CYMRU INTER HOSPITAL ACUTE NEONATAL TRANSFER SERVICE - NORTH WALES

STANDARD OPERATING PROCEDURES

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CHANTS – NORTH

1 INTRODUCTION

1.1 This Standard Operating Procedure (SOP) provides a framework within which the North Wales Neonatal Transport Service Operates.

1.2 The Transport Service is part of Betsi Cadwaladr University Health Board. The team is based at Ysbyty Glan Clwyd (YGC) and will be co-located within the Sub-Regional Neonatal Intensive Care Centre (SuRNICC).

1.3 The Service serves a population of approximately 700,000 people and 7,000 births per annum.

1.4 It is expected that all individuals working as part of the Transport Service are aware of, and work within the agreed Clinical Governance Structures.

1.5 The Service sets out to meet the standards set by the All Wales Neonatal Standards, 2nd Edition¹ and the National Institute for Health and Clinical Excellence for the provision of specialist transport² services in partnership with the Cheshire & Merseyside Neonatal Transport Service (CMNNTS) hosted by Liverpool Women’s Hospital³.

2 SCOPE OF SERVICE

2.1 Uplift:

The stabilisation and transfer of sick and potentially unstable babies to provide the necessary intensive or high dependency care. These transfers might be referred to as step up transfers.

2.1.1 This includes transfer of any ventilated or sick baby from the local hospital to receive intensive or high dependency care either in the SuRNICC or unit outside of North Wales e.g. Arrowe Park, Liverpool Women’s Hospital.

2.1.2 Transfer may also be necessary for cardiac, surgical or other specialised services. These services will usually be provided at Alderhey Hospital.

2.1.3 To undertake uplift transfers; the services of a highly competent and skilled team will be provided together with specialised transport equipment – incubator, ventilator, infusion delivery devices, monitoring etc.

2.2 Repatriation:

The repatriation of the baby to the SuRNICC or home unit once their condition has improved.

2.2.1 Repatriations usually involve babies who are stable. It involves babies retrieved back from Cheshire & Merseyside Neonatal Network (CMNN) or babies transferred back from the SuRNICC to the local hospital.

2.2.2 It will depend on the condition of the baby whether a medical or nurse-led transfer is needed.

2.2.3 These transfers are usually undertaken in a planned fashion within normal working hours, Monday – Friday, preferably in the morning.

¹ All Wales Neonatal Standards 2nd Edition, 2013
² NICE provision of Specialist Transport. 2012
³ Service Level Agreement with CMNNTS, 2015
2.3 **Resource-Capacity:**
The transfer of a baby out of the unit to another unit to provide ongoing care due to lack of capacity or to free up space.
2.3.1 It will depend on the condition of the baby whether medical or nurse-led transfer is needed.
2.3.2 These transfers are usually undertaken in a non planned fashion and the provision of the service will depend on the availability of the team and time of the day.

2.4 **Outpatients:**
The transfer of the baby to another hospital (usually within Cheshire & Merseyside Neonatal Network,) for assessment or investigations.
2.4.1 It will depend on the condition of the baby whether medical or nurse-led transfer is needed.
2.4.2 These transfers are usually undertaken in a planned fashion within normal working hours.

