Quality and Safety Programme
Inter-hospital transfers - paediatrics

London quality standards

October 2014
**Introduction**

A lack of robust inter-hospital transfer and acceptance standards is a current issue for some cohorts of patients in London with delays experienced in initial transfers and repatriation. The need for transfers between hospitals is likely to increase as a result of service changes underway in London and it is therefore essential to ensure that the quality of care and experience received by patients is improved and that transfer protocols are consistent across London’s hospital sites. The standards have been developed by the clinical expert and patient panels of the quality and safety programme and the London Ambulance Service.

- The standards apply to the transfer of children and neonates (under 18 years), unless paediatric transfer is covered by CATs (Children’s Acute Transfer Service), STRs (South Thames Retrieval Service) or NTS (Neonatal Transfer Service).
- The standards do not override any existing agreed formal network arrangements. Any future network arrangements should consider the standards.
- The standards do not override the minimum expectations defined by London Ambulance Service.
- The standards override locally agreed transfer protocols and Trust/Hospital transfer policies.
- The standards cover transfers between acute hospitals sites, and between acute Trusts.
- The standards apply to all transfers regardless of day or time.
- The standards apply to all categories of patients unless specified otherwise.
- The standards apply to transfers from midwifery led units to obstetric units when not covered by NTS.
- The standards apply to transfers from hospitals to hospices.
- The standards apply to initial patient transfers and the repatriation of patients, unless stated otherwise.

All acute hospitals are to form networks where an acute service is provided on some but not all hospital sites. All transfers will be the responsibility of the defined network, including the clinical governance arrangements.
The standards apply to the following types of transfers:

<table>
<thead>
<tr>
<th>Types of Transfer</th>
<th>Provider</th>
<th>Definition*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical transfers</strong></td>
<td>London Ambulance Service (LAS)</td>
<td>Critical transfers are undertaken where a patient requires immediate life-saving intervention at a specialist centre.</td>
</tr>
<tr>
<td><strong>Immediate transfers</strong></td>
<td>London Ambulance Service (LAS)</td>
<td>Immediate transfers are undertaken where patients require transfer for life or limb saving treatment (ambulance dispatch within the hour) or management and the patient’s clinical condition must necessitate the use of a fully equipped Accident and Emergency vehicle.</td>
</tr>
<tr>
<td><strong>Clinical transfers</strong></td>
<td>London Ambulance Service (LAS)</td>
<td>Clinical transfers are undertaken where a patient is not critical or immediate but the patient’s clinical conditions necessitate the use of a fully equipped Accident and Emergency vehicle. They are those in-patients with limited mobility or who are currently monitored, who require transportation for assessments, appointments and/or medical investigations.</td>
</tr>
<tr>
<td><strong>Non-urgent transfers</strong></td>
<td>Patient transport service (PTS)</td>
<td>If a patient does not fall into either the critical, immediate or clinical transfer categories, it is the responsibility of the hospital’s PTS provider to undertake the journey. Where a patient is clinically stable, the default position is that the hospital’s PTS provider is responsible for any transfer.</td>
</tr>
</tbody>
</table>

*Definitions provided by London Ambulance Service.
** Medically sick children would usually be transferred by the paediatric retrieval teams and not London Ambulance Service. Critical transfers of injured children are likely to be carried out by London Ambulance Service. Time critical neurological transfers ie. those requiring immediate surgical intervention should be managed by LAS and hospital team, other neurological transfers should be transferred by a retrieval team.
The standards do not apply to following types of transfer:

