

The Newcastle upon Tyne Hospital NHS Foundation Trust

Transfer of Patients Policy

Effective: November 2010

Review: November 2012

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 Discharge Policy](#).

2. Policy 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. Policy Aim

- 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 and to highlight the need for clear and effective communication between all personnel involved, including documentation within the nursing component of the patients health record.

4. Policy Objectives

- Accountability – that clear records of patient transfer are maintained throughout the transfer and retained thereafter according to the Trust [Clinical Record Keeping Policy](#)
- Audit – that the application of this policy is audited
- Dignity and wellbeing of the patient is optimised at all stages of the process.

5. 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.

6. 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).

7. Standards for transferring patients

7.1 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.

7.2 In all cases the decision to transfer a patient will be made following consideration of the ability of the receiving ward 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.
- This must be following discussion with the Consultant or Senior Medical Staff and in liaison with a Senior Nurse 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 care needs.
- When considering unplanned transfers the following points must be considered:
 - Clinical safety and ability of receiving ward to provide care for patients,
 - The number of previous ward moves, if any,
 - Any patient disabilities or cognitive impairment,
 - Level of patient co-operation,

- Transfers should only occur between 08:00 and 22:00. Patients should only be transferred to Walkergate Hospital between 08:00 and 17:00. Patients must not be transferred to Walkergate Hospital after 5pm, without discussion and agreement with the receiving Consultant.
- 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.

7.3 All patients will experience safe transfer of care when moving between wards and between specialties and hospitals 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 treatment,
 - resuscitation status,
 - any disability or cognitive impairment,
 - risks and alerts.
- The patients 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 be 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.
- All of 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. (Please refer to the Patients Property Policy for further detail).
- All of 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 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.

7.4 Patients with Known 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 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 [Control of 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](#).

7.5 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 cardiorespiratory 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.

7.6 Documenting Transfer

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

- The ward the patient is transferring to, and
- Confirmation 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 incorporated at transfer checklist; alternatively Appendix 1 can be used.

8. Monitoring

The policy will be monitored on behalf of the Patient Services Manager by an ongoing rolling programme of audit co-ordinated by the Clinical Governance and Risk Department.

The audit should identify compliance with key elements of transfer information / documentation:

- The health records pertaining to the patient are transferred
- 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.

Author: Patient Services Manger/Head of Nursing.

Transfer Checklist

Name	
D.O.B.	
NHS No:	
Male/Female	
Hospital Number	

Does the patient have:	Yes	No	Not Applicable
Notes			
x-rays			
Drug kardex			
Fluid balance			
TPR chart			
Own medication			
Property			
Disclaimer form			
Locker check			
Have relations been informed			
Infection status and relevant treatment confirmed to ward			
Ward handover			
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
IMPACT ASSESSMENT – SCREENING FORM A

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

Policy Title:	Transfer of Patients Policy	Policy Author:	Dot Kyle
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against the individual on grounds of, Nationality, race, gender, sexuality, religious belief, ethnicity, culture or disability
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If “yes”, please answer sections 4(b) to 4(d)).</i>	No	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable):
	Not applicable

Name and Designation of Person responsible for completion of this form: Dot Kyle Patient Services Manager Date: 15 November 2010

Names & Designations of those involved in the impact assessment screening process: Dot Kyle Patient Services Manager

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

For advice on answering the above questions please contact Helen Lamont, Director of Nursing, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.