3 **GENERAL PRINCIPLES OF REFERRALS**
3.1 Whenever possible in-utero transfer is preferable to postnatal transfer. The availability of CHANTS - NW should not lead to a decline in in-utero transfers.
3.2 All Wales in-utero transfer guidelines\(^4\) have been developed and should be followed. The service will not provide resuscitation at birth. This is Standard 2.1 of the All Wales Neonatal Standards, ‘that the referring hospital is required to provide resuscitation and initial stabilisation’.
3.3 The transfer service is not available for babies born at home or in a Midwifery-led unit. Emergency response will be met by requesting a 999 emergency Ambulance, for transfer to the nearest paediatric or neonatal unit as per the All Wales Midwife-led care guidelines\(^5\).
3.4 Requests to transport a neonate will only be accepted after the birth of the baby.
3.5 The transport team may be notified before birth in anticipation of a likely need for transfer, enabling plans to be made, advice to be provided, a cot to be located and other services to be notified e.g. surgical or cardiac if necessary.
3.6 The transport team will not set out to retrieve until after the birth and following a further telephone conversation and advice regarding the condition of the baby.
3.7 The transfer team will not accept / set out for transfer until a suitable cot is located and booked except in exceptional circumstances.
3.8 The transport team will wherever possible agree to undertake transfers of babies requiring intensive care or high dependency care.
3.9 Babies receiving special care may need to be transferred using the local unit staff. In such instances the local unit Nurse in Charge must notify the transport team neonatal nurse so that a full record can be maintained of numbers and reasons for all the inter hospital neonatal transports for North Wales.

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\(^4\) All Wales In-utero Guideline 2015
\(^5\) All Wales Midwife-Led Care Guidelines, 2015
3.10 Some procedures e.g. ROP will be undertaken as a day case where the baby is transported, operated upon and returned to the home unit on the same day. The baby will remain under the care of the transport team before and after the Procedure.

3.11 The dedicated Neonatal Ambulance Vehicle can be released during day case procedures, if there is an emergency transfer during the same time WAST will provide and ambulance for the return journey.

3.12 The dedicated Neonatal Ambulance Vehicle will be mobilized to retrieve the baby and transport team following the day case procedure.

4 HOURS OF OPERATION
Once in full operation:
4.1 The dedicated transport team will be operational from 8am - 8pm every day of the week.
4.2 Changeover of the transport team consultant will occur at 8am on Monday morning.
4.3 It will be normal practice for the consultant changing over to share information regarding any problems in the preceding week and any anticipated transfers, or alternatively if there are no anticipated transfers. This will be done by speaking directly with the consultant on for transport that week.

Interim Service (Current):
4.4 Saturday and Sundays do not currently have full consultant cover, therefore weekend referrals must be discussed with the transport team in YGC. Nurse only transfers can be performed during the weekend. Acute and time critical transfers may be undertaken depending on medical personnel availability.
4.5 Time Critical and Acute Transfers will be undertaken by the CMNNTS as set out in the agreement and in line with the guidelines set by the BAPM & NTG (Neonatal Transport Group) Neonatal Transfer Dataset 2012 and the Transport Pathways for CHANTS – North. CHANTS – North might undertake these transfers depending upon the availability of appropriate staff and will be the decision of the consultant neonatologist.

5 HOW TO MAKE A REFERRAL TO THE TRANSPORT TEAM WITHIN HOURS

5.1 For all requests for transfers please phone the transport team on 01745 534686 (Neonatal Unit, YGC).
5.2 Whenever possible please complete the form entitled ‘Referral document’ which Can be faxed to 01745 534681.
5.3 All referrals must have medical team involvement and where ever possible there should be a consultant to consultant discussion for uplifts but if this is not achievable then it should be between the most senior clinicians available on both sides.
5.4 Uplifts: Based on the category and acuity of the transfer, referrals should be consultant to consultant whenever possible and made directly to the transport team.

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6 BAPM & NTG Neonatal Transfer Dataset 2012
7 North Wales Neonatal Transport Pathways Nov 2014, Working Draft – Currently under review
5.5 **Repatriation:** The referring unit should liaise with the accepting unit. All the relevant clinical information should be provided. Once the repatriation has been agreed, a request may be made to the transfer team.

5.5.1 Whenever possible repatriations must be provisionally booked with the transfer service in advance (aim for 24 hours notice). However if a more pressing transfer arises the repatriation may need to be postponed or alternative arrangements made.

5.6 Repatriations would usually be undertaken during the morning. If for any reason, the booked cot becomes unavailable the transport team should be informed immediately. If the baby is already in the dedicated neonatal ambulance vehicle and on the way to the destination hospital the journey will continue.

