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

Contents

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

- All patients who require transportation between sites or hospitals must be escorted by a nurse.
- 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.
- 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 infrequent 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
- Oxygen will be taken (via cylinder) on all transports.
- Patients that require respiratory support 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)

Capsule transfer by road

- 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).
- Parent-only escort must have consultant medical officer written approval.
- 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.

Transfer Planning and Process

Planning Steps

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. Liaise with peripheral hospital for bed availability.
    c. Discuss transfer with parents.
    d. Inform Neobase and Milk room staff of potential transfers each day.
    e. Liaise with area manager and driver for availability of staff and transfer times.
2. Bed side nurse to complete MR440 (Inter-hospital transfer form).
3. Bedside nurse to photocopy Flow and weight chart along with MR440.
4. Medical staff to complete the discharge check and NACS, and handover to the accepting paediatrician.
5. Discharge Coordinator / Shift Coordinator to give a verbal and email handover to Nurse Manager/Coordinator of accepting hospital.
6. Transfer Nurse to check backpack ensuring all contents are present (using Appendix 2: Backpack Contents List).
7. For patients requiring oxygen to travel, prepare and take size B or C cylinder in oxypack carrier.

Additional Planning Steps – Cosypod and Air Transfers

Cosypod:

- 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.

Air Transfer:

- 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

Transfer Steps – By Road

1. Transfer nurse to ensure patient is dressed appropriately and placed correctly into the capsule.
2. 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.
3. Attach monitoring (oxygen saturation monitoring is a minimum).
4. Transfer nurse to do a baseline set of observations on MR400.02 before leaving and then every 15 minutes during the transfer.
5. Complete final observations on arrival at destination before handover and document on MR400.02.
6. Complete ISOBAR handover to receiving team.
7. Transfer nurse to complete 'Back transfer data sheet' (Appendix 4).
8. 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
9. Transfer nurse to re-stock backpack and return to storage location.
10. If transferring by taxi, ensure cab charge stub and receipt is returned to Discharge Coordinator (KEMH) or NETS WA CNC (3B).
11. Report any adverse incidents to Clinical Nurse Consultant/Discharge Coordinator. Adverse events to be reported on eCIMS (patient event) or OSH Hazard/Incident Form (staff event).

Additional Transfer Steps – Cosypod or Air Transfer

Cosypod:

- Transport nurse will ensure Cosypod is cleaned and restocked after each transfer (Appendix 3: CosyPod Checklist).

Air Transfer:

- For infants <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.
- 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 125mLs/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.
- For infants <35 weeks gestation who will be returning to Perth by plane before they are 3 months corrected gestational age, the transport nurse is to reinforce inflight oxygen education during the flight and on arrival at their destination.

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 immediate assistance for help to transfer to the closest hospital for stabilisation and NETS retrieval as required.** 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.
- **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 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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Appendix 1: Staff competency requirements

All staff should have at least 1 supernumerary transfer with each transfer type prior to first solo transfer.

Type of Transfer	Nursing Competencies
Road Transfer (Capsule)	≥3 months in unit Completed and up to date Neonatal Hospital Life Support (practical and theory) Achieved competency at recognising and responding to acute deterioration.
Cosypod (flatbed)	Road transfer competent Achieved competency at recognising and responding to acute deterioration. Completed and up to date Neonatal Hospital Life Support (practical and theory) ≥6 months in unit (orientation complete) Orientated to use of Cosypod and lifter
Air Transfer	Road transfer competent Completed and up to date Neonatal Hospital Life Support (practical and theory) Achieved competency at recognising and responding to acute deterioration. ≥6 months in unit (orientation complete)

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
1	Anequip – one for patient use (0 - 4L)
1	Anequip – to bleed cylinder (4 - 25L)
1	Portable Rad 5 SPO_2 Monitor
1	Disposable BVM & Appropriate Size Cushion mask
1	Mucous Extractor
1	Stethoscope
2nd Pocket	
MONITORING PACK	
1	Masimo SpO_2 probe
1	Strappit
1	Thermometer
4	AA Batteries
PBF PACK	
1	Low flow nasal prongs
>2	Pre-cut fixamol
NASOGASTRIC PACK	
1	6F Gastric tube
1	20ml enteral syringe
1	10ml enteral syringe
2	Adhesive remover wipes

4	Pre-cut Fixamol
1	pH Test strips
NAPPY PACK	
2	Nappies
4	Chux or baby wipes
2	Pairs disposable gloves – S,M & L
1	Small rubbish bag
MISCELLANEOUS ITEMS TO ADD	
1ea	Blanket & Cuddly wrap
	Discharge medications
	Baby's EBM in esky including a feed ready to give or formula and teat
Front Pocket	
1	For staff use
4	Face masks
1	Alcohol Gel attached to bag – check date and volume

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