<table>
<thead>
<tr>
<th>Types of Transfer</th>
<th>Provider</th>
<th>Definition*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer of a critically ill child</td>
<td>Children’s Acute Transfer Service (CATs) Usually north London</td>
<td>CATS make a decision about mobilising the retrieval team on a case-by-case basis, based on patient acuity, potential for deterioration and the resources available at the referring hospital. Their primary role is, however, to perform retrievals of children needing admission to a PICU (paediatric intensive care unit). Referrals to CATS can be made if a senior clinician is concerned that the child is deteriorating, even if the patient does not fulfil absolute criteria for PICU admission. Referrals can be made if the child is not intubated but needs PICU admission.</td>
</tr>
<tr>
<td>Transfer of a newborn baby to and from a neonatal unit</td>
<td>South Thames Retrieval Service (STRs) Usually south London</td>
<td>STRS make a decision about mobilising the retrieval team on a case-by-case basis, based on a number of variables including the potential for deterioration and the resources available locally and within the region. There are no set criteria by which a child requires transfer and intensive care. A proportion of the children transferred by STRS are not ventilated.</td>
</tr>
<tr>
<td></td>
<td>Neonatal Transfer Service (NTS)</td>
<td>NTS is a dedicated transfer service which co-ordinates and aims to find cots for newborn babies, according to clinical need and to transport them safely from the referring to the receiving unit. NTS uses ambulances which have been specially designed for transportation of neonates.</td>
</tr>
</tbody>
</table>

*Definitions taken from Retrieval service website, 2012*
<table>
<thead>
<tr>
<th>Standard 1</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust boards to be accountable for having and monitoring robust and cohesive policies for inter-hospital transfers (IHTs) - including repatriations – that encompass the agreed pan-London standards. All hospitals to be linked into networks for clinically indicated IHTs.</td>
<td></td>
</tr>
<tr>
<td>- DH (2006) The acutely or critically sick or injured child in the DGH</td>
<td></td>
</tr>
</tbody>
</table>

Supporting information:
- The Trust’s IHT policy is to be ratified by the Board and reviewed annually.

<table>
<thead>
<tr>
<th>Patient experience standards:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Standard 2</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child’s privacy and dignity is to be maintained as far as possible throughout the transfer.</td>
<td></td>
</tr>
<tr>
<td>- NICE (2012) Patient experience standards</td>
<td></td>
</tr>
<tr>
<td>- Doncaster and Basetlaw Hospitals (2010) Policy for the transfer of Patients and their records</td>
<td></td>
</tr>
</tbody>
</table>

Supporting information:
- Inform (conscious) child and child’s parent/carer where and why they are being transferred, discussion of transfer should be documented in the patient’s notes
- Keep the child covered and warm
- All transfer notes in a single opaque folder
- Transfer all child’s possessions in a single closed bag
The parents/carers of a child requiring transfer must be fully informed of the need for transfer, the plan of care and where and when the child is being transferred should be explained. If inappropriate for parent/carer to travel with the child then the sending hospital is to provide all possible help to assist the parents/carers in getting to the receiving hospital.

Supporting information:
- Where the parents/carers are not present, they should be contacted as soon as possible and given the appropriate information.
- Help to the parent/carer may include information on transport, hospital location, car parking and location of unit to which their child is being transferred.
- A child’s parent/carer is to be allowed in the ambulance when a child is transferred unless clinically unsafe or their presence would compromise the care being given.
- A birthing partner is to be allowed in the ambulance when a woman in labour, in the immediate post-natal period, or for any obstetric complication, is transferred from a midwifery led unit to an obstetric unit unless clinically unsafe or their presence would compromise the care being given.
## Standard 4

<table>
<thead>
<tr>
<th>All IHT agreements to be made with consultant involvement from both the sending and receiving organisation.</th>
</tr>
</thead>
</table>

### Supporting information:
- Clinical involvement is to be recorded in notes and available for audit.
- The referral may be made by a ST4 doctor (middle grade doctor) or equivalent but with the prior knowledge of the responsible consultant, to ensure that the referral is made in a timely manner to ensure there is no delay to a transfer. An ST4 equivalent could be non-medical according to trust policy. E.g. an advanced neonatal nurse practitioner with non-medical prescribing authority.
- When making an agreement on an IHT SBAR communication tool is to be used between clinicians at the sending hospital, and between clinicians at the sending and receiving hospital.
- Ensure use of appropriate resources/specialists on the hospital site before decision to transfer child.

### Adapted from source:
- Doncaster and Baselaw Hospitals (2010) Policy for the transfer of Patients and their records
### Standard 5

The receiving hospital is to inform the sending hospital whether it can accept a proposed IHT within the agreed timeframes.

