**SCOPE:**

This policy and procedure applies to Registered Nurses (RNs), Registered Respiratory Therapists (RRTs), Anesthesia Assistants (AAs), Logistic Attendants and Physicians with privileges at the Royal Victoria Regional Health Centre (RVH) involved in the intra-hospital transportation of critically ill, unstable and/or unconscious adult patients.

**POLICY STATEMENT:**

It is the policy of RVH to ensure safe and timely internal transportation for our patients.

This policy guides staff and physicians through the process and responsibilities for preparing and safely caring for a patient who requires an intra-hospital transfer. All patients shall be transferred appropriately and safely with consideration for the patient’s clinical condition. Every effort shall be made to anticipate the care needs of the patient, given their clinical presentation, including securement of an advanced airway. Prior to any transfer of unstable/unconscious patients, determination shall be made to perform diagnostic procedures at the bedside, when appropriate, to minimize transfers.

1. Transportation of unstable/unconscious patients shall require a minimum of two regulated health care providers for whom it is within their scope of practice, and have the knowledge, skill and judgement to care for highly complex patients with unpredictable course and high risk for negative outcomes.
2. RRTs shall accompany patients with advanced airways or with a high degree of suspicion of airway compromise during transport, and patients who require mechanical ventilation.
3. Documentation of the insertion length of the advanced airway shall be completed pre and post transfer.
4. All RNs accompanying unconscious/unstable patients on transfer shall have completed annual delegation education session with successful completion of the RVH’s Learning Management System (LMS) Quiz in Life Saving Drugs and Defibrillation, as well as current Advanced Cardiovascular Life Support (ACLS). Exception being Operating Room nurses who shall be accompanied by a regulated health care professional who has the scope to perform defibrillation and delegation to administer life-saving medications.
5. When an unstable/unconscious patient is being transferred to a different inpatient unit, transfer of accountability shall be completed by The Situation-Background-Assessment-Recommendation-Documentation (SBARD) report at the bedside and documented (Refer to RVH Policy and Procedure: *Transfer of Accountability).*
6. Any practitioner accompanying an unstable and/or unconscious patient during transfer shall have the knowledge, skill and judgement as determined by any applicable RVH policy and procedure, medical directives and/or regulatory college standards to meet the patients’ needs during transfer.

Prior to intra-hospital transfer of an unstable and/or unconscious patient, the following safety concerns and guiding principles shall be addressed:

1. Communication:
	1. Ensure all appropriate personnel are informed of transport, and receiving locations are ready to receive the patient.
	2. Decisions regarding transfer of accountability are made.
2. Personnel:
	1. Ensure decisions surrounding what regulated personnel shall be part of the transportation are based on the clinical presentation of the patient.
	2. Personnel who initiate transport shall participate for the entire transport, unless transfer of accountability to appropriately trained personnel is necessary due to length of procedure and/or transport.
	3. If there is a high degree of suspicion of airway compromise during the transport, a physician with advanced airway training, an AA and/or RRT shall support transport.
3. Equipment:
	1. Ensure all required medications, equipment and advanced emergency equipment are identified and accompany the patient on transport.
	2. Ensure one large bore (minimum 18 gauge), secure intravenous (IV) access site is in situ prior to transport. Two IV access sites are preferable if time and patient’s clinical presentation permits.
4. Monitoring:
	1. All patients shall receive the same level of basic or advanced physiological monitoring during transport as pre-transportation, unless otherwise ordered by the physician. This shall include electrocardiogram (ECG) monitoring for all patients, and pulse oximetry for all patients dependent on mechanical ventilation (includes Bipap), and/or requiring a FiO2 greater than or equal to 50% or requiring greater than 6Lpm.

It is the expectation that staff shall adhere to the principles outlined in this policy.

**DEFINITIONS:**

**Unstable and/or unconscious patient:** Clinical change in the physical systems assessment and/or any concerns in the patient’s condition. This includes a high degree of suspicion of acute deterioration during transport. Clinical indications of this may include, but are not limited to:

1. Heart rate less than 50 or greater than 120 beats per minute;
2. Systolic blood pressure less than 90 or greater than 180 mmHg;
3. Oxygen saturations less than 90%, or patient is requiring FiO2 greater than 50% or oxygen flow rate is greater than six litres per minute (lpm);
4. Respiratory rate less than 10 or greater than 30 breaths per minute;
5. Glasgow Coma Scale less than nine, and/or retractable intracranial pressure requiring frequent intervention;
6. Unstable cardiac rhythm despite antiarrhythmic therapy (i.e. transvenous pacemaker);
7. Active bleeding requiring ongoing resuscitation.

