanent place of residence or another healthcare organisation are classed as discharges – please refer to Trust Transfer out of Hospital Policy

2 Scope

This policy is relevant to all staff employed by the Newcastle upon Tyne Hospitals NHS Foundation Trust and relates to all patients regardless of age.

3 Aims

- To clarify the clinical accountability of the nursing, medical and support staff that are responsible for the patients’ care, to ensure the safe transfer of patients between wards and departments.

- To ensure that care continues with minimal interruption and risk.

- To outline the responsibilities of all staff members involved in the patient transfer including documentation within the nursing component of the patients health record.

- To highlight the need for clear and effective communication between all personnel involved, and between staff, patients, families and carers.

4 Duties (Roles and responsibilities)

Heads of clinical and non clinical departments or directorates are responsible for ensuring that the policy is implemented within their individual departments and that the audit results are reviewed and acted upon.

Registered Nurse, caring for the patient in the transferring ward or department will take responsibility to ensure that the patient is appropriately and safely prepared for transfer.
All inpatients transferring “permanently” between wards/departments will be accompanied by a member of the healthcare team, where appropriate.

**Registered Nurse**, in the receiving ward or department will take responsibility to ensure the transfer is completed safely.

### 5 Standards for transferring patients

Transfers may occur as either planned or unplanned patient movement.

- **Planned patient transfer is:** part of a planned care pathway. The most common example is when patients are admitted for Elective Surgery, arrive at a Day of Surgery Arrival area, transfer to theatre and then following a period in a recovery area, are transferred to a base ward.

- **Unplanned transfer:** refers to patients who are transferred due to unexpected reasons; for example transfer to a cubicle in another ward due to an isolation requirement or a patient who is boarded, due to their own care needs or to make provision for the care needs of another.

In all cases the decision to transfer a patient will be made following consideration of the ability of the receiving ward to meet the individual needs of patients and to provide safe, effective and high quality care.

- The patient will be identified as medically stable for transfer by the medical team and this must be clearly documented within the health record. Vital signs and NEWS must be stable at point of verbal hand over. Any changes in the patient’s vital signs/NEWS from the previously recorded vital signs at the time decision to transfer must be reviewed by the medical team to ensure that if there is reported deterioration the receiving ward remains the appropriate place of care. In the event of a Pregnancy or and post-natal patient considerations should also be taken into account

- There must be discussion with the Consultant or Senior Medical Staff and liaison with a Senior Nurse, Hospital at Night Practitioner or the Patient Services Co-ordinator. The decision must also involve the nurse accountable for the care of the patient.

- The transferring ward must ensure the receiving ward understands the patient’s individual care needs.

- When considering unplanned transfers the following points must be considered:
- Clinical safety and ability of receiving ward to provide appropriate care for patients.
- If the patient is to be 'boarded' out of speciality the boarding criteria must be adhered to (appendix 2)
- The number of previous ward moves, if any.
- Any patient disabilities, cognitive impairment and individual communication and emotional support needs.
- The wishes of the patient.
- Time of Day.
- The majority of patient transfers should occur between 08:00 and 22:00hrs, acknowledging that there will be a clinical requirement to transfer some patients outside of these hours.
- Transfers within the Trust to CAV site should be between the hours of 08:00 – 17:00hrs Monday to Friday. Patients should only be transferred to CAV outside of these hours i.e., after 17:00hrs and at weekends and on Bank Holidays, by exception and following Consultant review and authorisation.
- Only in exceptional circumstances should the transfer of patients occur outside of these hours. Exceptions must be discussed with a Senior Medical staff and/or a senior nurse or PSC.
- Presence of a Deprivation of Liberty authorisation which is specific to a ward and would necessitate informing the authorising body via the Adult Safeguarding team

All patients will experience safe transfer of care when moving between wards and between specialties and hospital sites within the Trust.

- All documentation in relation to transfer must be in line with the Trust Clinical Record Keeping Policy.
- The verbal handover of essential care information must include where relevant the following aspects of care;
  - Infection and isolation status including current and previous relevant treatment
  - Resuscitation status
  - Any disability, cognitive impairment, and communication support needs
- Risks and alerts
- Pressure Ulcers including Datix number and skin condition
- Communication and information needs

- The patient and their relatives/carers must be informed by the nurse accountable for the patient’s care that they are leaving and advised of where they are going. In circumstances where relatives have not been contacted, the receiving ward must be notified and this must be clearly documented in the nursing notes.

- The receiving ward must be given a verbal handover and told whether the patient’s relatives/carers have been informed or not.

- The transferring ward will agree a time and contact the receiving ward prior to leaving with the patient.

