

Enhancing Safety in Intrahospital Transport of Critically ill Patients: Developing an Intrahospital Transport Tool

S. Lal, C. Lock, S.H. Danial, G. Curley

Department of Anaesthesia and Critical Care Medicine at Beaumont Hospital, Dublin 9, Ireland.

Dear Sir,

The transport of critically ill patients is a high-risk procedure. The overall incidence of adverse events (AEs) during the intra-hospital transfer (IHT) of critically ill patients reportedly ranges from 1.7 % to 75.7 %.¹⁻² It is crucial to record the physiological parameters, ventilatory requirements and hemodynamic support of all critically ill patients undergoing transfer. NICE guidelines recommend using standardized care systems (e.g., checklists, staffing and equipment) when transferring critically ill patients within or between hospitals.³ However, we found a lack of practical and clinically acceptable evidence-based tools that could be used to document the intra-hospital transfer of critically ill patients in our hospital.

We audited the intra-hospital transfer documentation of 100 critically ill patients admitted to our intensive care unit. Data were collected retrospectively from the electronic charts. We reviewed the patients' ventilation mode in addition to inotropic support and sedative requirements for transfer. We also recorded the time elapsed during each transfer (e.g., the amount of time each patient was off the intensive care unit). Of the 100 charts reviewed, all patients were mechanically ventilated during transfer, and more than 30% required inotropic and significant ventilatory and oxygen support.

We reviewed the current local policies and guidelines regarding transfer documentation. Based on our findings, developing an intra-hospital transfer documentation tool was of great need. We followed the national guidelines, particularly addressing pre-transport preparation, ongoing monitoring, and management specific to patient co-morbidities and events leading to the intensive care unit admission. After several meetings, a simple, clinically acceptable electronic tool was developed to ensure documentation of the intra-hospital transfer to enhance patient safety and continuity of care.

The agreed electronic intra-hospital transfer note was divided into two sections: Pre-transfer documentation and post-transfer documentation. The pre-transfer documentation includes the patient's airway, ventilatory requirements, inotropic support, sedation, medical equipment, and monitors. The post-transfer documentation records the total time elapsed off the intensive care unit, details about any equipment and clinical issues, and the names/roles of the escorting personnel. We ensured that this new electronic intra-hospital transfer documentation tool was accessible to both doctors and nurses, as patients not requiring mechanical ventilation and inotropic support are routinely transferred by nurses in our clinical setting.

This tool was found to be crucial and clinically easy to use. Since its development, it has ensured adequate documentation of the intrahospital transfer of critically ill ventilated patients, which has enhanced patient safety during the transfer process.

Corresponding Author:

Dr. Shankar Lal,

Fellow Neuroanaesthesia and Neurocritical Care Medicine.

E-Mail: shankar.anaesthesia1@gmail.com

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