5.7 **Resource-Capacity:** as per 5.4 and 5.5

5.8 **Out-patient:** as per 5.4 and 5.5

5.9 For all Transfers the referring unit should ensure that a photocopy of the notes is available for the receiving team as well as a high quality badgernet summary, as this information will be required by the receiving unit. We would not expect the transfer service to be aware of all the details regarding the case.

6 **LOGGING CALLS**

6.1 All calls with request for transfer must be logged whether they can be Undertaken, or not.

6.1.1 The call must be entered onto the referral log with a note of whether accepted / declined / deferred.

6.2 **Standing down from duty**

6.2.1 If a transfer request - not time critical or acute - is received after 5 pm at night, the transfer will be deferred to the following day.

6.2.2 If a time critical or acute request is received within 1 hour before the transfer team is due to stand down, the ability to accept the call will depend on the availability of the transfer team to work beyond their duty hours.

6.2.3 If it is not possible for CHANTS – North to assist, the referral will be directed to the CMNNTS – in this situation the plan of transfer will be discussed with CMNNTS team and a suitable cot (in North Wales or in Cheshire & Merseyside) will be sought.

6.3 **Out of hour’s requests**

6.3.1 Out of hours requests for time critical and acute uplifts should be discussed with the Neonatologist (or Consultant Paediatrician) in YGC and it will be either directed to the CMNNTS following the usual referral pathways or an alternative arrangement will be agreed.

6.4 **Time critical transfers include the following:**

6.4.1 Surgical transfers that are unstable or have a potential to deteriorate without surgical intervention (gastroschisis, NEC, diaphragmatic hernia etc)
6.4.2 Duct dependent cardiac conditions with inadequate mixing that may need emergency septostomy (some duct dependent lesions stable on prostin are not time critical).
6.4.3 Therapeutic hypothermia for HIE.
6.4.4 Neonatal illness such as PPHN and severe RDS that require specialised expertise and equipment not available in the referring unit i.e. HFOV, Nitric Oxide.
6.4.5 Any other situation where transfer is deemed to be time critical as per local agreement and clinical judgment.
6.4.6 There will be an immediate response protocol to ensure that a suitable ambulance will be available for these transfers.

6.5 Essential information when making a referral at any time

6.5.1 Referral should be consultant to consultant whenever possible but as a minimum must have medical team involvement. Clinical details should be documented using the transfer form.
6.5.2 A completed badgernet summary will be required when the team arrives. It is helpful if the notes are photocopied and all documentation is available for the team to prevent any delays.

6.6 Advice from the transfer team to the referring unit

6.6.1 The transfer team will provide the referring team with telephone advice on the management of the baby. This should be recorded for medico legal and risk management reasons.
6.6.2 If the team is already out on a transfer, advice may be provided by the consultant covering the unit. However the medico legal responsibility for the decisions regarding the baby remain with the referring team, until such time that the baby is formally handed over to the transfer team, when the team is physically present on the referring unit.
6.6.3 The time of the handover should be documented and signed with time and date by both parties.

7 CRITERIA FOR PRIORITIZATION OF REQUESTS (Time Critical transfers will get priority over acute transfers)

When more than one request for transfer is received simultaneously the transport consultant on duty will have the final authority and responsibility for prioritisation. The following should be regarded as a framework of practice and decision making:

7.1 Acute surgical conditions with potential for deterioration in a nonsurgical unit i.e. unstable NEC, Gastrochisis, Diaphragmatic hernia will get priority over babies needing transfer for routine ongoing care for prematurity.
7.2 Diagnosed or suspected duct dependent cardiac condition or cardiac condition that will need an urgent septostomy will get priority over routine prematurity related transfers.
7.3 Stable cardiac babies with a confirmed echocardiographic diagnosis and well established on prostin do not conform to this category.
7.4 Transfers that require initiation of specialised treatment within a definite time frame i.e. therapeutic hypothermia in a term asphyxiated baby will take priority over routine prematurity related transfers.

