GUIDELINE

Transfer by Road and Air of Stable Infants

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

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Aim

To ensure safe transportation of infants to other hospitals.

Risk

Patients who are not transferred appropriately using the correct process may be compromised.

Key Points

- Transfers MUST adhere to each hospital's individual accepting criteria. Discuss transfer criteria with KEMH Discharge Coordinator/3B CNS and/or CNCs.
- All patients who require ongoing treatment at another health facility must be transferred to health facility with appropriate transport methods via NETSWA or Neonatology Hospital Transport unless discussed with NICU Consultant.
- Parents MUST be informed of the plan to transfer.
- One nurse will be allocated per patient for all transfers.
- Observations will be recorded every 15 minutes on MR400.02 for the duration of the transfer.
- All patients will have continuous oxygen saturation monitoring for the duration of the transfer.
- Infants requiring cardiac monitoring, IV fluids, thermoregulatory support and <1650g need to be transferred on a flatbed (Cosy Pod or transport cot)
- Oxygen will be taken (via cylinder) on all transports.
- Patients that require respiratory support and / or having frequent desaturations and bradycardic events will be transported by NETS WA.
- Transport nurse **must** wear hospital ID for all transfers including by air.
- Transport nurse must undergo skill training and be deemed competent (see Appendix 1).
- All stable patients requiring road transport between sites or to another hospital are to be escorted by a nurse (seated in the back with the infant).
- Transport will take place in a WA Health fleet vehicle or approved taxi.
- In the interests of workplace health and safety and for insurance purposes staff are not permitted to escort patients in private vehicles.
- All transfers are to use the capsules supplied by CAHS Neonatology.
- Parent-only escort must have consultant medical officer written approval.

Transfer Planning (Medical and Nursing Responsibilities)

1. Discharge Coordinator / Shift Coordinator (3B) / Clinical Nurse Consultant / 3B Clinical Nurse Specialist will:
    a. Identify suitable infants for transfer, in consultation with medical team.

b. Discuss transfer with parents.
c. Liaise with peripheral hospital for bed availability.
d. Complete verbal handover to receiving hospital nurse management / coordinator.
e. Inform NeoBase and Milk room staff of potential transfers each day.
f. Liaise with area manager and driver for availability of staff and transfer times.
g. Contact NETSWA if infant on respiratory.

2. Medical staff will:
    a. Complete discharge check prior to contacting receiving hospital. Document date and time.
    b. The medical officer is to provide a comprehensive Clinical Handover using ISOBAR format to the receiving medical team MUST document name of accepting doctor and details of handover in Progress Notes MR420 and Neonatal Inter/Intra Hospital Medical Transfer form MR440.02
    c. Complete NaCS summary FOR ALL BABIES, one copy in purple Child Health Record book, and one for the receiving hospital.
    d. Complete “Fitness to Fly” including flight oxygen documentation clearance if transferring by air.
3. Bedside nurse will:
    a. Weigh and measure infant prior to transfer and plot on weight and length chart.
    b. Complete Inter-hospital Nursing Transfer form MR440 and photocopy for receiving hospital.
    c. Photocopy Neonatal Flow Chart MR485.02, Medication Chart MR 811 and weight chart along with MR440.
    d. Notify NeoBase for neonatal discharge summary on weekdays.
    e. Have frozen EBM packed with ice bricks in freezer bags from Milk Room readily available for Transfer nurse.
4. Transfer nurse will:
    a. Check back transfer backpack has all contents as per Backpack Contents List Appendix 2.
5. Prepare B or C cylinder in Oxypack.

Regional / Remote Area Considerations

Consider the following when transferring infants to regional / remote areas

- Any medical or social issues outstanding must be discussed with the neonatal consultant *prior to initiating transfer (e.g. booking flights, etc)*.
- If less than 7days of age, a 'Fitness to Fly' clearance must be completed. This form is available from the ward clerk or Discharge Coordinator at KEMH
- All airlines require infants to be over 48hrs of age before flying. Check if mother needs 'Fitness to Fly'.
- The receiving Paediatrician / GP / LMO must approve the transfer, as well as the midwifery / nursing staff at the receiving hospital if an inter-hospital transfer.
- Infants under 35 weeks gestation at birth.
    - Discuss with the neonatal consultant and neonatal discharge coordinator/ Clinical Nurse Consultant to arrange
        - Teaching of parents on use of the oxygen cylinder.
        - Flight oxygen clearance documentation.
        - Delivery of oxygen cylinder.