<table>
<thead>
<tr>
<th>Category</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical transfer</td>
<td>Instant decision</td>
</tr>
<tr>
<td>Immediate transfer</td>
<td>Decision within 30 minutes</td>
</tr>
<tr>
<td>Clinical transfer</td>
<td>Decision within 1 hour</td>
</tr>
<tr>
<td>Non-urgent (PTS)</td>
<td>Decision within 1 hour</td>
</tr>
</tbody>
</table>

### Supporting information:
- This standard applies to initial IHT and not repatriations.
- When requesting a transfer the sending hospital must agree to take the child back once the specialist intervention has occurred and if it is clinically appropriate for the child to be repatriated.
- Acceptance implies that a bed is available for the child at the receiving hospital.
- For critical and immediate transfers once a decision has been made to transfer a patient and a patient has been accepted then the transfer should be booked as soon as the patient is ready to be transferred.
- For critical transfers, investigations not relevant to a clinical decision on whether to accept the child are to be carried out at receiving hospital.
- Local demand management plans (DMP) are to be enacted during periods of high demand.

Adapted from source:
### Standard 6

When LAS or PTS agree to an IHT they are to dispatch or arrive at the hospital within the agreed times.

<table>
<thead>
<tr>
<th>Critical transfer</th>
<th>Next available ambulance: category A response – arrival at the referring hospital in eight minutes in 75% of cases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate transfer</td>
<td>LAS will aim to dispatch to the referring hospital within 60 minutes of the transfer request being made.</td>
</tr>
<tr>
<td>Clinical transfer</td>
<td>LAS will aim to dispatch to the referring hospital within two hours of the transfer request being made or within 45 minutes of a booked transfer time.</td>
</tr>
<tr>
<td>Non-urgent (PTS)</td>
<td>PTS will aim to arrive within two hours of the request being made or within 45 minutes of a booked transfer time. If a patient is being transferred for a pre-booked appointment the patient is to arrive on time for the appointment.</td>
</tr>
</tbody>
</table>

**Supporting information:**
- Within 45 minutes of a booked transfer time would be – if a transfer was booked for 15:00 hours then transport should arrive between 2.30pm and 3.15pm.
- Unless in the clinical interest of the child transfers are not to take place between the hours of 10pm and 6am.

### Standard 7

If a specialist centre is unable to accept an IHT on clinical grounds clear reasons for the decision and targeted advice on further care must be provided to the sending hospital. The name of the specialist giving advice should be recorded in the child’s medical notes at the sending hospital.

**Supporting information:**
- Networks are to undertake as minimum an annual audit of those cases where transfers were refused.
<table>
<thead>
<tr>
<th>Standard 8</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where a specialist centre within a network lacks capacity to take an IHT, the specialist centre is responsible for finding an alternative destination for the child.</td>
<td>• Celia Ingham Clark (2011) Draft guidelines for a networked approach to surgical services London.</td>
</tr>
</tbody>
</table>

Supporting information:
- Appropriate timescales are detailed in standard 5.
- A conversation is to take place outlining the alternatives and issue escalated if a resolution cannot be found.
- Existing local policies for acceptance apply to patients aged 15 to 18 years who are being transferred to an adult ITU.

<table>
<thead>
<tr>
<th>Standard 9</th>
<th>Adapted from source:</th>
</tr>
</thead>
</table>
| A request to LAS and PTS for an IHT is not to be made until agreement to transfer has been reached between hospitals with appropriate clinical involvement. | • LAS (2009) Acute NHS Trust guidance on London Ambulance Service inter-hospital transfers  
• Doncaster and Basetlaw Hospitals (2010) Policy for the transfer of Patients and their records |

Supporting information:
- The child must be ready for transfer at the point the request is placed with LAS and PTS.
<table>
<thead>
<tr>
<th>Standard 10</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the request for transfer is made to LAS and PTS the sending hospital is to request any specialist equipment or special requirements for the transfer which are required.</td>
<td>- Royal College of Nursing (2011) Transferring children to and from theatre: RCN position statement and guide to good practice</td>
</tr>
<tr>
<td></td>
<td>- Doncaster and Baselaw Hospitals (2010) Policy for the transfer of Patients and their records</td>
</tr>
</tbody>
</table>

