ALS GROUND INTER-FACILITY TRANSFER GUIDELINES

Inter-facility transport is defined as the movement a patient from one health care facility “as defined in the EMS Act” to another in a licensed ground or air ambulance. The transfer of patients between facilities is a fundamental component of the health care system. As such, the Emergency Health Services Federation has developed the following regional guidelines to ensure that quality patient care be provided by appropriately qualified EMS personnel.

I. General Guidelines
   A. Pre-Transport
      The attending physician determines the need for transfer. The receiving facility is contacted for acceptance and bed availability. Upon confirmation of accepting physician and available and appropriate bed at receiving facility, mode of transport is then determined.

      The transport service and its medical director are responsible for insuring that their transport personnel can provide quality care within their scope of practice and are skilled in the use of transport equipment. COBRA/EMTALA requires transport by qualified personnel with appropriate transportation equipment, to provide any necessary and medically appropriate life support measures during the transport. The transport personnel must be qualified to handle potential complications or deterioration in the patient’s condition that might occur during the transport. (Appendix A)

   B. Sending Facility
      Under the Federal COBRA/EMTALA legislation, the sending facility must provide the ALS practitioner transferring the patient a report (and pertinent patient records) including complete medical history (past and present), current treatment underway, and medications being administered. In the event that hospital nursing staff will be accompanying the patient, they will follow orders given to them by the attending physician. If hospital staff is not present, then the ALS practitioner should consider contacting a medical command physician for assistance. (Appendix B).

   C. Patient Transport (ALS practitioner responsibilities)
      1. Receive patient report from sending facility staff and ensure that appropriate staff and equipment are available for the ALS practitioner to safely and effectively care for the patient.
      2. Receive name of receiving facility, receiving physician, phone number for receiving facility, and room number at receiving facility. (Appendix B)
      3. Receive copy of pertinent medical records, to include lab work, x-rays, etc. as appropriate.
      4. Perform appropriate physical assessment of patient
      5. If the ALS practitioner considers the patient stable, then a medical command physician does not need to be notified prior to leaving Sending Facility.
6. If patient is considered unstable, then the ALS practitioner must contact a medical Command Physician from the Sending Facility prior to leaving the facility. The Medical Command Physician should be advised of the following: this it is an inter-facility transfer, identify both sending and receiving physicians as well as receiving facility, any ancillary personnel that are to accompany patient, pertinent patient assessment, and any standing medication orders for transport. The Medical Command Physician should confirm patient care orders for the transport and make arrangements for accessing medical command during the transport. These arrangements must be acceptable to the medical command physician. (Appendix A)

7. During transport, the ALS practitioner shall continue to monitor patient (as appropriate to stability of patient status). This shall include but not limited to vital signs, ECG, LOC, perfusion, ongoing medications, etc. as well as pertinent physical reassessments as indicated by individual patient needs.

8. If patient condition deteriorates or if situation warrants (as per Regional Protocol) then a Medical Command Physician should be contacted. In the case of the unstable patient, the initial Medical Command Physician should be notified, as he/she is already aware of the patient and status.

9. Should the ALS practitioner need to provide treatment outside of provided transport orders then Regional Protocol shall be instituted until contact with a Medical Command Physician is made.

D. Documentation
The ALS practitioner shall maintain an accurate transport record on the patient to include but not limited to patient demographics, PMH, HPI, current medications, allergies, PE, changes in status and treatment provided with coinciding times as well as contact with a Medical Command Physician and orders received, vital signs and ECG (frequency per individual patient need and condition).

E. Receiving Facility
Upon arrival at Receiving Facility, transfer care and information to appropriate staff this shall include but not limited to patient belongings, the copies of records from sending facility, as well as patient report, any treatments or interventions provided during transport and a copy of transport documentation and any ECG strips.
Appendices

Appendix A: COBRA/EMTALA Excerpts

EMTALA allows for Sending or Receiving Facility Medical Command as long as it is decided upon jointly prior to transfer and the end decision is communicated to the ALS practitioner accompanying the patient. This Medical Command Physician is an aid for ALS decisions for treatment and is not accepting responsibility for the patient. The Medical Command Physician is a liaison between ALS and the in-house medical personnel. The National Association of EMS Physicians offers the following guidelines in Pre-hospital Emergency Care (October/December 2000 Vol. 4 pages 361-364):

♦ The transferring physician has the responsibility of selecting the most appropriate means of transport to include qualified personnel and transport equipment.

♦ The transport service and its medical director are responsible for ensuring that their personnel can provide quality care within their scope of practice and are skilled in the use of the transport equipment.

♦ The responsibility of online medical direction during transport should be decided upon prior to transport and be a mutual agreement between the transferring and the accepting physicians as well as the transport services medical director.

♦ Inter-facility transport should be defined by state statute/regulation as a component of the EMS system.

♦ System or service protocols should define the scope of practice of the transport service.

♦ The EMS system should educate the medical community about inter-facility transport standards.

♦ EMTALA is the governing authority for the sending physician/hospital concerning the transfer of patients. An appropriate transfer is defined by four variables:

1. The provision of medical treatment within the transferring physician/hospital’s capacity that minimizes risk to the patient.
2. Requires an accepting facility that has available space and qualified personnel for treatment of the patient and agrees to accept the patient in transfer.
3. Requires the medical records from the transferring hospital be sent to the accepting hospital.
4. Requires transport by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during transport. The transport personnel must be qualified to handle potential complications or deterioration in the patient’s condition that might occur during transport.

♦ The transport crew must have a physician they can contact for on-line direction at all times during the transport in the event the patient becomes unstable and transfer orders or service protocol do not address the crisis. This should be agreed upon prior to transfer.

Appendix B: Ancillary Personnel

Oftentimes in the interest of patient care, it is necessary to have additional personnel accompany the patient during an inter-facility transport (i.e. respiratory therapist, registered nurse or as directed by hospital policy of the sending or receiving facility). Responsibility for the patient during the inter-facility transfer rests primarily with the ALS practitioner while ancillary personnel maintain responsibility within their individual scopes of practice i.e. in the event of registered nurse accompaniment, the ALS practitioner still maintains primary care responsibilities within their scope of practice and the RN is responsible within their individual scope of practice as defined by their employing institution.
In the event a physician is accompanying the patient for an entire transport, any orders received during transport must be written, dated and signed by the physician prior to transfer of care at the receiving facility. The physician is responsible for overall patient care and the ALS practitioner is responsible for their own care within their scope of practice.

The ALS practitioner is encouraged to work collectively with these personnel for optimum patient care. In the event of a life threatening change in the patient status during transport, it is the ALS practitioner’s primary responsibility for the resuscitation and care of the patient. Ancillary personnel may assist within their scope of practice.

Appendix C: Family Accompaniment

In the interest of patient and crew safety, it is recommended that the family travel separately. They should be provided with appropriate directions to the receiving facility. The family should be cautioned against trying to follow the transport vehicle as this can be dangerous to both the family and the transport vehicle occupants. Families should also be cautioned that occasional use of lights and sirens may be indicated and that the family is to obey standard traffic laws separate from the transport vehicle’s mode of travel.

It is recommended that in the event a single family member is to accompany the transport crew, then that individual should use an appropriate safety restraint device (i.e. seatbelt).

Appendix D: Practitioner Endangerment

In the event that the ALS transport crew feels that it would be unsafe to perform the transfer (i.e. inclement weather, violent patient, inadequate equipment for transfer, etc.) they should immediately notify the sending facility/physician and make them aware of the concern. They should then work together to find an acceptable solution and should utilize medical command as well as the service’s medical director for guidance as needed.