Transfer between KEMH AND PCH

At times, infants at KEMH may need to attend PCH for investigations, procedures or surgery. These infants may return to KEMH for continuation of care if cleared by treating specialty.

The following physical MR forms needs to go with the patient on transfer between KEMH and PCH, all other documents are scanned in to DMR:

- MR410 Neonatal History
- MR430 Admission/Discharge Plan
- MR485.02 Neonatal Summary Flow Sheet
- MR485.03 Neonatal Problem List

KEMH

- If transfer to PCH, arrange transport for the infant and transfer nurse for the agreed time.
    - Page the Discharge Co-ordinator at KEMH to see if NICU driver is available.
- If the infant requires a NETS WA back transfer – liaise with the NETS WA transport team.

PCH

- If the infant requires a NETS WA back transfer – liaise with the NETS WA transport team.

- Liaise with 3B Shift Co-ordinator and CNC.
- Book transport and record details on Admission /Discharge Plan MR430.

Transfer Process

Transfer Steps By Road
1. Prior to placing the patient in the capsule/CosyPod the bedside nurse and the transfer nurse must independently check that the patient has 2 ID bands in situ with the 3 approved patient identifiers. Refer to Identification of the Infant. 2. Transfer nurse to ensure patient is dressed appropriately and placed correctly into the capsule/CosyPod. 3. The patient must not be transferred immediately following a full feed (at the risk of aspiration). Feeds should be completed 60 minutes prior to travel. If a transport is required within 30 minutes after a feed, administer half the feed and complete on arrival. 4. Attach monitoring (oxygen saturation monitoring is a minimum). 5. Transfer nurse to do a baseline set of observations on MR400.02 before leaving and then every 15 minutes during the transfer. 6. Complete final observations on arrival at destination before handover and document on MR400.02. 7. Complete ISOBAR handover to receiving team. 8. Transfer nurse to complete 'Back transfer data sheet' (Appendix 4). 9. On return to the Neonatal Unit ensure the 'Back Transfer Data Sheet' is completed and placed in: a. 'Back Transfer Folder' in the cupboard next to the photocopier outside SCN3 or b. in the 'Completed paperwork folder' in NETS office on Ward 3B 10. Transfer nurse to re-stock backpack and return to storage location. 11. If transferring by taxi, ensure cab charge stub and receipt is returned to Discharge Coordinator (KEMH) or NETS WA CNC (3B). 12. Report any adverse incidents to Clinical Nurse Consultant/Discharge Coordinator. Adverse events to be reported on Datix CIMS (patient event) or OSH Hazard/Incident Form (staff event).
Cosy pod additional steps
• The following patients that meet **any** of the following criteria need to be transferred on a flatbed (Cosy Pod or transport cot): ○ <1650g ○ on continuous cardiac monitoring with minimal desaturations or bradycardic events - infants with frequent desaturations or bradycardic events may require transfer via NETS ○ on IV fluids ○ with temperature instability or nursed in an incubator

- on caffeine

- CosyPod is checked daily by SCN 2 admission nurse (Appendix 3: CosyPod Checklist)
- A maximum of 2 patients can travel in the Cosypod, they can be unrelated and traveling to the same or separate destinations.
- Transfer nurse will ensure Cosypod is cleaned and restocked after each transfer (Appendix 3: CosyPod Checklist).

Transfer Steps Air Transfer

- Prior to placing the patient in the capsule, the bedside nurse and the transfer nurse must independently check that the patient has 2 ID bands in situ with the 3 approved patient identifiers. Refer to Identification of the Infant.
- Each airline must approve a medical fitness-to-fly prior to the scheduled departure.
- Infants are at risk of hypoxia in flight. This cannot be predicted from the infant's clinical history.
- All infants will be required to travel with oxygen.
- The transport nurse will be required to carry a travel pack approved for use on the plane
- The transport nurse must carry the 'Dangerous Goods Operator Airline Approval Card' at all times during the transfer.
- EBM must be transported in a thermal bag with a freezer ice brick (not ice cubes). The transport nurse must contact the milk room for an approval letter to carry EBM on flight
- For infants born <35 weeks gestation who will be returning to Perth by plane before they are 3 months corrected gestational age, parents must attend in-flight oxygen training prior to scheduling flights. The transport nurse is to reinforce inflight oxygen education during the flight and on arrival at their destination.
- Parents must be ready to depart the nursery at least thirty minutes prior to the taxi's arrival. If parents have a large amount of luggage, they should consider sending some luggage home prior to the transport.
- Parents accompanying the infant on a flight need to be informed that their luggage is restricted to what they can carry themselves; the nurse is unable to assist with carrying luggage.
- The transport nurse must ensure that the following are available (in addition to the standard items for transfer)
  - Photo identification in addition to hospital identification badge.
  - Taxi vouchers.
  - Copy of flight details and hospital transport/taxi arrangements.

