

# EMERGENCY DEPARTMENT INTERFACILITY AND OVERSEAS TRANSFER PROTOCOL

## *Protocol 11: Decision, Stabilization, Acceptance, Transport, Handover, and International Referral*

**DRAFT FOR CLINICAL, NURSING, AMBULANCE, AEROMEDICAL, GOVERNANCE, FINANCE, AND PATIENT-SAFETY REVIEW**

**Safety rule: A patient shall be transferred only when the expected clinical benefit exceeds the transport risk, the receiving service has explicitly accepted the patient, and the required level of care can be maintained from departure until formal handover. Administrative, financial, passport, visa, or transport arrangements must be pursued in parallel and must never interrupt emergency stabilization.**

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Document owner	Emergency Department / Medical Services / Nursing Services / Ambulance and Transport Services
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Approved by	[Clinical Governance Committee / Executive Management / Medical Director]
Related protocols	Protocols 1-10; resuscitation; medication safety; infection prevention; blood transfusion; safeguarding; maternity; paediatric; mental-health; mass-casualty; death and bereavement
Applies to	ED clinicians and nurses, consultants, ambulance and transport staff, anaesthesia/critical care, paediatrics, maternity, radiology, laboratory, pharmacy, finance/overseas referral office, security, and receiving services
Supersedes	[Insert previous policy or “New protocol”]

## 1. Purpose

To establish a safe, timely, equitable, and accountable process for transferring patients from the Emergency Department to another health-care facility within the country or overseas when required care cannot be provided safely at the referring hospital.

## 2. Scope

This protocol applies from the first consideration of transfer until the receiving facility confirms arrival, completes formal handover, and assumes responsibility. It applies to urgent and planned transfers by ground, sea, rotary-wing aircraft, fixed-wing aircraft, or commercial travel with a medical escort. It does not replace specialty-specific neonatal, paediatric, obstetric, trauma, psychiatric, infectious-disease, or critical-care transport algorithms.

## 3. Core policy statements

- Transfer is a clinical intervention with foreseeable risks; it shall not be treated as a purely administrative movement.
- The treating team shall first determine whether the patient needs a service, procedure, diagnostic capability, or level of care unavailable locally and whether transfer offers a meaningful net benefit.
- Immediate life-saving transfer shall not be delayed for non-essential investigations, paperwork, payment authorization, or completion of routine administrative processes when delay creates greater clinical harm.
- A named clinician at the receiving facility shall explicitly accept the patient and the intended destination shall be confirmed before departure, except under an approved disaster, mass-casualty, or standing network arrangement.
- The patient shall be resuscitated and stabilized to the greatest degree reasonably possible before transfer, while balancing stabilization time against the urgency of definitive treatment.
- A senior clinician shall document the transfer risk assessment, required transport modality, escort competencies, monitoring, equipment, oxygen, medication, and contingency plan.
- The standard of care during transport shall be appropriate to the patient's needs and shall not knowingly fall below what is required to prevent avoidable deterioration.
- A driver is not a clinical escort. Interfacility transfer requires a transport operator and a provider capable of delivering the required care unless a senior clinician documents an exceptional risk-benefit decision.
- The patient, representative, and family shall receive honest information about the reason, benefits, risks, destination, alternatives, expected logistics, likely costs under local policy, and arrangements for accompanying relatives.
- All referral information, investigations, imaging, medication details, treatment limitations, infection precautions, safeguarding concerns, and pending results shall accompany the patient or be electronically accessible.
- Continuous or scheduled monitoring, treatment, clinical events, communication, and deterioration during transport shall be documented contemporaneously.
- Responsibility transfers only after structured verbal and written handover to an identified receiving clinician and nurse or equivalent team.
- Overseas transfer decisions shall be based on clinical need and transparent authorization criteria, not social status, personal influence, or ability to navigate informal networks.
- Every transfer, delay, cancellation, diversion, adverse event, equipment failure, or unexpected deterioration shall contribute to quality improvement and system learning.

## 4. Definitions

Term	Operational definition
Interfacility transfer	Movement of a patient between separate health-care facilities for a higher, different, or continuing level of care.
Overseas transfer / medical evacuation	Transfer across a national border or to another island/jurisdiction, using air or sea transport, for care not safely available locally.