Supporting information:
- The ambulance/PTS liaison must be informed at the time of booking if a car seat/booster seat is required, along with the age of the patient so that an appropriately sized seat is provided.
- The Royal College of Nursing (2011) Transferring children to and from theatre recommend appropriate equipment which should be available. For children who have undergone anaesthesia, as a minimum, oxygen and suction should be available.
<table>
<thead>
<tr>
<th>Standard 11</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The sending hospital retains clinical responsibility for the child until</td>
<td>• LAS (2009) Acute NHS Trust guidance on London Ambulance Service inter-</td>
</tr>
<tr>
<td>handover at the receiving hospital has taken place. Handover should take</td>
<td>hospital transfers</td>
</tr>
<tr>
<td>place within 15 minutes of arrival.</td>
<td>• DH (2006) The acutely or critically sick or injured child in the DGH</td>
</tr>
<tr>
<td></td>
<td>• Paediatric Emergency Services Standards (2011)</td>
</tr>
<tr>
<td></td>
<td>• Doncaster and Basetlaw Hospitals (2010) Policy for the transfer of</td>
</tr>
<tr>
<td></td>
<td>Patients and their records</td>
</tr>
</tbody>
</table>

**Supporting information:**

- 24 hour on-call paediatric consultant advice from the referring hospital is to be available to the clinical escort team if the child deteriorates en route to the receiving hospital.
- In the case of transfer to a higher acuity setting the receiving hospital is responsible for providing advice on patient management if required.
- This standard applies to both initial transfers and repatriations – ie. the hospital the child is moving from retains responsibility.
### Standard 12

The sending hospital is to ensure the child is accompanied by an appropriate clinical escort(s) during the transfer who is ready for transfer when LAS or PTS arrive.

Prior to the IHT of any child a risk assessment must be undertaken by a suitably competent member of clinical staff to determine the level of anticipated risk during transfer and identify the child’s minimum clinical escort requirement.

### Supporting information:
- London Ambulance Service is unable to guarantee a paramedic crew for critical, immediate and clinical transfers.
- A clinical escort may be required to travel with a patient transferred via Patient Transport Service (PTS).
- The sending hospital must have arrangements in place for transportation of the escorts with equipment.
- All hospitals should use a risk assessment tool to establish escort requirements. Appendix 1 is given as an example. The assessment must be documented in notes and available for audit. Each case is to be considered in its own and may need a higher level of escort.
- Appropriate clinical escorts are to be able to undertake any treatment that may be needed during the journey. An acutely or critically sick child will normally be escorted by a doctor and a nurse with experience and/or training in (a) care of the critically sick child, and/or (b) emergency transfer, and/or (c) airway management.
- All transfers of women and their baby in the immediate post natal period should be accompanied by a midwife.
- Prior to the moment of transfer the child is to be reviewed.
- Clinical escorts are to be aware of child protection plans in place or any safeguarding concerns.
- Where the transfer is delayed more than 15 minutes the LAS crew will be stood down and the transfer will need to be re-booked.

### Adapted from source:
- Royal College of Nursing (2011) Transferring children to and from theatre: RCN position statement and guide to good practice
- DH (2006) The acutely or critically sick or injured child in the DGH
<table>
<thead>
<tr>
<th>Standard 13</th>
<th>Adapted from source:</th>
</tr>
</thead>
</table>
| It is the responsibility of the sending hospital to ensure that all clinical escorts have child protection skills and experience of at least level 2 safeguarding competencies. | • DCSF (2010) Working together to safeguard children  
• RCPCH (2012) Standards for children and young people in emergency care settings  
• RCPCH (2010) Safeguarding Children and Young people Roles and Competencies. Intercollegiate Document |
<table>
<thead>
<tr>
<th>Standard 14</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The specialist centre receiving a child is to inform the sending hospital with the estimated date of discharge/repatriation as soon as possible, and no later than 24 hours of admission.</strong></td>
<td>- London Trauma System (2012) Transfer of care / repatriation policy</td>
</tr>
<tr>
<td></td>
<td>- NWL cardiac and stroke network (2009) Patient movement protocols for NW London stroke services</td>
</tr>
<tr>
<td></td>
<td>- Paediatric Emergency Services Standards (2011)</td>
</tr>
</tbody>
</table>