- The patient’s property and valuables must be transferred with the patient. This must include where appropriate teeth, hearing aid, spectacles and mobility equipment. There may be specialist equipment needs which should also be considered. If property has been taken into safe keeping e.g., lodged with the cashiers, the receiving ward must be made aware and the cashiers notified of the transfer by the transferring ward.

(Please refer to the [Patients Property Policy](#) for further detail).

- The patient’s health records must be transferred where available. This will include medical records, assessment documentation and therapist notes. Where both or either ward uses paper or electronic records special attention should be paid to full and complete document transfer.

- The transferring ward must ensure that all relevant medications accompany the patient to the receiving ward along with medication and associated equipment brought into hospital. This will be achieved through effective communication between transferring areas.

- The transferring ward must ensure patient transfer details are entered onto the patient administration system and ensure the PAS information transfer on eRecord takes place in line with ‘real time’ bed management system.

- Where a clinical need is identified observation and vital signs should continue during the transfer process.
• The Registered Nurse accepting the patient on the receiving ward must ensure they have necessary information to care for the patient safely and correctly and ensure continuity of care.

• The patient should be moved with the minimum amount of disruption and all aspects of privacy, dignity and patient comfort should be optimised during the transfer process.

• Only appropriately skilled personnel trained in manual handling should transfer patients between wards.

• When completing a transfer the person accompanying the patient is responsible for completing Datix in the event of an incident.

5.1 Patients with Known or Suspected Infections

It is recognised that specific groups of patients transferring between wards and departments may have enhanced requirements in respect of their care when transferred.

• The transfer of patients with a known or suspected infection should be avoided if at all possible. This must be discussed with Infection Prevention and Control Team prior to transfer. There are specific guidelines for the transfer/discharge of patients with MRSA, principles of which should be followed. These can be found in the Newcastle upon Tyne Hospitals NHS Foundation Trust MRSA Policy. Staff should contact the Infection Prevention and Control team for further advice as required, particularly for specific specialised patients.

• At all stages of the transfer staff must comply with Trust Infection Control Standard Precautions.

5.2 Patients on oxygen

In general, patients who require oxygen during transfer from one area to another should be accompanied by a trained member of nursing staff. The need for oxygen implies significant cardio respiratory disease and a risk of deterioration should the oxygen supply be interrupted. Some clinically stable patients tolerate mild hypoxemia and oxygen can be disconnected for during transfer. Others who are at low risk can be transferred on oxygen without nursing supervision. The need for oxygen, clinical supervision and monitoring of oxygen saturation should be assessed in all cases prior to transfer by a registered nurse accountable for the patient’s care.
If the patient is not accompanied by a nurse, clear instructions must be provided for personnel involved in the transfer. These should include the oxygen delivery device and flow rate.

5.3 Documenting Transfer

All patient transfers must include documentation in the clinical notes of:

- The ward the patient is transferring to, and
- Confirmation by the nurse in charge of the patient that the patient’s next of kin/relative/carer has been informed or, where this has not been possible, that the receiving ward is aware that communication of transfer has not been achieved.

Alternatively, a nursing transfer checklist can be completed. Some nursing assessment documents incorporate a transfer checklist; alternatively Appendix 1 can be used.

5.4 Moving and Handling

- Only personnel who have undertaken appropriate manual handling training to provide a manual handling procedure, in accordance with the Moving and Handling Policy.
- Porters should be used to transfer patients between wards and departments. If appropriate and the patient’s condition is assessed as stable, transfer can be undertaken by a porter and a nurse, as long as the nurse is confident that they will be able to contribute to manoeuvring the bed for the duration of the transfer. If the patient’s condition necessitates the nurse to provide direct clinical care, then 2 members of portering staff should be used to undertake the transfer in addition to the nurse.
- Bed rails may be erected during the period of transfer when direct supervision is in place. At the point of transfer and on arrival at the transfer destination, the decision regarding the placement of bed rails must be in line with the patient’s current bed rail assessment.
- Where specific manual handling issues are raised in the patient assessment form the receiving ward should review the assessment after the transfer is complete, in accordance with policy.
- For guidance on the moving and handling aspects of transferring bariatric patients, the Moving and Handling of the Bariatric Patient Policy should be referred to.
5.5 Provision of Escorts

Patients transferring from wards and departments temporarily, e.g. for investigations or tests, will always be provided with an escort where a patient is deemed to be high risk. This will be assessed and defined by the clinician caring for the patient in conjunction with the registered nurse accountable for their care.

The level of skill required of the escort staff is the decision of the nurse accountable for the care of the patient in question. The escort should always have knowledge of the patient’s care plan. Where appropriate the necessary monitoring equipment should be used by staff who have been trained and assessed as competent to use any equipment required during transfer.

Where difficulties occur with the provision of an escort, the Matron or Department Manager should be contacted in hours and out of hours, the Patient Services Co-ordinator (PSC).