Term	Operational definition
Referral	A clinical request for another clinician or facility to assess, advise on, accept, or assume responsibility for specified patient needs.
Acceptance	Explicit agreement by a named receiving clinician or authorized service to receive and manage the patient.
Retrieval	A transfer in which a specialized team, usually from a receiving or regional service, travels to the referring facility to stabilize and transport the patient.
Repatriation / counter-referral	Return of a patient to the referring country or lower level of care after the specialized episode has been completed.
Clinical escort	A health professional with the competence and authority required to monitor and treat the patient during transport.
Transport provider	The ambulance, aeromedical, maritime, or other authorized service responsible for the vehicle, crew, operational safety, and dispatch.
Transfer risk assessment	A documented evaluation of current physiology, likely deterioration, transport stresses, journey duration, mode, equipment, and intervention needs.
Time-critical transfer	Transfer required within a clinically defined interval to prevent death, loss of limb or organ, irreversible disability, maternal/fetal harm, or other major deterioration.
Fit to transfer	A clinical judgment that the expected benefit exceeds the risk and the required care can be maintained through the journey; it does not mean that the patient is physiologically normal.

## 5. Roles and accountability

Role	Minimum accountability
Hospital executive / Medical Director	Approves the national and overseas referral framework, funding and authorization pathways, transfer governance, contracts, indemnity, escalation chain, and equity safeguards.
ED senior clinician / referring consultant	Confirms need, benefit-risk balance, urgency, stabilization plan, destination, acceptance, risk category, escort competencies, and final fitness to depart.
Treating ED clinician	Performs assessment and stabilization, prepares referral information, communicates with the receiver, documents the plan, and continues care until transfer responsibility changes.
ED nurse in charge / assigned nurse	Coordinates nursing preparation, medication and device checks, documentation, family communication, handover, and safe departure.
Receiving clinician / facility	Reviews referral information, confirms acceptance and destination, advises on pre-transfer care, identifies contraindications or required preparation, and prepares to receive the patient.
Ambulance / transport dispatch	Confirms vehicle, crew, route, timing, communication method, operational readiness, security, weather constraints, and contingency options.

Role	Minimum accountability
Clinical escort / transfer team leader	Independently reviews the patient, accepts the transfer plan, checks equipment and supplies, provides care and documentation in transit, and completes handover.
Anaesthesia / critical care / paediatric / maternity teams	Support stabilization, airway/ventilation, haemodynamic management, specialty risk assessment, retrieval, and escort selection when indicated.
Pharmacy / laboratory / radiology	Ensures medications, antidotes, blood products, results, imaging, reports, and pending-result processes are complete and transferable.
Overseas referral coordinator / finance / administration	Coordinates authorization, receiving facility documentation, guarantees of payment, immigration/travel documents, insurer or government approvals, and family logistics without obstructing urgent clinical care.
Patient safety / governance lead	Maintains forms and checklists, audits activity and outcomes, reviews incidents, monitors equity, and oversees training and improvement.

## 6. Standard transfer pathway

Stage	Required action
1. Recognize need	Identify care, expertise, diagnostics, procedure, or level of support unavailable or unsafe locally.
2. Stabilize and define urgency	Treat immediate threats, determine what must happen before departure, and classify the clinical time window.
3. Select destination	Choose the facility that can provide the required care and is realistically reachable within the clinical window.
4. Refer and obtain acceptance	Use SBAR/ISBAR, agree pre-transfer actions, receiving unit, accepting clinician, and contingency plan.
5. Assess transport risk	Match route, modality, escort competencies, equipment, oxygen, medications, and monitoring to the patient.
6. Coordinate logistics	Activate transport, overseas referral authorization, documents, financial arrangements, security, weather, and family support in parallel.
7. Prepare and pause	Complete final ABCDE reassessment, checklists, records, equipment, power, oxygen, medications, and patient packaging.
8. Transport and monitor	Continue treatment, record observations and events, communicate changes, and divert or stop when required.
9. Handover and transfer responsibility	Deliver verbal and written handover, transition onto receiving equipment, resolve questions, and document the receiver.
10. Confirm completion and learn	Notify the referring facility, reconcile equipment, arrange counter-referral, and report incidents or delays.

