TRANSFERS TO ACCESS URGENT CLINICAL CARE

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THE GOOD NEWS

- 23% reduction in total over 4 hours LOS in NSW EDs between 2012 and 2013/2014 (all patients, all hours of stay)

Inter-facility Transfer Process for Adult Patients Requiring Specialist Care

NSW GOVERNMENT Health

PROCEDURES

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NSW GOVERNMENT Health

POLICY STATEMENT

INTER-FACILITY TRANSFER PROCESS FOR ADULT PATIENTS REQUIRING SPECIALIST CARE

PURPOSE

The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report.

2 KEY PRINCIPLES

Each LHD must have a clear and readily available policy incorporating the following principles:

- **Good Communication and clinical handover**– between referring and receiving Senior Clinicians that involves the Patient Flow Units, resulting in the coordination of timely and safe patient transfer for ongoing care within medically agreed timeframes.
- **Patient Flow Responsibility** -all facilities have personnel tasked with coordinating patient flow, available 24/7 at all sites (e.g. Patient Flow Manager, After Hours Nurse Manager, Bed Manager).
- **Inter LHD Transfers** – where clinically appropriate patient transfers to occur within the LHD.
- **Existing Clinical Referral Networks**- where existing historical clinical referral networks are working well, these should be continued to facilitate timely access to specialist care. As part of the development of the new LHD Health Care Plans, formalised clinical networks will be determined.
- **Nominated Referral Centres** – accessing the nominated tertiary referral centre where existing clinical referral networks don't exist or where time is delaying the patient's access to ongoing specialist care as per Appendix 2.
- **Direct to inpatient bed** – the patient should be admitted directly to an inpatient bed and avoid the Emergency Department (ED) where possible unless deterioration in the patient's condition requires assessment in the ED.
- **Return Transfers-** on completion of specialist care patients are returned to the originating or other clinically appropriate facility within 24hrs or one working day.
- **Timely Escalation** – immediate escalation is to occur with the appropriate service managers for decision making, when an issue regarding patient transfer arises which will impact on the patient accessing safe and timely care within the medically agreed timeframe.

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URGENT TRANSFERS SCOPE: SYSTEM WIDE

2013/2014

- 53,949 patient transfers out of an ED to other hospitals (28% increase since 2012 (42,203))
- aggregate Over NEAT LOS for transfers was 6,641 days at the 1st facility = 19 beds for a year
- More time wasted at the destination ED = substantial beds
- Transfers account for at least **5.5%** of total greater than 4 hours LOS ("Over NEAT" LOS) for all ED visits and **1.9%** of patients presenting an to ED were transferred (in 2012)

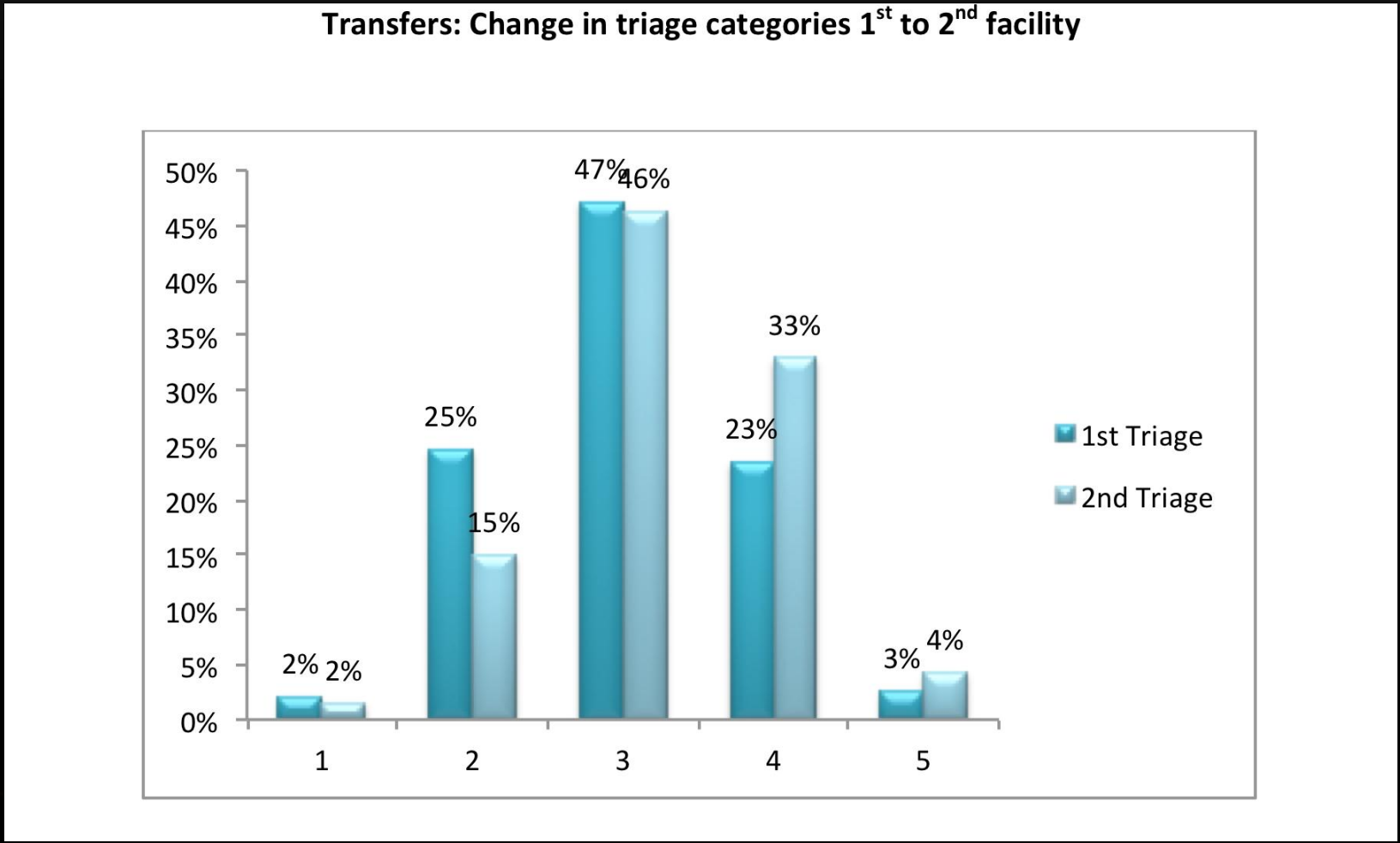
- This EXCLUDES inappropriate use of EDSSU for transfers in and out

