**Cheshire and Mersey Adult Critical Care Network**

**Guideline for stepdown interhospital transfers of patients from Critical Care Units**

Background

Although there is no specific guidance against transferring a patient from a critical care unit in one hospital directly to a ward in another hospital (for example when repatriating a patient who is ready for ward step-down) usual clinical practice is to undertake a critical care to critical care transfer then assess the patient at the receiving critical care unit for ward step down. The reason for this practice is because of concerns about the potential for deterioration of the patient during transfer that might require critical care support on arrival at the receiving hospital. An alternative approach is to step the patient down to ward level prior to transfer and undertake a ward-to-ward transfer.

Certain situations may warrant transferring a patient from a critical care unit in one hospital to a non-critical care ward in another, such as:

- Delayed repatriation where there is no critical care capacity available at the receiving hospital and the patient has been deemed ward ready and stable for a number of days.
- Transfer for specialist care for example cardiac that is provided in a ward level setting, for a patient that does not have ongoing general critical care requirements

Clinical Guidance

Relevant general principles from national critical care guidelines (ICS and FICM 2021 currently being updated)

- In line with national guidance, transfer to a specialist facility for immediately life-saving intervention should not be delayed due to lack of critical care or ward capacity at the receiving hospital. The patient should be transferred for appropriate immediate treatment while arrangements are made for ongoing care post lifesaving intervention.
- Repatriation of patients from specialist centres back to their referring centres once they no longer require specialist care is entirely appropriate and should normally occur within 48 hours of the patient being identified as suitable for repatriation.
- Once a patient has been accepted by a receiving unit, the bed must be kept available to receive the patient until the patient arrives or until the transfer is stood down. This is particularly true of repatriations

This specific guidance applies to patients who have either have no critical care organ support requirements or have single organ support requirements that can be provided in specialist ward environments (e.g. renal replacement therapy or long-term ventilation).

Organisational factors, such as capacity and demand may influence consideration of undertaking critical care unit to ward level interhospital transfers, particularly in the context of repatriations where the receiving hospital does not have available critical care capacity and the patient is suitable for ward level step down.

When considering a critical care to ward inter-hospital transfer, a risk assessment should be undertaken to assess the level of risk of the transfer for the patient. This should be discussed and

agreed between referring and receiving sites, documented in the patient record prior to transfer and included in transfer communication. Where stepdown transfer is being considered, it must be explicitly discussed and agreed between the referring critical care team and the receiving ward team.

The risk assessment should include the following considerations:

- Clinical needs of the patient, including any organ support requirements and nursing care requirements. The patient must be stable for transfer and the referring critical care team must be confident, based on the patient's clinical course and condition, that deterioration is unlikely
- Presence of any agitation or delirium which requires enhanced nursing ratios or 1 to 1 care
- How long the patient has been suitable for ward level step down and stability during that time. Stepdown transfer to ward level care in another hospital should only be undertaken when the patient has demonstrated clinical stability for ward level step down over a period of time (e.g. at least 48-72 hours)
- Risk of deterioration during transfer and ability of receiving unit to manage the patient in event of deterioration
- Timing of the transfer – i.e. daytime vs out of hours. Transfers out of hours should be avoided unless there is an urgent clinical requirement for transfer

Transfer and handover documentation should include the patients current risk factors, including delirium/cognitive status and details all medications administered within the prior 24-hour period.

Reference

Intensive Care Society and Faculty of Intensive Care Medicine(2021) *Transfer of the Critically Ill Adult guidance.* Guidance currently being reviewed and updated.