

**CONTROLLED DOCUMENT**

## Patient Internal Transfer Policy

<b>CATEGORY:</b>	Policy
<b>CLASSIFICATION:</b>	Clinical
<b>PURPOSE</b>	To set out the principles and framework for the transfer of patients from ward to ward, department and site within the Trust.
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<b>Controlled Document Sponsor:</b>	Chief Nurse
<b>Controlled Document Lead:</b>	Lead Nurse Quality and Clinical Assurance
<b>Will this Controlled Document impact upon any contracts held by the Trust?</b>	<input type="checkbox"/> Yes <sup>1</sup> <input checked="" type="checkbox"/> No
<b>Approved By:</b>	Chief Executive
<b>On:</b>	April 2020
<b>Review Date:</b>	April 2023
<b>Distribution:</b> <ul style="list-style-type: none"> <li>• <b>Essential Reading for:</b></li> <li>• <b>Information for:</b></li> </ul>	Trust staff/departments involved in the transfer of patients within the Trust.  All Staff

<sup>1</sup> If this Controlled Document will have an impact on any contracts held by the Trust, once approved, this will need to be sent to the Procurement Team requesting that it be added to the Procurement Policy Portal

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## 1. Policy Statement

- 1.1 The aim of this policy is to ensure the safe and timely transfer of patients within University Hospitals Birmingham NHS Foundation Trust (the 'Trust'). In particular, it ensures that:
  - 1.1.1 The risks associated with transferring patients are identified and managed appropriately (CQC, 2018; Health and Social Care Act, 2008); and
  - 1.1.2 Transfer practices are measured and any incidents are reported to support practice improvement (Health and Social Care Act, 2008);
  - 1.1.3 Transfers of both adults and children:-
    - a) Are appropriate;
    - b) Have adequate equipment and personnel during the transfer;
    - c) Have sufficient and/or appropriate information given to the receiving area; and
    - d) Have adequate personnel/equipment in the receiving area.
- 1.2 An internal transfer refers to any transfer arranged by or on behalf of University Hospitals Birmingham NHS Foundation Trust, irrespective of site or location, to another clinical area within the Trust.
- 1.3 Transfer to another healthcare provider is classed as a discharge. Please refer to the associated Discharge and Transfer of Care Policy and associated procedures.

## 2. Scope

- 2.1 This policy applies to all individuals employed by the Trust including students, locum and bank/agency staff and staff employed on honorary contracts who are involved in Trust business, on or off Trust premises.
- 2.2 It applies to all patients registered as inpatients within the hospitals or those attending the hospitals for emergency/urgent assessment and being transferred to a ward/department or another site, following a decision being taken to admit the patient.
- 2.3 It applies to patients being admitted, and thus transferred, from outpatient or ambulatory care to inpatient areas.

- 2.4 It applies to patients being transferred to and from theatres, critical care and dialysis. It applies to patients being transferred temporarily for an investigation, procedure or therapy session.
- 2.5 This policy does not apply to:
  - 2.5.1 Patients attending as outpatients;
  - 2.5.2 The permanent transfer of a patient (discharged) to another Trust/healthcare provider; or
  - 2.5.3 The transfer of deceased patients from wards / departments to the mortuary.

### **3. Framework**

- 3.1 This section describes the broad framework for the Patient Internal Transfer Policy. The operational instructions for the processes required when undertaking a patient transfer, including the escort requirements, are described within the associated procedures.
- 3.2 The Chief Nurse shall approve all procedural documents associated with this policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy. Associated Trust procedures exist for adult and paediatric patients. Additionally, the Trust adopts the transport and retrieval (neonatal) Clinical Guidelines (Bedside Clinical Guideline Partnership in association with the Staffordshire, Shropshire, and Black Country Neonatal Operational delivery Network and Southern West Midlands Operational Delivery Network).
- 3.3 The associated procedures are to be followed for all patients within the scope of this policy. The procedures set out specific transfer requirements for the following patient groups:
  - 3.3.1 Patients with infections;
  - 3.3.2 Patients being temporarily transferred from their ward/department for an investigation, procedure or dialysis; and
  - 3.3.3 Patients requiring transfer to the Discharge Lounge.
- 3.4 Patients are either internally transferred temporarily to another department or clinical area for a procedure or investigation; or permanently from one clinical area to another.
- 3.5 The Trust will ensure that all internal patient transfers take place appropriately by ensuring that:

- 3.5.1 The decision to transfer a patient is made by an appropriate registered practitioner who will then be responsible for ensuring the patient is prepared for transfer;
- 3.5.2 The transfer either benefits the patient or another patient. This will include transfers for clinical reasons, infection prevention measures, to comply with same sex accommodation or other privacy and dignity concerns, or transferring (outlying) a patient to another ward to allow the transfer of a patient who has a greater need for the care, into the clinical area;
- 3.5.3 The surgical checking processes must be followed for all transfers to and from theatres. The associated sections of the theatre and other procedural areas (such as endoscopy) documentation must be completed;
- 3.5.4 The associated procedures are followed for all transfers to and from dialysis and critical care;
- 3.5.5 Before a patient is transferred, an assessment is undertaken and documented, to establish:
  - a) Any risks to the transfer; and
  - b) The needs of the patient during the transfer.
- 3.5.6 Adequate equipment and staff with the necessary competencies are available during a transfer and in the receiving area;
- 3.5.7 Appropriate information is given by the transferring clinician to the receiving area; and
- 3.5.8 In the case of a permanent transfer of a patient from one clinical area to another, a transfer checklist is completed.
- 3.6 The property of transferring patients will be transferred in accordance with the associated Policy for the Handling of Patients' Cash, Valuables and Property.
- 3.7 In the event that a patient is transferred inappropriately, an incident form must be completed in accordance with the Trust's Procedure for the Reporting and Managing of Incidents.

## **4. Duties**

### **4.1 Chief Nurse**

The Chief Nurse is responsible for overseeing compliance with this policy, and will provide assurance to the Board of Directors on

compliance and raise matters of concern with the relevant Division/Department.

#### **4.2 Divisional Directors/Divisional Directors of Operations/Associate and Deputy Associate Directors of Nursing**

Divisional Directors/Divisional Directors of Operations and Associate and Deputy Associate Directors of Nursing are responsible for ensuring that the wards/departments and staff within the Division are aware of and implement this policy, and where there are deficiencies or concerns in delivery, these are investigated and reported via the Divisional Clinical Quality Groups.

#### **4.3 Managers**

Managers of staff involved in the process for internal patient transfer must ensure that:

4.3.1 All staff have access to this policy and associated procedural documents;

4.3.2 All staff adhere to and implement this policy and associated procedural documents;

4.3.3 The appropriate staff, equipment and stationary are available to enable this policy to be followed; and

4.3.4 Staff have the necessary training to enable them to implement this policy.

#### **4.4 All staff involved in the process of internal patient transfer**

All staff involved in the process of internal patient transfer are required to familiarise themselves with all relevant Trust policies and procedures referred to within this document. They must ensure that they comply with them in their areas of work at all times.

### **5. Implementation and Monitoring**

#### **5.1 Implementation**

This policy and its associated procedures are available on the Trust intranet and disseminated to staff through the divisional management and internal team structures within the Trust.

#### **5.2 Monitoring**

Appendix A provides details on how the policy will be monitored.

## 6. References/Bibliography

Care Quality Commission (2018) **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12**

<http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment#full-regulation>

[Accessed 27.11.19]

NHS England; NHS Improvement (2019) **Delivering same-sex accommodation.**

[https://improvement.nhs.uk/documents/6005/Delivering\\_same\\_sex\\_accommodation\\_sep2019.pdf](https://improvement.nhs.uk/documents/6005/Delivering_same_sex_accommodation_sep2019.pdf)

[Accessed 08.10.19]

Health and Social Care Act (2008)

<http://www.legislation.gov.uk/ukpga/2008/14/contents>

[Accessed 08.10.19]

## 7. Associated Policy and Procedural Documentation

Discharge and Transfer of Care Policy and Procedures

Policy for the Reporting and Management of Incidents including Serious Incidents Requiring Investigation

Procedure for the Handling of Patients' Cash, Valuables and Property

Procedures for the Transfer of Adults across University Hospitals Birmingham NHS Trust Sites

Procedures for the Transfer of Children across University Hospitals Birmingham NHS Trust Sites

Same Sex Accommodation Policy and Procedural Documents

## Monitoring Matrix

## Appendix A

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
Correct documentation has been completed for internal patient transfers	Clinical Governance and Patient Safety/Lead Nurse Quality and Clinical Assurance	Operational Quality Assurance Group	Correct completion of the transfer documentation will be monitored through the Nursing Documentation Audits	Annual
Monitoring of incident trends associated with patient transfer	Clinical Governance and Patient Safety	Care Quality Monitoring Group (CQMG)	Details of any trends relating to patient transfer will be included in the aggregated report as and when they occur	Quarterly
Theatre checking processes are followed to ensure patient safety	Lead Nurse Quality and Clinical Assurance	Operational Quality Assurance Group	Annual audit will be completed by the Quality and Clinical Assurance Team/Division1 and reported to the Associate Directors of Nursing at the Operational Quality Assurance Group	Annual
Appropriate escorts are utilised when transferring patients temporarily to Imaging areas within the Trust	Division 1 Divisional Director of Nursing	Operational Quality Assurance Group	Quarterly audit will be completed by the Division 1 Imaging Teams and reported to the Associate Directors of Nursing at the Operational Quality Assurance Group	Quarterly



Monitoring of out of hours transfers of patient with dementia	Lead Nurse Quality and Clinical Assurance	Operational Quality Assurance Group	Data will be requested from Informatics and reported to the Healthcare for Older People Group quarterly and annually to the Operational Quality Assurance Group as part of the evidence of policy monitoring compliance	Annually
	Lead Nurse Older Adults	Healthcare for Older People Group		Quarterly