7.5 Uplift transfers will get priority over repatriations. i.e. babies requiring transfer from a level 1 unit will get priority over a similar baby in a level 2 or level 3 unit in that order.

7.6 Repatriations from level 3 units will take priority over similar transfers from other units, so that cots are vacated for further babies who may require intensive / high dependency care.

7.7 Transfer requests for capacity reasons (even if ventilated) should only be undertaken during working hours, in the absence of other emergency transfer requests, unless such transfer will free up space for a concurrent emergency to occupy the same cot.

7.8 Transfer requests for routine PDA ligation and specialist assessments will be accommodated, but emergency transfer requests will have priority.

7.9 There will be a log kept of all transfer requests. This will document whether the transfer was accepted or rejected and if rejected give reasons why.

8 TEAM DISPATCH

8.1 For a **Time Critical transfer** CHANTS – NW will aim to depart from base within 30 minutes of the time of acceptance of the referral call (the dispatch time).

8.2 For an **Acute transfer** the transport team will be at cot side within 3.5 hours from the time the referral was made.

8.3 If there are calls which are stacked the transfer team may not accept the transfer, until other transfers have been completed.

8.4 A transfer will be regarded as complete when a comprehensive handover to the receiving unit has taken place, documents photocopied and the transfer equipment has been cleaned and replenished to working order.

8.5 The dispatch time for the next transfer will be counted from the time of completion of the last transfer.

8.6 For successive non time critical transfer, the transfer team is entitled to a short break for meals and refreshments not exceeding 30 minutes but this period will be included in the dispatch time.

8.7 The time the first request is made to the transfer team must be recorded. This is to ensure that important information on the demand for the service is collated. However calls to retrieve made prior to birth of the baby will not be counted.

8.8 The transfer document will contain a time line which will contain the time of various stages in the transfer process for audit purposes.

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8 CMNNTS work within the standard of 1 hour dispatch time. The all Wales Standard is also 1 hour and this criteria will be used for All Wales data collection and reporting
WHO WILL UNDERTAKE THE TRANSFER?

9.1 The aim is to provide 12 hour a day consultant transport cover.
9.2 The Transport neonatal nurse will be supernumerary to the neonatal unit staffing compliment, to ensure availability for medical and nurse led transfers.
9.3 The staff provided to undertake the transfer of the infant will be appropriately skilled and experienced.

9.4 An experienced transfer clinician or ANNP (medical transfer) must accompany the team in the following intensive care transfers:

9.4.1 Babies below 1 kg weight.
9.4.2 Babies below 28 weeks gestation less than 48 hours of age.
9.4.3 Babies on NCPAP after extubation from a period of ventilation.
9.4.4 Unstable high dependency babies.
9.4.5 Babies with complex cardiac problems or those on medication to maintain a duct dependent lesion.
9.4.6 Babies with complex surgical problems.
9.4.7 Neurological problems that require constant monitoring and treatment to maintain stability.

9.5 Nurse only transfers can be undertaken for the following patient groups

9.5.1 Stable special care babies.
9.5.2 High dependency babies who have been stable for 48 hours with no increasing oxygen requirement, significant bradycardia, or desaturation.
9.5.3 Surgical referrals where the baby is stable for transfer and does not require interventions to maintain stability.
9.5.4 Neurological disorders where the baby has been stable for 48 hours.
9.5.5 Babies who have been extubated 24 hours after being electively intubated for surgery and are stable in air.

9.6 Prior to accepting or undertaking a nurse only transfer a full history must be taken and discussed with the Transport Consultant who must agree for the transfer to be undertaken.

9.7 If during a routine repatriation, a transfer nurse is asked to accept a baby which has become unstable, she should discuss the situation with the Transport Consultant by phone. Together they will make a decision whether or not accept the handover or proceed with the transfer.

9.8 If the baby is considered too unstable for nurse only transfer, the decision should be made to decline and leave the baby in the care of the referring unit.

9.9 The Transport Consultant should then discuss with the consultant covering that unit the reasons for the decision.