  - Phone contact names and numbers for receiving hospital and transport/taxi service.
- Plan to arrive at the airport at least 60 minutes prior to take-off.
- Remove all monitors from the patient whilst going through airport screening.
- Check positioning and taping of nasal cannula and IGT (nurse may carry pre-cut tapes - scissors cannot be carried on board the flight).
- If oxygen saturations fall below 85% for 2 minutes, or less than 75% for any duration, commence oxygen at 200mLs/min and titrate oxygen to keep oxygen saturations over 90%.
- The receiving hospital staff may receive the infant from the transport nurse at the destination airport and escort the infant back to the receiving hospital.

Responding to clinical deterioration during road transport

- If patient shows signs of deterioration such as desaturation, provide chin support to lift the head slightly (position in the capsule may cause the head to fall forward and occlude the airway).
- If there is no improvement, the driver must pull over at the safest opportunity; ensuring hazard lights are turned on.
- Remove baby from the capsule and place on a flat surface.
- Perform systematic assessment as per (Resuscitation: Newborn)
- If the baby improves, they may be returned to the capsule. Continue monitoring for the remainder of the journey to ensure breathing, oxygen saturations and heart rate are maintained.
- **If acute clinical deterioration, the driver must call 000 and request an ambulance for transfer to the closest hospital for stabilisation. NETS retrieval WILL BE DETERMINED BY HOSPITAL.** Nurse to provide information to 000 via speaker phone if able and follow instructions. Nurse to continue basic neonatal life support with Laerdal bag and mask.
- **For advice from NETS regarding non urgent issues call 1300 638 792**

Responding to clinical deterioration during flight

- If oxygen is available, and oxygen saturations fall below 85% for 2 minutes, or less than 75% for any duration, commence oxygen at 125mLs/min and titrate oxygen to keep oxygen saturations over 90%.
- If patient shows signs of deterioration, perform systematic assessment as per (Resuscitation: Newborn)
- If there is no improvement, alert flight staff for assistance and call 000 to request immediate assistance for help to transfer the patient to the closest hospital for stabilisation and NETS retrieval once you have landed. Nurse to provide information to 000 via speaker phone if able and follow instructions.

Nurse to continue providing basic neonatal life support with the use of the Laerdal bag and mask following the newborn resuscitation algorithm.

Escort by the Parent

An infant being transported to another hospital by his/her parents must meet the following criteria:

- The consultant medical officer approves the parents transporting the infant without a nurse.
- Parent/s willing to transport the infant without a transport nurse.
- An approved safety restraint is to be used. Ensure parents have access to resources for support (Kidsafe House offers a car seat fitting service http://www.kidsafewa.com.au/).
- The infant does not require continuous oxygen saturation and/or cardio-respiratory monitoring (unless the infant is being discharged/transferred with a home monitor and parents have been instructed in its use and infant CPR).
- The infant's temperature has been maintained within normal limits in an open cot for > 24 hours.
- Infants should not be transported on a full stomach for risk of aspiration. Feeds should be arranged so that the infant is fed 1-2 hours prior to transport.

Related CAHS internal policies, procedures and guidelines
CAHS | Child and Adolescent Health Service - Newborn Emergency Transport Service
Clinical Handover
Identification of the Infant.
Recognising and Responding to Clinical Deterioration (health.wa.gov.au)
Resuscitation: Newborn

Useful resources
http://www.kidsafewa.com.au/

This document can be made available in alternative formats on request.

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Healthy kids, healthy communities

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

Appendix 1: Staff competency requirements

Type of Transfer	Nursing Competencies
Road Transfer (Capsule)	Completion of Interhospital Transfers – Capsule/Taxi Competency Attendance at NeoResus First Responder Course
CosyPod (flatbed)	Completion of Interhospital Transfers – CosyPod and Flight Transfers Competency Attendance at NeoResus First Responder Course
Air Transfer	Completion of Interhospital Transfers – CosyPod and Flight Transfers Competency Attendance at NeoResus First Responder Course

