Guideline

Single Clinician Neonatal Transfers

1 Scope

For use within the Paediatric and Neonatal Decision Support and Retrieval Service (PaNDR) for the East of England. This document relates only to the neonatal arm of the service.

2 Purpose

To ensure that single clinician transfers are appropriate and safe according to the clinical needs of the infant. Single clinician transfers are predominately nurse led but doctors who have completed single clinician competencies can also complete these transfers when appropriate.

3 Definitions and abbreviations

PaNDR	Paediatric and Neonatal Decision Support and Retrieval Service
CPAP	continuous positive airways pressure
GI	gastrointestinal
PN	parenteral nutrition
ROP	retinopathy of prematurity
EBS	emergency bed service
ETA	estimated time of arrival
FiO2	fraction of inspired oxygen
PVL	peripheral venous cannula
EPIC	electric health record used by PaNDR
NCO_2	nasal cannula oxygen
HHF	humidified high flow
LMA	laryngeal mask airway

PaNDR clinician – PaNDR nurse / ANNP / middle grade doctor / Consultant

4 Criteria for single clinician transfers

Occasionally it may be appropriate to deviate from these criteria on a case-by-case basis after discussion with the PaNDR consultant. The transport team should mutually agree on team configuration prior to departure.

- Infants being transferred to a hospital < 3 hours away
- Infants >28 weeks corrected gestation.

- Infants >1kg in weight at the time of transfer. Infants who are just under this weight (>800g) may be considered for single clinician transfer if their other clinical needs (requirements for respiratory support and PN) are low.

- FiO_2 requirement consistently < 0.3 (higher at nurse' discretion and team agreement)

- Infants on nasal CPAP of ≤6cmH_20 or high flow nasal cannula ≤6L/min who have been stable for 48 hours with no increasing oxygen requirement and no apnoea, bradycardia or desaturation requiring intervention.

- Infants with neurological disorders who are self-ventilating or receiving respiratory support fulfilling the criteria above, who do not require treatment to maintain stability.

- Infants needing transfer post elective surgery (including ROP treatment) should be stable and requiring a similar level of support as required pre-operatively for at least 24 hours prior to transfer. This support should not exceed the parameters described above.

- Infants symptomatic of GI obstruction who otherwise qualify for single clinician transfer may be suitable; requires careful discussion with the team and PaNDR consultant.

- Infants going for planned surgery who are otherwise well (such as ROP, hernia repair, reversal of stoma).

- If there are concerns about the clinical status, a conference call can be set up between the referring unit, PaNDR team and the PaNDR consultant to clarify concerns about the clinical status, formulate an agreed contingency plan and consultant to document decision in the electronic record.

5 Method

- Initial referral is made to the emergency bed service who complete the relevant documentation.

- If demographic details fulfil a single clinician transfer, a member of the clinical PaNDR team telephones the referring unit for clinical details. The referral should then be discussed with the on call consultant to confirm the category of the job and team composition.

- The clinical PaNDR team telephones the referring unit again, accepts/ refuses the referral dependent on team availability or the clinical condition of the infant and advises regarding a potential time and date for transfer.

- On the day of transfer, a member of the clinical team confirms that the infant's clinical status remains stable.
- EBS confirms cot availability at receiving unit.
- On arrival at the referring unit if there are clinical concerns about the suitability of the infant for a single clinician transfer, discuss with the on call PaNDR consultant.
- Inform receiving unit on departure from referring unit.

6 Observations during transfer

- HDU and special care transfers – vitals on arrival to cot side; every 30 minutes whilst in unit; on transfer to transport incubator; every 15 minutes on transfer; on arrival at receiving unit and once transferred to local cot
- If infant on respiratory support, a blood gas is to be done within the 12 hours pre-departure.
- If there is pre departure instability, respiratory support setting changes or increase in FiO_2 requirement – consider a pre-departure blood gas and discussed with PaNDR consultant prior to departure.
- If at referral, the infant is not on monitoring, place on SpO2 monitor prior to transfer to assess for level of stability prior to transfer.

7 IV access and IV fluids

- If the infant is on continuous or bolus 1 hourly feeds request 1 working PVL and fluids for transfer (consider 2nd PVL if transfer ≥ 2 hours)
- If the infant is on bolus 2 hourly feeds, consider requesting one working PVL and fluids depending on length of transfer and condition of infant.
- If the infant is on 3 – 4 hourly bolus feeds, consider length of transfer and agree plan with PaNDR consultant.

8 Communication

- Any changes to clinical management should be clearly documented in EPIC
- Call to EBS to inform of transition from one clinical area to another (referring unit to ambulance etc.)

- On departure from referring unit, inform EBS who will transfer call to receiving unit for a clinical update and ETA.

- If changes are anticipated during transfer (adjustments in flow/pressure) these should be where possible agreed and documented prior to transfer.

9 In an emergency

- If there is a clinical deterioration, contact the on call PaNDR consultant.

- If respiratory deterioration, consider escalating respiratory support as planned – NC O2 or HFNC if not already receiving.

- In the event of respiratory arrest follow NLS guidelines for airway management (consider airway adjunct or LMA to assist stabilisation) and if necessary, divert to nearest emergency department.

- Update PaNDR consultant ASAP and request EBS update receiving unit.

- Update parents.

Monitoring compliance with and the effectiveness of this document

The transport team will periodically audit adherence to the guideline and the results will be presented to the senior team at a governance meeting.

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

Document management

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