**Advanced airway:** A device inserted via the nose, mouth or trachea to provide an opening for ventilation. These definitive airways provide an unobstructed route for spontaneous and/or mechanical ventilation.

**Transfer of Accountability (TOA):** An interactive process of transferring patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity of care and the safety of the patient.

**SBARD:** The **S**ituation-**B**ackground-**A**ssessment-**R**ecommendation-**D**ocumentation (SBARD) best practice communication methodology used at RVH when communicating significant patient findings with the interprofessional team and particularly during bedside shift reporting. This is one tool used in TOA.

**Intra-hospital Transfer:** Transporting a patient for a test, procedure, or to another unit/department within the hospital.

**PROCEDURE:**

Equipment:

1. Working portable suction.
2. Portable oxygen delivery device and oxygen source appropriate for patients’ clinical presentation and length of transport (i.e. bag valve mask, BiPAP, transport ventilator, non-rebreather mask etc.).
3. Portable transport monitor (capable of continuous cardiac monitoring, invasive or non-invasive blood pressure monitoring, continuous oxygen saturation monitoring; if deemed clinically necessary and/or if transfer will be to an area without immediate access to a defibrillator, a portable transport monitor with defibrillation capability).
4. Medications required for patient during transport, such as analgesia, sedation, and for support of hemodynamic stability as ordered by the most responsible physician.
5. Personal Protective Equipment (PPE) based on risk assessment.

Pre-procedure care by RN, AA and/or RRT

1. Ensure the interdisciplinary team has discussed all safety concerns regarding transport, including risk-benefit analysis of need for transport for test, procedure, transfer to higher acuity unit, etc.
2. Perform hand hygiene and don appropriate PPE based on risk assessment.
3. Identify patient utilizing two patient identifiers.
4. Introduce self, utilizing AIDET format. Explain procedure to patient and/or support personnel and provide support as necessary. Ensure family and/or substitute decision maker is aware of transfer and consent for procedure was obtained, if appropriate.
5. Ensure all equipment is operational, contains enough battery life and volume of infusion for the anticipated length of transfer, plus a minimum of 30 minute to one hour reserve. All oxygen tanks shall have enough capacity for transport, with the capability to switch tanks or attach to a central oxygen source at the destination. If this is not possible, two tanks, at least three quarters full.
6. Attach cardiac monitor to the patient; ensure all pertinent data is being displayed, and alarm parameters are set specific to patient requirements. This monitor shall be visible to the regulated staff responsible for transport at all times. Alarms shall be on at all times.
7. Attach the patient to portable oxygen delivery device and oxygen source to ensure adequate and appropriate amount of oxygen delivery during transfer.
8. Ensure patient safety by putting side rails up where applicable.
9. Ensure patient’s health record accompanies the patient throughout transport and confidentiality is maintained.

During Transfer

1. All regulated health care professionals shall provide safe, effective and ethical care according to their professional scope of practice, adhering to specific college standards and any applicable RVH policy, procedures and/or medical directives.
2. If the patient is being transferred between units, a TOA report using a SBARD tool (Refer to RVH Policy and Procedure: *Transfer of Accountability)* shall be given at the bedside, before or after physical transfer is complete. The exception to this is upon transfer to the Operating Rooms and/or Cardiac Intervention Unit (CIU), when the Preoperative/Pre-procedural checklist shall be utilized.
3. If the transport is for the purpose of a test or procedure, the accompanying regulated staff shall remain with the patient at all times, until final patient disposition has been reached.
4. Throughout transport, monitoring data such as heart rate and rhythm, blood pressure, oxygen saturation, and respiratory rate shall be documented a minimum of every 15 minutes and as patient’s condition warrants.

Post Transport

1. Documentation shall include: assessments, monitoring, data analysis, any and all medications administered, interventions and outcomes on the most appropriate patient specific health record.
2. Return and/or waste all medications not used during transport in the appropriate receptacle and record in automatic dispensing unit (ADU) if applicable.

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