Appendix 2: Back Transfer Backpack Contents List

BACK TRANSFER BACKPACK CONTENTS LIST		
Rear Pocket	**1** Clipboard • Back Transfer Data Sheet • Neonatal Back Transfer Obs Form (MR400.02/MR821.21) • Transfer and discharge protocol • Dangerous goods operator airline approval card • WA hospital phone number list • Low Flow O_2 conversion table Add Discharge paperwork including Child Health Book	
3rd Pocket	**1** Oxygen cylinder in BOC approved carry bag	
	1x Anequip – one for patient use (0 - 4L)	
	1x Anequip – to bleed cylinder (4 - 25L)	
	1x Portable Rad 5 SPO_2 Monitor	
	1x Disposable BVM & Appropriate Size Cushion mask	
	x1 Mucous Extractor	
	1x Stethoscope	
2nd Pocket	**MONITORING PACK**	**NAPPY PACK**
1x Masimo SpO_2 probe		**2x** Nappies
1x Strappit		**4x** Chux or baby wipes
1x Thermometer		**2x** Pairs disposable gloves – S,M & L
4x AA Batteries		**1x** Small rubbish bag
NASOGASTRIC PACK		**PBF PACK**
1x 6F Gastric tube		**1x**Low flow nasal prongs
1x 20ml enteral syringe		**>2**Pre-cut fixamol
1x10ml enteral syringe		**MISCELLANEOUS ITEMS TO ADD**
2x Adhesive remover wipes		Baby's EBM in esky including a feed ready to give or formula and teat
4x Pre-cut Fixamol		**Front Pocket (Staff use)**
1x pH Test strips		**4x** Face masks
Misc	Discharge medications	**1x** alcohol gel attached to bag, -check date and volume
	1eaBlanket & Cuddly wrap	

Appendix 3: Daily Cosypod Checklist

Power Supply

- □ 2 power cables to both the Cosypod & Mansell power lifter are plugged into 240v mains power.

Power Lifter

- □ Infant Retrieval System Locked green light is lit
- □ 'charged' or 'charging' indicators are lit and then switch the power lifter on and briefly extend and retract both front and back legs
- □ power lifter is switched off when not in use, with the 'charging' or 'charged' indicators lit.

Oxygen Supply – Inhalo cylinders

- □ two Inhalo cylinders are > ¾ full

Cosypod Incubator's

The incubators should contain the following items:

- □ Sheet
- □ Disposable grey restraint straps

ASTOPAD heating unit and mattress

- □ green charging light is lit

Laerdal Suction Unit (LCSU4)

- □ Turn the unit on, checking mains power (green) and charge indicator (orange) are lit
- □ Size 10F suction catheters x 2 and suction tubing
- □ 2 x Neotech little suckers standard (yellow) & blue cover
- □ Second suction canister and suction tubing

Philips X3 Monitor

- □ charging light is lit
- □ Check that the following cables are attached:
  - ECG cable
  - SaO2 cable
  - Skin Temperature probe

2 x Small Blue Bag – near suction unit

- □ Spare Sats probe for Philips X3
- □ Posey wrap (Strappit)

B Braun Perfuser Space infusion pumps

- □ Both mains power and battery levels are indicated on the front panel and power light lit

Please sign and date checklist book located in Perspex holder on the wall

Appendix 4: Back Transfer Data Sheet

BACK TRANSFER DATA SHEET

UMRN: _____

FULL NAME: _____

D.O.B. _____ M / F

Please complete **this** data sheet and the Neonatal Back Transfer Observation Form MR400.02/MR821.21 for all **capsule, flight or Cosypod cot transfers** to metro or rural hospitals.

Co-ordinating Neonatologist Full Name: _____

Full Name of Nurse: _____ **CN NNT RN EN**

Full Name of Training Nurse: _____ **CN NNT RN EN**

Discharged from: PCH 3B / KEMH (nursery) _____

Discharged to (Hospital): _____

Date & Time of departure from PCH/KEMH: _____

Date & Time returning to PCH/KEMH: _____

Mode of transport: (please circle) 1. Cosypod Cot 2. Capsule

a) SCN Driver name: _____ Transfer Van or SCN Car (Kia)

b) Taxi Driver name: _____ Cab charge voucher no: _____Cost: _____

c) Ambulance Crew No: _____ NETS Van No:_____SJA Van No:_____

Commercial flight Oxygen required during flight: No / Yes @ [ ] mls/min

Please note any complications with the transfer (i.e. equipment, delays) **OR** ☐ **NIL ISSUES**

_____

_____

***Please photocopy Obs Sheet* and leave original copy with ward clerk to be filed in patient's file.**

'ace completed data sheet and photocopy of Obs form:

For all PCH discharges in paperwork folder in NETS office

For all KEMH discharges in folder in cupboard near SCN 3 printer for Database Nurse