

Transfer of Care Reporting System

Quick Facts

What is the Transfer of Care Reporting System?

It's a centralised, web based application that allows you to view your hospital's Ambulance 'Transfer of Care' time any time of the day or night. It is the first system in NSW Health that allows for matching of Ambulance and ED data. This system has enormous potential for future research, especially in trauma.

'Transfer of Care' – a new measure

'Transfer of Care' time is a new measure that is replacing 'off stretcher' time. It is captured using:

- ASNSW Ambulance arrival time as the start time and
- To facilitate Transfer of Care, a clinical handover using a structured approach such as 'IMIST AMBO' must occur between the treating Paramedic and accepting ED clinician.
- Transfer of Care is deemed complete when clinical handover has occurred and the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

Logging on to the Transfer of Care Reporting System

There should be a direct link to the login page on your intranet page, if not the URL to log in is: -

<http://tcrs.doh.health.nsw.gov.au/Transferofcare>

Accessing your login details

Every hospital & every Local Health District have their own generic login details. If you forget your login details & password. Click on the 'Forgot Password' icon and it will be emailed to you

How the Transfer of Care Reporting System works

The system uses the Ambulance Incident Number (handwritten sheet)

or Case # (on the EMR print out) and date to match patients from the ambulance service with patients in the ED.

What do Emergency Department staff need to do?

1. Entry of Ambulance Incident Number (handwritten sheet) or Case # (on the EMR print out), into your ED system (full patient registration screen).
2. Correction of 'unmatched patients' & checking of the 'error report'. Each hospital will decide who will be responsible for this. It is recommended that this is done on a daily basis

What do Ambulance paramedics need to do?

1. Paramedics are required to legibly write 'incident number' on handwritten case sheets & communicate "incident number" (or Case #) at all communication points within EDs i.e. Triage, ED Clerk, patient handover, etc.
2. Paramedics are still required to press the Off Stretcher Button on the Ambulance mobile data terminal.

Incident number location

The Ambulance 'Incident Number' is the 5-digit, handwritten number located on the top of the Ambulance Case Sheet or the Case # on the EMR print out. It also appears on the Ambulance Status Board in your ED.

Why are Ambulance Incident numbers used?

At the present point in time, date in combination with Ambulance Incident Number/Case # is the only unique identifier of patients across both system.

Using the Transfer of Care Reporting System

There are 3 links for you to access 'Home', 'Reports' & 'Help Desk'. Each link has a brief explanation of what its for and what it will produce

Changing information in the Transfer of Care Reporting System

The Transfer of Care Reporting System only allows you to view information. Information you are viewing can only be changed at its original source. This means that if an incident number/case # is incorrect you will need to correct it within the ED System. Ambulance electronically generates true & accurate incident numbers.

Timeliness of Information in the Transfer of Care Reporting System

This system allows you to view yesterdays data. This is because it operates via daily batched data extraction. Which means that daily data is taken from both the ambulance & ED systems & matched within the Transfer of Care Reporting System once a day (approx. 5am for the previous day's data).



Transfer of Care KPI means that **90% patients will have their care transferred from an Ambulance Paramedic to an ED clinician within 30min**

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Most Frequently used reports

The KPI report

- Total ambulance arrivals
- % patients with care transferred from paramedic to an ED clinician within 30min (ToC KPI) , 1hr, 2hrs, 3hrs & >3hrs

Summary report

- Summarises your information by triage category
- i.e. Ambulance arrivals, ToC KPI, unmatched patients

Daily validation of information is recommended

- The **'Unmatched Patient Report'** alerts you to patients from both Ambulance & ED that are not able to be matched. Most of the time this is due to incorrect entry of incident number/case # into your ED system. It is recommended to use this report daily to locate the right incident number/case # & enter it into your ED system.
- The **'Error Report'** alerts you to when something unusual has occurred with matched patients e.g. ambulance arrival time is after ED registration time , ambulance left before transfer of care time, etc.

NOTE: We also recommend to keep an electronic copy of these reports for future reference.

How does Incident Number/Case # get entered into our ED System?

The Incident Number/Case # is set up to be entered in the full ED patient registration screen, after ambulance arrival mode has been selected. At most hospitals it is generally the ED clerical staff who will do this.

NOTE: Patient care is the priority of the Triage nurse & ED Clinicians.

What happens if an Incident Number is entered incorrectly?

If this occurs patients are not able to be matched & 'Transfer of Care' time will automatically **default to the ambulance 'Off Stretcher time'**. Once the incident number is entered correctly (in the ED system) it will appear as matched the following day.

What happens when 2 patients arrive in the 1 Ambulance?

This scenario occurs extremely infrequently. Two patients in one Ambulance will only produce a single incident number. The data from the first patient will be linked in the system to produce Transfer of Care Time. Because the Transfer of Care Reporting System is a statistical recording system of *'% patients transferred from an ambulance paramedic to an ED clinician within 30min'*, it has been shown not to be significantly impacted by these events.

Alerts that appear in the 'Error Report'

- Patient Registration is before Ambulance arrival time
 - Ambulance leaving time prior to Transfer of Care
 - The Ambulance Facility Code differs from the ED Facility Code
 - Missing Time of Ambulance Delayed Available (i.e. end point of ambulance OST)
 - Patient registered more than 2Hrs after Ambulance Arrival
 - Missing Time Leaving Ambulance Location (i.e. End point of Transfer of Care time)
- NOTE:** Patients appearing in the error report may still have all information as correct, this could be due to something highly unusual may have occurred during their stay.

Further Information

The TCRS User Guide is available on the **Home Page** of the Transfer of Care Reporting System: -



User Guide



Ambulance arrives at hospital



Patient transferred into hospital



Patient is Triage



Sharing of Care between Paramedics & Clinicians



Transfer of Care



Paramedics return to Ambulance

30 min