# THEMES FROM THE VICTORIAN QUALITY COUNCIL INTERHOSPITAL PATIENT TRANSFER WORKSHOP

## Group Work Summary

Themes arising from the Victorian Quality Council (VQC) Interhospital Patient Transfer Workshop - 12 March 2008

Responsible Working Group: VQC Workplace Culture Working Group

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# Interhospital Patient Transfer Workshop

## Group Work Summary

The Victorian Quality Council's (VQC) Interhospital Patient Transfer Workshop was held on 12 March 2008 at the Melbourne Cricket Ground (MCG). The workshop attracted 150 participants from metropolitan, rural, regional public and private health services, metropolitan, rural and private ambulance services, Department of Human Services, other experts in the field, specialised patient retrieval services, general practitioners, and consumers. Attendees heard from specialist services such as Neonatal Emergency Services (NETS) and the newly formed Adult Retrieval Service Victoria that have successfully coordinated transfer processes.

The objectives of the workshop were:

1. Discuss issues related to interhospital patient transfers
2. Look at ways to improve interhospital hospital patient transfer and transfer of information

The workshop used group work technology to generate many useful ideas and suggestions that will be used to develop objectives for future work on the transfer of information. The group was asked to respond to a number of key questions:

1. How should we standardise inter-hospital patient transfer in relation to the process?
2. How should we standardise inter-hospital patient transfer in relation to the documentation?
3. How should we standardise inter-hospital patient transfer in relation to the content?
4. What are the three priority actions?

The main findings from the workshop were:

1. Difficulty in arranging patient transfer
2. Lack of standardisation of escalation process
3. Issues relating to timeliness of transfer
4. Lack of understanding of resources and support availability in rural areas by larger regional or metropolitan hospitals
5. Inconsistency use of terminology and category of patient
6. Lack of honesty in reasons given for transfer
7. Lack of standardised transfer information required
8. Issues relating to the quality of information given

## TOP THREE PRIORITY ACTIONS SUGGESTED BY THE GROUP

(Top down based on the number of responses)

1. Standardise the information transfer process - both communication and documentation (electronic or manual)
2. Establish state-wide centralised service/s for adult patient transfer (either one centralised service for all or separate services based on acuity, network or region)
3. Standardise transfer process – Acuity categories, modes of transfer, escalation process, etc

## ISSUES RELATED TO INTERHOSPITAL PATIENT TRANSFER

The following are the major themes derived form the workshop:

(**Bold black- denotes major theme (More than two entries) from the responses)**

- Transfer process
  - **"Difficulty in arranging patient transfer, especially finding a bed"**
  - **Lack of standardisation of escalation process – "mixed message"**
  - Lack of standardised process/criteria for hospitals to accept patient
  - "Lack of accountability of patient ownership"
  - **Issues relating to timeliness of transfer**
- Knowledge
  - **"Lack of understanding of resources and support availability in rural areas' by larger regional or metropolitan hospital".**
  - "Lack of understanding across network of each other's resources and capacity"
  - Lack of knowledge of what services are available at specialty hospitals
  - Lack of understanding of distance and response time
- Communication
  - **Inconsistent use of terminology , category of patient among hospitals, between hospitals and ambulance services**
  - **"Lack of honesty in reasons given for transfer "**
  - Poor communication among hospitals and between hospital and ambulance services
  - Lack of feedback
- Transfer information
  - **Lack of standardised transfer information required**
  - "Too many forms"



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  - **Quality of information given – " poor documentation", "incomplete", "inaccurate"**

- Government
  - "Lack of resources and transport funding for transport services to move patients in a timely manner"
  - "Funding does not match the total number of transfer"
  - Lack of computerised clinical record access in hospital
- Others
  - Demands exceed hospital capability
  - "Geographical"



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# SUGGESTIONS TO IMPROVE INTERHOSPITAL PATIENT TRANSFER

## System

The majority of the respondents would like to have a centralised service based on the Newborn Emergency Transport Service (NETS) model. While most of the respondents did not specify whether they would like one system for all adult patient transfers or separate systems for emergency and non-emergency patients, almost 7% of respondents suggested a separate but similar system for non-emergency and back transfer. The suggestions are outlined below:

### Centralised adult retrieval/triage service like NETS – single point entry/one phone call

- **A centre responsible for coordinating the transfer and care of the patient. The centre could:**
  - **“take responsibility for governance”**
  - **utilise teleconference to triage, handover and assist the communication process**
  - **“be responsible for bed finding – state-wide bed register like NETS”**
  - **“prioritise transfer and timely transfer of patient”**
  - **provide retrieval team to stabilise critically ill patient**
  - “pass information to NETS, ARV and other retrieval services”
- **Provide consultancy and expert advice on patient management to referring hospital at all hours (including patient waiting for transfer), provide easy access to senior retrieval personal**

### Other suggested systems

- **Establish separate adult service/s for semi-urgent, non-urgent and back transfer**
- Establish “series of hubs with a central point for contact similar to trauma service”
- **Establish and formalise referral network and links between hospital**
  - “Look at referring pattern”
  - “Better utilisation of existing network”
- **“Centralise and regionalised responsibility for catchments management** – e.g. non-critical patient management based on ARV/NETS model with web based data centre”
- “Reduce the reasons for need to transfer”
  - “Using capacity smarter “
  - “Future resource expansion in growth areas – outer Melbourne and regional areas”