SCOPE : THE TRANSFERRED PATIENT

In 2012

- Patients admitted and transferred (AT) spent twice as long in ED as those departed and transferred.
  - ALOS for AT patients 8.6 hours, range 2.3 hours (very small ED) to 16.3 hours (very busy ED) for individual sites.
  - 71% over 4hrs in ED before transfer.
  - At destination, 53% wait in ED again, where the average length of stay is an additional 6.9 hours.
  - Only 6% are not admitted at the subsequent facility.
- For patients departed and transferred (DT), all (99%) receive treatment at subsequent ED; and only 31% of patients are not admitted.

ARE THEY TOO SICK TO GO TO THE INPATIENT BED?



WHAT TYPES OF MEDICAL CONDITIONS?

Transfers: ICD patient description and Over NEAT LOS

ICD codes	Over NEAT LOS days	No transfers
Mental disorder, not otherwise specified	41	802
Chest pain, unspecified	37	508
Other and unspecified abdominal pain	35	398
Unspecified renal colic	20	83
Sepsis, unspecified	19	224
Pneumonia, unspecified	17	97
Suicidal ideation	14	304
Unspecified fall	14	132
Low back pain	13	69
Fever, unspecified	12	127

Transfers: SNOMED patient description and Over NEAT LOS

ICD codes	Over NEAT LOS days	No transfers
Chest pain (finding)	205	788
Abdominal pain (finding)	178	1,395
Chronic obstructive lung disease (disorder)	118	297
Systemic infection (disorder)	85	519
Psychotic disorder (disorder)	74	361
Fracture of neck of femur (disorder)	73	303
Urinary tract infectious disease (disorder)	71	273
Depressive disorder (disorder)	67	287
Renal colic (finding)	63	266
Mental disorder (disorder)	58	262