**Supporting information:**
- The specialist centre is to update the sending hospital if the estimated date of discharge/repatriation changes.
- The Bed Management Team and clinical team should be informed at the sending hospital.
- The sending hospital is the hospital where the patient was transferred from. If a child is repatriated to a local hospital closer to their home rather than the sending hospital, the estimated date of discharge/repatriation is to be sent to the hospital the child is expected to move to.
Once a child is clinically fit for transfer back, a repatriation notification is sent to the Bed Management Team and clinical team at the sending hospital. The repatriation should occur within 24 hours of the notification.

Supporting information:
- Appropriate clinical teams at both hospitals to agree that the patient is clinically fit for repatriation and a named consultant and speciality are confirmed.
- Repatriation notification is to include the time and date the patient is fit for transfer.
- The repatriation notification should not be sent earlier than 24 hours prior to patient being fit for transfer.
- The sending hospital is to confirm bed allocation, time and date bed available for patient.
- The repatriation is not to take place between the hours of 10pm and 6am.
- The escalation process is to be activated if repatriation has not occurred with 24 hours of repatriation notification.
- Hospitals should audit the use of repatriation procedures.
- The sending hospital is the hospital where the patient was transferred from.
- During handover all relevant clinical information should be communicated.
<table>
<thead>
<tr>
<th>Standard 16</th>
<th>Adapted from source:</th>
</tr>
</thead>
</table>
| **All IHTs to be carried out with appropriate clinical documentation. On arrival at the receiving hospital, an adequate structured verbal handover is required to the receiving team.** | • Royal College of Nursing (2011) Transferring children to and from theatre: RCN position statement and guide to good practice  
• North central London critical care network (2008) Adult critical care record of transfer  
• Whittington Health (2012) Transport of the critically ill patient  
• ICS (3rd edition 2011) Guidelines for the transport of the critically ill adult |

**Supporting information:**
- Photocopies of relevant notes should travel with the child or the documentation should be sent electronically via a secure connection. Non-availability is to be documented.
- All relevant investigation results including PEWS score must be transferred to the receiving hospital via IEP (Image Exchange Portal) or within transfer documentation.
- The checklist in appendix 4 is to be used to ensure that all relevant information is reported on the transport form.
- Details of a child protection plan in place or any safeguarding concerns are to be documented on the transfer form.
- The transfer form is to be signed by a clinician in the receiving hospital and a photocopy inserted into the patient’s original notes in the transferring organisation.
- All patient records and information transferred between organisations must be treated confidentially.
### Standard 17

**All hospitals to have an escalation process in place which is instigated where timescales are not met for all IHTs.**

<table>
<thead>
<tr>
<th>Supporting information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If a request to transfer has been refused or transfer of care has not occurred with appropriate timescales communication should be initiated between the named accountable or responsible consultant for the patient at sending and receiving hospital.</td>
</tr>
<tr>
<td>- The escalation policy is to follow the bronze (bed manager), silver (general manager level), gold (executive team level) chain.</td>
</tr>
<tr>
<td>- The escalation policy applies to all transfer categories.</td>
</tr>
<tr>
<td>- Children should continue to be cared for in the appropriate facility by the appropriate team while waiting for the transfer to take place.</td>
</tr>
</tbody>
</table>

**Adaption from source:**

### Standard 18

**Unless otherwise directed by the receiving hospital at the point the transfer is agreed, all children are to be received via the emergency department to be booked in and receive resuscitation if appropriate.**

Supporting information:
- This excludes ward to ward transfers or children being repatriated.
- Children transferred directly from one ward to another ie. to a paediatric ward, should be received directly in the receiving ward - entry to the ward should be arranged at the point of transfer agreement between hospitals in order to mitigate obstacles entering the ward.
- Clinically injured children are to be received via the emergency department.
- Children being repatriated should be received directly in the receiving ward - entry to the ward should be arranged at the point of transfer agreement between hospitals in order to mitigate obstacles entering the ward.
- If a woman is in labour she should be received in a maternity unit – entry to the maternity unit should be arranged at the point of transfer agreement between hospitals in order to mitigate obstacles entering the unit.
- If a child is to be received outside of the emergency department, the discussion between hospitals and the receiving location is to be formally documented on the transfer form and London Ambulance Service/Patient Transport Service to be informed at the point of request.

