INTER-FACILITY TRANSPORT

GENERAL PRINCIPLES

In general, health care facilities, other than hospitals, should access 911 to ensure the most immediate EMS response. A more sophisticated medical facility that maintains a staff fully trained and equipped to provide ACLS may elect to contact an ambulance transport provider directly, if the patient is currently stable and any potentially unstable events are fully treatable by the services provided at their facility. An arrangement such as this requires that there be a letter of agreement between the jurisdictional fire agency and the facility which acknowledges this arrangement.

Interfacility transport will occur at BLS, ILS, ALS, and Critical Care levels within the following special categories:

- ✓ Transfer between facilities for admission for services not available at initial facility.
- ✓ Transfer and return of patient to facility for diagnostic evaluations at second facility.
- ✓ Transfer from hospital to extended care facility.
- ✓ Transfer of patient between facilities at patient and/or physician request.
- ✓ Transfer of a psychiatric patient to a psychiatric facility.

As a general rule, it is the responsibility of the transferring facility to ensure that the medical necessities for safe patient transfer are met. Medical instructions of the attending physician and registered nurses will be followed unless specifically contrary to EMS protocols. If treatment is recommended that is contrary to protocol or beyond the scope of training of the EMS personnel, medical control at the receiving facility should be contacted for advice. The physician, if attending the patient during transfer, will direct all care regardless of standing orders. A registered nurse, if attending the patient, will direct the care of the patient from the standing orders given by the physician at transfer or by contact with the receiving hospital physician. The registered nurse may choose to defer emergency care in some situations to

the EMT or paramedic as long as it's within the EMS provider's scope of practice.

The responsibility for transfer to another facility resides with the transferring facility. Patients will not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to ensure that transfer of a patient will not, within reasonable medical probability, result in the following: material deterioration of the condition, loss and/or serious impairment of bodily functions, parts, organs, or death. Furthermore, the benefits of transfer to the next facility outweigh the risks of transfer to that facility. Evaluation and treatment of patients prior to transfer are to include the following:

- ✓ Establish and ensure adequate airway and ventilation.
- ✓ Cardiac monitoring and emergency defibrillation, when indicated.
- ✓ Establish control of hemorrhage.
- ✓ Stabilize and splint the spine or fractures, when indicated.
- ✓ Establish and maintain adequate access routes for fluid administration.
- ✓ Administer adequate fluid and/or blood replacement.
- ✓ Determine that the patient's vital signs (blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. Initiate important therapeutic regiments that can be started in a timely fashion and safely continued during transport.

For requests for transports not meeting the above criteria, the following may apply:

- ✓ The transporting personnel may request compliance with the above criteria.
- ✓ If the transporting personnel do not think the plan for transfer can be safely accomplished, contact the receiving physician for concurrence or consultation.

It is also the transferring facility's responsibility to establish the need for BLS, ILS, ALS, or Critical Care transport. If a BLS/ILS transport is requested and it is the judgment of the BLS/ILS crew that the patient needs to be transported by an ALS or Critical Care team, it is mandated that dispatch be contacted and an ALS or Critical Care crew be dispatched.

Similarly, if an ALS transport is requested and it is the judgment of the ALS crew that the patient needs to be transported by a Critical Care team, it is mandated that dispatch be contacted and a Critical Care team dispatched. Under no circumstances should an EMS crew transport a patient if, in their judgment, the patient requires a higher level of care than that crew can provide (Mass-casualty incidents are an exception).

Specific conditions requiring the presence of a critical care RN, during transport, provided the RN is available within an acceptable time interval:

- ✓ Cardiogenic shock
- ✓ Post cardiac arrest (acute)
- ✓ Unstable arrhythmias
- ✓ Complicated IV infusions (more than 2 pumps or 3 IV lines)
- ✓ Severe or worsening ischemic chest pain
- ✓ Complicated patients who have a fibrinolytic infusion may require a critical care RN according to physician's discretion
- ✓ Unsuccessful fibrinolytic infusion

A Paramedic level ALS crew may transfer stable patients on IV infusions and/or drugs not typically used for prehospital care, provided the following conditions are met:

- ✓ That the drugs being used do not have direct hemodynamic effects
- ✓ That the rate of administration is controlled by a mechanical pump and was established prior to transfer
- ✓ That the Paramedic in charge during the transfer has had specific MPD approved training relevant to the effects and potential side effects of the IV infusions and/or drugs involved

If during a patient transport, an emergency condition develops that was not anticipated prior to transport, prehospital patient care procedures and protocols will immediately apply. Medical Control should be contacted for concurrence of any orders as appropriate. The receiving facility should be contacted ASAP to inform them of changes in the patient's condition.

INTERFACILITY TRANSFER OF HOSPICE PATIENTS

Patients discussed in this policy: Patients (either themselves or via their surrogates) who have requested hospice care and are being transferred to one of the hospice houses.

Issue: Medical care in transit as well as questions of change of destination based on clinical appearance.

Background:

- ✓ Patients who have accepted hospice care at the hospice houses have undergone extensive counseling and informed consent discussion regarding their medical care and disposition.
- ✓ These patients have chosen DNR status as the hospice houses do not offer resuscitation services.
- ✓ These patients have chosen a palliative approach to their end of life care and wish to receive this care in one of the hospice houses.

Since these patients have undergone a significant informed consent process that reflects the above, it is **contraindicated** to divert the patient back to an acute care hospital if their medical status deteriorates in route.

Resources for Hospice of Spokane:

Director of Hospice House care and admissions:	Alicia Reid RN	509-994-6224
Medical Director	Robert Bray MD	509-413-3707
Hospice of Spokane	Administrator on call	509-456-0438