TRANSFER DELAYS CONTRIBUTE TO ED LOS EXCEEDING NEAT 2013/2014

Table 1: Transfers: EDs with the highest total Over NEAT LOS

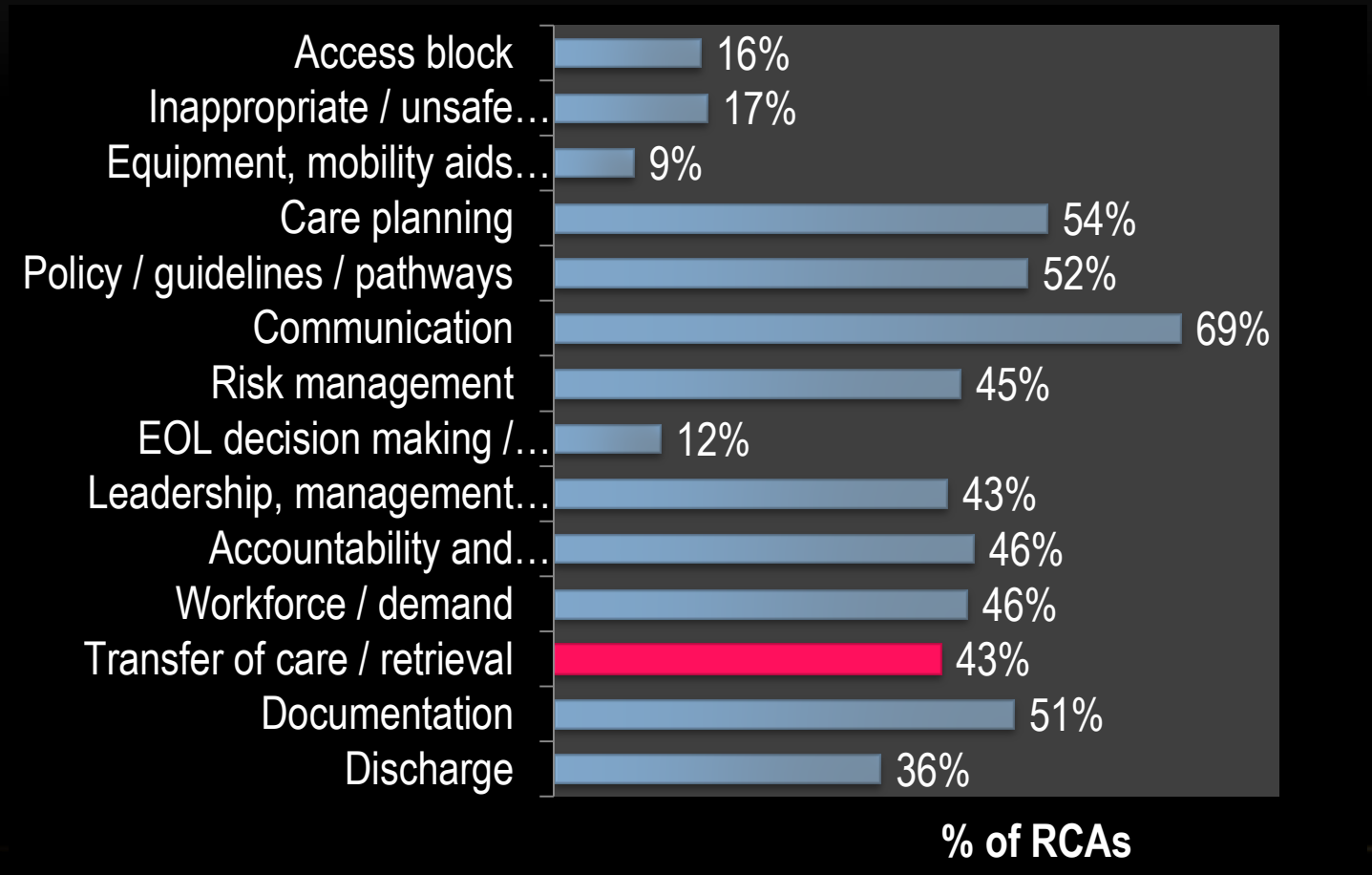
ED	Over NEAT LOS days	No Transfers
Mount Druitt Hospital	1,438	4,183
Shellharbour Hospital	505	2,088
Wyong Hospital	407	2,725
Shoalhaven and District Memorial Hospital	296	1,254
Maitland Hospital	261	1,118
Blacktown Hospital	232	941
Campbelltown Hospital	193	841
Wagga Wagga Base Hospital	181	639
Dubbo Base Hospital	165	663

DAYS IN ED AT SECOND FACILITY 2013/2014

1st facility	LOS at 2nd Facility Days
Mount Druitt Hospital	811
Shellharbour Hospital	412
Shoalhaven and District Memorial Hospital	406
Blacktown Hospital	228
Wyong Hospital	195
Campbelltown Hospital	166
Royal Prince Alfred Hospital	162
Wollongong Hospital	136
Ballina District Hospital	134
Westmead Hospital	125

IS THIS A PROBLEM?

CONTRIBUTORY FACTORS: RCAS RELATED TO ED NOV 2012- DEC 2013



REAL PATIENT STORIES:

Case 1

Diagnosed acute leukaemia in small rural ED early hours Sunday morning, “accepted” for admission at network tertiary hospital later that morning.

Next 7 days, told “no bed available”, subsequent days facility tried to access appropriate specialist care

Subsequent septic shock MSOF and died without accessing higher care

Case 2

Patient on warfarin, sustained fall. Found to have # ribs, haemothorax, uncontrolled bleeding. Referral facility contacted: no beds, refused to take patient. Subsequent transfer 20 hours later: needed ICU admission

Case 3

19 year old male, motorbike accident, thoracic spine # x 2, vomitting +++ no bed available at tertiary facility. CT showed unstable #, no spinal injury evident but unable to TF to tertiary site for 48 hours.

4 ACCESSING THE LEVEL OF CARE REQUIRED

LHDs are required to establish a single telephone contact number within 6 months of implementation. The purpose of this contact number is to provide all clinicians with clinical support and advice on clinical care and access to appropriate care and clinical referral pathways.

Patients who require transfer for specialist treatment fall broadly into two categories:

1. Those who require urgent specialist care (<24hrs) not available at the originating site

2. Those who require inpatient specialist care (24-72 hrs) not available at the originating site

The decision to transfer and determination of the urgency of transfer (medically agreed timeframe) must be made through discussion between the senior clinician at the referring site and a senior clinician from the specialist service at the receiving facility.

Next steps