### Standard 19

**It is inappropriate for the child to remain in the emergency department of the receiving hospital unless when the emergency department offers the only appropriate facilities and expertise that are suited to the child’s current condition. The receiving hospital must arrange an immediate transfer to the most clinically appropriate department.**

Supporting information:
- Once received in an emergency department, children who require critical transfer for emergency operation should be transferred directly to the operating theatre complex or imaging suite of the receiving hospital.
- Once received in an emergency department, children who require immediate transfer for emergency operation, children who require emergency medical specialist care and children who require interventional radiology should be transferred directly to the paediatric ward of the receiving hospital.
For all IHTs on arrival at the receiving hospital a child must be seen by the receiving specialist team within the agreed timeframe.

<table>
<thead>
<tr>
<th>Transfer Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical transfer</td>
<td>Immediately</td>
</tr>
<tr>
<td>Immediate transfer</td>
<td>Within 30 minutes</td>
</tr>
<tr>
<td>Clinical transfer</td>
<td>Within 1 hour</td>
</tr>
<tr>
<td>Non-urgent (PTS)</td>
<td>Within 1 hour</td>
</tr>
</tbody>
</table>

Supporting information:

- The receiving medical team who accepted the child takes responsibility for the patient once handover is complete in the receiving hospital, even if the child was handed over in the emergency department.
- For repatriation the receiving team can be considered to be a multidisciplinary team if appropriate.
### Audit:

#### Standard 21

All IHTs should be subject to continuous prospective audit involving all hospitals in the network, with at least annual review.

### Supporting information:

- As a minimum the audit must include:
  - Standard 4 (level of clinical involvement in decision to transfer)
  - Standard 5 (timeframe for decision to accept transfer)
  - Standard 6 (the time the transfer took place)
  - Standard 12 (risk assessment documented in notes)
  - Standard 20 (timeframe to see specialist/on-call team)
  - Standard 16 (inclusion of information in transfer documentation)
  - Standard 15 (timeframe for repatriation)

- The audit must include both those children successfully transferred and those children where a transfer was deemed inappropriate or found not to be possible.

- The audit is to feed into organisation quality and risk management structures.

### Adapted from source:

- Celia Ingham Clark (2011) Draft guidelines for a networked approach to surgical services
- AAGBI (2009) Safety guideline: inter-hospital transfer
- ICS (3rd edition 2011) Guidelines for the transport of the critically ill adult
- DH (2006) The acutely or critically sick or injured child in the DGH
Appendix 1: Example of a Risk Assessment Tool for minimum escort requirements
[Source: Sailsbury NHS Foundation Trust]

The Transfer of Children and young People (under 16) between Wards/Departments

Child/Young person:

- Airway:
  - Fluctuating conscious level or sedated

- Breathing:
  - Invasive/Non Invasive Ventilation
  - Oxygen administration required
  - Tachynpoeic
  - Chest Drain In situ
  - Artificial airway i.e tracheostomy

- Circulation:
  - Cardiac Monitoring in situ
  - Cardiovascularly unstable i.e. hypotension, tachycardic

- Other:
  - Any Infusion including blood transfusion

Consider – is it appropriate for this patient to be moved at this time

Child/Young person:

- Behaviour: Disorientated, confused, aggressive including self harm
- Has a recognised learning disability
- Requires 2 or more to help change position
- Wound drains
- Subject of a care order
- Admitted with a non-accidental injury

Child/Young person:

- Mobile and orientated
- Can change own position
- No interventions are normally required

IMPORTANT NOTES

- This document has been produced as a guide for staff, is not exhaustive, and does not replace clinical judgement. However any departure from the basic guidance given above must be documented in the patient record with clear rationale for the decision (includes if no RN available to transfer)

- The Registered nurse responsible for the care of the patient must assess the patient's physical and mental health to determine if an escort is required and if so who should undertake this role.

- It is the nurse’s responsibility to ensure that all appropriate documentation accompanies the patient.