Safe Inter-hospital Transfer of the Critically Ill Patient

B. M. Schyma, R. Goswami, A. Ng, M. Ramany, Mayuree, J. Qin, M. Ishak, J. Wallace, Z. H. Fang, W. K. Foo, E. H. P. Min

**Background**

- The transfer of critically ill patients is a necessary but high risk process.
- Transfers occur out of office hours and at short notice
- The transfer environment is noisy and potentially dangerous.
- Transfer teams are isolated from hospital based support
- CGH transferred about 240 critical ill cases in 2014 from Accident and Emergency department and Intensive Care Units.
- Risk of litigation for hospital

**Problems identified**

- Current transfer practice was substandard
- No documentation of transfer events
- No audit process
- Inadequate staff training and supervision
- Inadequate equipment
- Unavailability of some essential fixtures in the ambulance

**Implementations**

**ICU Capable Ambulance Arrangement**

Equipped with safety harness and contain mounting points for equipment and carry oxygen reservoirs and power

**Transfer Bag**

- Compartmentalised design with an Airway/ Breathing/ Circulation layout
- Provides secure storage for additional oxygen cylinder

**Transfer Document**

- Pre-departure checklist
- Recording of clinical parameters and events
- Audit/ data collection form to tract quality improvement

**Conclusion**

The implemented measures have reduced the risk associated with inter-hospital transfers and increased the quality of clinical care provided.

**Future steps**

- CGH ambulance will be retrofitted to an ICU standard
- Dedicated critical patient transfer trolley
- Training programme for staff involved in transfer

**Methodology**

The patient transfer process from the decision to transfer to the arrival at the destination was mapped. High risk points were analysed and mitigation measures were implemented. The Accident and Emergency (A&E), Medical (MICU) and Surgical (SICU) Intensive Care Units were focus areas.