6 Training

All staff involved in the transfer of patients should be aware of this policy and the standards expected.

7 Equality, Diversity and Human Rights

The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to providing services that meet the equality and diversity needs of staff and service users within the framework of current equality legislation. Protected characteristics within equality legislation include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. It is the responsibility of managers and staff to ensure that they act on this policy in a manner that meets the needs of people with these protected characteristics. It is always best to check with individual staff / service users what their needs are, but needs may include providing information in an accessible format, considering mobility and communication issues, being aware of sensitive and cultural issues.

8 Monitoring compliance

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy will be monitored on behalf of the Patient Services Manager through an annual audit co-ordinated by the Clinical Governance</td>
<td>The audit should identify compliance with key elements of transfer information / documentation: The health records pertaining to the patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Governance and Risk Department.</td>
<td>Patient Services Senior Team meeting</td>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>
Documentation that transfer is taking or has taken place
Confirmation that the patient’s next of kin/relative/carer has been informed of the transfer or,
Where confirmation has not been possible, that the receiving Ward is aware that communication of transfer has not been achieved.

Following each audit cycle the Clinical Governance and Risk Department will produce a report which the Patient Services Manager will share with the Patient Services Senior Team meeting and develop actions to address any identified deficiencies.

9 Consultation and review

Comment in relation to this revised policy have been invited from members of the Discharge Review Group.
Ratification of the policy is the responsibility of the Clinical Policy Group.
## Transfer Checklist

<table>
<thead>
<tr>
<th>Name</th>
<th>D.O.B.</th>
<th>NHS No:</th>
<th>Male/Female</th>
<th>Hospital Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does the patient have?</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>x-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug kardex (where in place)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPR chart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property in safe keeping with cashiers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclaimer form</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locker check</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have relations been informed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection status and relevant treatment confirmed to ward including completed MRSA/Diarrhoea/C Difficile care pathway if applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk of Falling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical or Non Clinical alert in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward handover</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Given by
To whom
Signature
Print
Date
Time
Transferring Ward
Date of admission to Ward
Date and time of transfer
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 18th Oct 2017

2. **Name of policy / strategy / service:**
   - Transfer of Patients Policy

3. **Name and designation of Author:**
   - Julie Waite/Melanie Cunningham

4. **Names & designations of those involved in the impact analysis screening process:**
   - Julie Waite, Lucy HALL Equality and Diversity Lead

5. **Is this a:**
   - Policy [x]  Strategy [ ]  Service [ ]
   - Is this:
     - New [ ]  Revised [x]
   - Who is affected
     - Employees [x]  Service Users [x]  Wider Community [ ]

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?**
   (These can be cut and pasted from your policy)
   
   This policy is written to clarify the requirements of patients who are transferring between wards or departments on Trust sites, and the role and responsibilities of Trust staff in this respect.

7. **Does this policy, strategy, or service have any equality implications?**
   - Yes [ ]  No [x]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
   - Consideration given to this as outlined below
### Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Patients whose first language is not English may not understand written information provided. Therefore policy refers to the provision of additional support Mandatory EDHR Training</td>
<td>Potential indirectly because of communication needs</td>
<td>Add communication and information support needs to section 5</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>Mandatory EDHR Training</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Trust chaplaincy services available should they be required to support Mandatory EDHR Training</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>Mandatory EDHR Training</td>
<td>LGB patients may feel more vulnerable than other patients in relation to a move from a place where staff have gained the confidence of the patient. This should be taken into account in factors to consider when moving patients.</td>
<td>Add to section 5 consideration of emotional needs</td>
</tr>
<tr>
<td>Age</td>
<td>Trust Dementia services in place, provision available for those who lack capacity for decision making. Consideration of disabilities included in the policy Mandatory EDHR Training</td>
<td>Potential indirectly – provision has been made to mitigate this</td>
<td>No</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>Organisational support available for those patients with learning/physical disabilities with reference to transfers</td>
<td>Potential indirectly – provision has been made to mitigate this</td>
<td>No</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>Mandatory EDHR Training</td>
<td>Trans patients may feel more vulnerable than other patients in relation to a move from a place where</td>
<td>Add to section 5 consideration of emotional needs</td>
</tr>
</tbody>
</table>
staff have gained the confidence of the patient. This should be taken into account in factors to consider when moving patients.

<table>
<thead>
<tr>
<th>Marriage and Civil Partnership</th>
<th>Mandatory EDHR Training</th>
<th>No</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity / Pregnancy</td>
<td>Mandatory EDHR Training</td>
<td>Pregnancy and post-natal care may affect ability to transfer</td>
<td>Add to section 5 under clinical consideration</td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes □ No □

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Name:
Julie Waite

Date of completion:
18/10/17

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)