## Transfer Process

A majority of the participants would like to have a single process for patient transfer. The transfer process should be patient centred, involve patient and family at all stages of transfer and be committed to improve transport safety for patients. The following is a summary of the themes:

- "One medical person in-charge of the transfer process"
- "The process should clarify who is responsible for the patient after the call"
- **Develop a standardised prioritisation process - "a consultative process between ambulance services/retrieval team and hospitals"**
- **Develop a standardised escalation process– "criteria based alert, escalation and response".** This escalation process will:
    - "have a clear definition about the patient categories/acuity and also clearly identified speed of transfer needed for each category of patients"
    - **"have a top down system to ensure people who need a bed get one in a defined time period"**
    - **"identify time critical patients – prompt for escalation"**
    - have options for the prioritisation of transport services
    - have a contingency to manage patients when there is a road-blocked – e.g. ambulance delay
    - **"enable the referring hospital to set a time limit for the escalation of transport – prioritisation will be based on patient status and the capacity of the facility"**
    - **provide a clear indication of how long the referring hospital can safely look after the patient based on the capacity of the facility**

  Other suggested ideas include:

    - "The escalation process is not specific to medical"
    - "Patient acuity based on non emergency patient transport regulation"
- "All patients who are sick enough to be transferred to a tertiary hospital should be seen by senior medical staff on arrival"
- Clarification of the platform for transfer (e.g. air, road etc) to reflect patient acuity
- "Standardised back-transfer process"



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## Information Transfer

The information transfer process includes verbal communication/handover and documentation. It was suggested that a critical review of current forms should be conducted. The following ideas were suggested:

- **The language used for the form and verbal communication should be standardised** (clear definition for terminology and abbreviations to eradicate misinterpretation)
- Standardise the format used for the form
- Standardise what information needs to travel with the patient
- The document should be short, concise and legible
- The information provided should be complete and accurate
- The criteria for the documentation should be standardised rather than the forms
- Personnel who need to have the transfer information and plan are:
  - **Patient/relative**
  - **Treating doctors (current and others)**
  - General Practitioner
  - Ambulance services
  - Receiving team
  - Retrieving team

### Documentation

Discussion on documentation improvement includes standardisation of transfer form, form content and checklist.

#### Format

Non-electronic

- **Minimum data set/core information/mandatory fields but allowing for specialities and patient requirement**
- **"Core information with prompts for additional diagnostic modules"** – e.g. modules to differentiate between categories of patients – critical care, geriatric, orthopaedic, paediatric
- **A number of standardised forms for different group of patients or acuity – e.g. acute care, sub acute care, time critical, return or non-urgent**
- **Identical data set for all services – hospital, transport team, booking, transport details (including time frame), mode of transport, order, treatment etc**



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Electronic

- **A set of standardised web based referral/handover tools – single entry point with multiple site views that interlink pathology/radiology between centres –** e.g like OASIS in South Australia
- **Standardised electronic forms with tick boxes/drop down menus – minimum data/default set and drop down modules as required for specific patients or specialities (e.g renal patients)**
- **"Prompts within system for critical information and diagnosis support"**

## Content

Summary comments

- The form should be a live document that can identify and document changes in condition and be easily updated
- Avoid duplication of forms, documentation such as observation, medication chart, investigation results and X-ray should be added to the existing standardised document.
- Form needs to be different for different patient groups (e.g. paediatric, adult, mental health).
- Use common language/definitions
- Set up of formal leadership/information flow entry point
- Modulise information so that it can be added or removed dependent on the patient being transfered
- Checkboxes to highlight specific issues

The following summary lists suggested form content based on the level of importance:

Note: *A number of content suggestion were classified high/moderate/low by different participants.*

Content that was classified as high importance

For all transfer

- Patient Demographic
  - Name, date of birth, weight
  - **Family and Social situation**
  - **Communication that has occurred with the family**
- Transfer details
  - Date and time of referral
  - **Urgency of transfer with defined timeframe of transfer – categories of transfer e.g. transfer in less than 30 mins, transfer within 6 hours**

    - Type of bed required – e.g. acuity dependent, specialty dependent
- Contact details
    - **Referral doctors**
    - **Receiving doctor**
    - **Contact person/LMO for further information**
    - Nurse who care for the patient
- **Patient assessment**
    - **Presenting complaint/current history**
    - **Diagnosis – confirmed and suspect**
    - **What is your concern ? – Problem list**
    - **Reason for transfer**
    - **Relevant past history**
    - **Co morbidity**
    - **Observation – in a format that highlight the latest observations** T, P, BP, R, O2 and pain – avoid transcript, attached photocopy
    - **Allergy status**
    - Functional history and status
    - Infectious status – e.g VRE
- **Treatment/intervention**
    - **What is the current order? What has been done?**
    - **What are the initial treatment and response** – key management issues
    - Level of care required during transfer
    - **Resuscitation status and documentation – NFR and LMTO**
    - **Current medications/chart** – what has already been given?
    - Blood products documentation
- **Investigation and latest results (including x-ray) – avoid transcription of result, test results or copies to be attached**
    - **What is ordered? What has been done? What is not done? What results are available? What is pending? How and where to access the pending result?**
    - Highlight abnormal result
- Sign off for treatment and investigation