**At every stage, staff must be able to answer: Why is transfer needed? Who has accepted the patient? What can go wrong during the journey? Who can manage it? What is the contingency if transport is delayed or the patient deteriorates?**

## 7. Indications and decision to transfer

The decision shall be made by a clinician with sufficient seniority and competence to evaluate both the disease risk and the transport risk. Common indications include:

- Time-critical specialist intervention not available locally, such as neurosurgery, interventional cardiology, vascular intervention, complex trauma, burns, dialysis, advanced obstetric/neonatal care, or critical-care support.
- Diagnostic or therapeutic capability that materially changes management and cannot be safely delayed.
- Need for a higher level of monitoring, ventilation, organ support, specialist nursing, or multidisciplinary care.
- Transfer to an approved mental-health, rehabilitation, long-term, or other facility when the ED cannot safely provide ongoing care.
- Repatriation or step-down transfer after specialist treatment, when clinically appropriate and formally accepted.
- Capacity transfer only as a last resort, after senior executive review confirms that safer local alternatives have been exhausted.

The referring clinician shall document the expected benefit, foreseeable transport risks, available alternatives, consequences of delay or non-transfer, and why the selected destination is appropriate.

## 8. Urgency and prioritization

The hospital and transport providers shall approve a common priority framework and response targets. The following categories are proposed for local validation:

Priority	Operational meaning
Priority 1 - Immediate rescue	Current facility cannot provide an immediate life-saving intervention or safe ongoing resuscitation. Mobilize transport and specialist support concurrently; stabilization is limited to actions that can be completed without harmful delay.
Priority 2 - Time-critical	Transfer is required urgently to prevent death, loss of limb/organ, irreversible neurological injury, maternal/fetal harm, or major deterioration. A clinically defined latest safe departure time shall be stated.
Priority 3 - Urgent	Transfer is required during the current episode, usually the same day, but a short preparation interval is acceptable.
Priority 4 - Planned / repatriation	Clinically stable transfer for continuing care, investigation, rehabilitation, or return closer to home. Timing shall minimize disruption and avoid unnecessary night transfer.

- The referring clinician shall communicate the clinical deadline, not simply use the word “urgent.”
- Dispatch and receiving services shall be updated immediately if urgency changes.
- Priority shall be based on patient need and not on social influence, payment status, or convenience.
- Transfers during severe weather, civil disruption, security threats, or transport-system failure require senior review and contingency planning.

## 9. Referral and explicit acceptance

### 9.1 Minimum referral content

- Two patient identifiers, age, sex, weight where relevant, current location, and contact details.
- Presenting syndrome, working diagnosis, severity, trajectory, and reason the required care is unavailable locally.
- Current ABCDE status, observations and trends, early-warning score, relevant examination, and treatment response.

- Relevant history, comorbidities, allergies, medications, pregnancy status, baseline function, frailty, capacity, and safeguarding concerns.
- Investigations, imaging, reports, treatments, procedures, blood products, and time-critical medications already given.
- Current oxygen, ventilation, infusions, vasoactive support, devices, drains, lines, immobilization, isolation, and monitoring.
- What is requested, the required timeline, and the consequences of delay.
- Potential deterioration, interventions that may be required in transit, treatment limitations, and contingency plan.

## 9.2 Acceptance requirements

- Record the accepting clinician's name, role, service, facility, contact details, date/time, and agreed destination.
- Document advice given, required pre-transfer actions, investigations or images to send, and whether a specialist retrieval team will be deployed.
- Confirm that the receiving unit has the required bed, staff, equipment, isolation capacity, and immediate access to the intended intervention.
- An administrative authorization, bed search, or message left with a switchboard is not clinical acceptance.
- If the first-choice facility cannot accept, the referral shall be escalated through the approved regional or overseas pathway without abandoning active care.

## 10. Risk-benefit assessment, consent, and capacity

- Assess whether the expected benefit of transfer is greater than the combined risk of delay, movement, transport physiology, communication failure, resource limitation, and destination uncertainty.
- Explain material benefits, risks, alternatives, and foreseeable consequences in language the patient or representative can understand.
- Obtain and document consent where the patient has capacity. Consent to transfer does not replace consent for procedures or treatment.
- When the patient lacks capacity, act under applicable emergency, best-interest, substitute-decision, child-protection, or mental-health law and document the basis.
- A competent patient may refuse transfer. Explore concerns, correct misunderstandings, offer reasonable alternatives, explain risks, document the discussion, and provide ongoing care that the patient accepts.
- Use an interpreter when needed. Family members should not routinely interpret complex consent unless no safe alternative exists.
- Financial counselling shall be transparent but shall not be used to coerce consent or delay emergency stabilization.