For Back transfer

- Capability of hospital accepting patient – resource, treatment available
- Clinical stage on discharge

For non-acute transfer

- Personal care status – continence, aids, mobility etc

Content that was classified as moderate importance

- Patient Demographic
    - Social situation
    - Insurance cover
- Contact details
    - **Contact person for further information** - e.g. LMO, referring doctor, GP
- Transfer details
    - Transport method
- Patient assessment
    - **Co morbidity**
    - Infectious status
    - **Risk alert –**falls, pressure ulcer
- Therapy
    - Lines, drips etc

For Back transfer

- Next of kin notification
- GP details
- Actual reason for transfer – e.g send back to die, send back to discharge, medical reason
- Capability and resource/level of care at returning facility
- Plan of care – including necessary treatment, special needs and availability, multidisciplinary

Content that was classified as lower importance

- Insurance/Health Care Card/pension status
- Timelines during transfer – time ambulance called, departed etc
- Level of care available at returning facility
- Allied health handover – intervention requirement
- Risk assessment – falls, pressure ulcer
- List of valuables and belongings

Content that was not classified

- Patient details
  - Interpreter requirement
  - Needs of family. relatives
- Contact details
  - Hospital name
  - Senior contact person coordinating the transfer process
- **Suitability of transfer platform**
  - Patient assessment
  - "Flags to indicate age of condition"
  - High light change in condition
  - Functional status –e.g. sensory impairment, skin condition, personal care status
  - Nil by mouth status if at risk of aspiration/bowel obstruction
- Treatment/intervention
  - **Pain management**
  - **Risk assessment and management – e.g. falls etc**
  - Other therapies such as PEG
  - Summary of care from the tertiary hospital when returning patient
  - **Pre- transfer management plan for back-transfer**
- Signed off by referral doctor



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### Checklist

- Pre-call checklist to get the facts right
- Checklist for transfer – what must be included in the transfer document – e.g. residential care envelope

## Verbal communication

### Who talks to whom? – Consultative process

- Hospital to hospital
    - **Senior clinician to senior clinician** – non judgemental
    - Beware that it is not always possible to talk to senior consultant after hours
- Hospital to ambulance services
    - **Suitability of transfer platform** (e.g. psych patient may need special consideration)
- Ambulance to ambulance

### When to communicate?

- **Agree time between services (hospitals, ambulance services)**
- **When there is a change in proposed timeline**
- **When there is a change in patient's condition that required escalation**

### What information?

- Where the patient might be (both receiving and referring hospital)?
- Advice managing deterioration of the patient condition while waiting to transfer patient out
- When returning patient
    - **Real reason for transfer**
    - **What resources and capability are available, whether the hospital is able to care for the patient?**
    - Any uncommon or unusual medication
    - Agree time for transfer

### What type of communication style?

- Two way dialogue, multidisciplinary
- **Standardised verbal handover**
    - **Situation, Background, Assessment, Recommendation ("SBAR ")**

  - MIST format (Trauma)

Who to feedback to?

- Both referral and receiving hospital

What to feedback?

- For both referral and receiving hospital - How people communicate
- For referring hospital - Patient progress, ability to access local process & treatment

## Decision making tools/flow chart for set criteria to aid management (available electronically)

- **Standardisation of care pathway**
- When do we make the transfer
- Process for reassessment of the patient within the hospital
- Point system to determine the urgency of transfer
- **When more information/update is required**

## Guidelines/Protocol

- **Standardised categories of patients acuity**
  - What type of management is required?
  - Transfer priority - Agree timeframe of transfer for each category of patient
  - Types of acuity/transfer service/expertise required
- **Standardised document on what each facility is able to provide**
  - **Resourcing and capability of hospitals taking back patients**
  - **Services available at specialised hospitals**
- Criteria to accept patient
- Guidelines for care of specialty patients in modules
- **Protocol for documentation** – what is important etc
- Standardised discharge process – e.g. to GP or to another hospital

## Education

- The use of SBAR
- "Set up training to streamline rural referral between rural sites and tertiary centres"
- **State wide education for users of the system to ensure standardisation and appropriate risk management**
- **Education to support standardised forms**
- Education on possible alternative health care venues

## Monitoring & audits

- Quality of information given
- Incident reporting in relation to handover

## Information technology

- **Single unit number/ state-wide or national electronic record to enable information access including pathology/radiology report**
- **Medicare card microchip or smart card carried by patient**
- Southern Health remote electronic monitoring trial
- Pull system
- Bluetooth
- VACIS auto populating field for display at emergency department

## Government

- Resourcing small, regional and rural hospitals to reduce the number of transfer
- Designate zones or leadership areas within state – geographical groups for tertiary centre/facilities
- Infrastructure improvement
- Resources/capacity adequate for system needs



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