## 11. Stabilization before transport

The goal is not to normalize every abnormality. The goal is to reduce preventable deterioration and ensure that required support can continue throughout the journey. Stabilization shall include, as applicable:

- Airway: assess patency, aspiration risk, cervical-spine needs, airway device position and security, suction, backup airway plan, and difficult-airway risks.
- Breathing: optimize oxygenation and ventilation, manage bronchospasm or pulmonary oedema, confirm ventilator compatibility, secure chest drains, and identify air-filled-space risks before flight.
- Circulation: control haemorrhage, establish reliable access, stabilize rhythm and perfusion, ensure fluids/blood/vasoactive medicines can continue, and secure all lines and drains.
- Disability: treat seizures and hypoglycaemia, document neurological status, address agitation, pain and sedation, and protect against pressure injury or falls.
- Exposure/environment: manage temperature, wounds, splints, immobilization, infection precautions, pregnancy-related risks, and safe access for reassessment.

- Complete interventions that cannot safely be performed in transit, unless the delay would prevent a time-critical definitive intervention.
- Trial the patient on the actual transport ventilator, monitor, infusion pumps, oxygen source, and transport trolley before departure when clinically relevant.
- Reassess after movement from bed to trolley; deterioration during this trial shall trigger review of transfer readiness.

**Time-critical exception: When definitive treatment is the only realistic means of stabilization, the senior referring and accepting clinicians shall agree the minimum essential preparation and the safest achievable transport plan. The reason for proceeding despite residual instability must be explicit.**

## 12. Transfer risk stratification and escort competencies

A senior clinician shall assign a transfer risk category after considering physiology, diagnosis, trajectory, movement risk, intervention probability, transport mode, weather, route, duration, and access to help. The categories below are illustrative and require local approval.

Risk level	Illustrative features	Minimum escort principle
Low risk	Stable physiology; no anticipated airway or haemodynamic intervention; simple oxygen or routine therapy; low likelihood of deterioration.	Registered nurse, paramedic, or other approved clinician with competence for the patient's needs and basic emergency response.
Moderate risk	Recent instability, significant oxygen need, altered mental status, active treatment, infusion, moderate pain/agitation, or credible risk of deterioration.	Clinician competent in advanced assessment, resuscitation, medication/infusion management, and the anticipated complications; additional escort as required.
High risk	Intubation/ventilation, vasoactive support, active bleeding, major trauma, severe obstetric/neonatal illness, unstable arrhythmia, refractory seizures, or likely need for advanced intervention.	Critical-care/anaesthesia/emergency or specialty retrieval team with advanced airway, ventilation, haemodynamic, procedural, paediatric/neonatal/obstetric, and transport competencies as applicable.

- The escort shall be competent with the actual equipment, medication, route, and mode of transport.
- Staff without verified competencies shall not undertake an unsupervised high-risk transfer.
- The transfer team leader may decline departure and request further stabilization, equipment, personnel, or a different transport mode when safety requirements are not met.
- The hospital shall maintain 24-hour escalation arrangements when the required escort cannot be released without creating unsafe staffing elsewhere.

## 13. Destination and mode of transport

### 13.1 Destination selection

- Select the nearest or most accessible facility that can deliver the required definitive care within the necessary time, unless another destination offers a clearly superior clinical pathway.
- Consider capability, acceptance, intervention availability, bed status, transfer duration, onward-transfer risk, language, family access, and repatriation arrangements.
- Avoid sequential transfers when direct transfer to definitive care is feasible and safe.
- Document why a more distant or overseas destination was selected when a closer option exists.

## 13.2 Transport mode

Mode	Selection considerations
Ground ambulance	Often fastest to mobilize for short or moderate distances; allows easier access and monitoring. Consider traffic, road quality, borders, ferry dependence, and ambulance capability.
Sea transfer	May be necessary between islands. Consider weather, sea state, vessel stability, boarding method, access to patient, duration, power, oxygen, communication, and evacuation alternatives.
Rotary-wing aircraft	Useful when geography or time favours helicopter access. Consider weather, payload, cabin space, noise, vibration, altitude, landing arrangements, and ground transfers at both ends.
Fixed-wing air ambulance	Appropriate for longer distances or high-acuity overseas transfer. Requires aeromedical crew, airport transfers, pressurization/altitude planning, equipment compatibility, and customs/immigration coordination.
Commercial flight with escort	Only for carefully selected, sufficiently stable patients after airline medical clearance. Consider seating/stretchers approval, oxygen rules, medication/security restrictions, airport mobility, delays, diversions, and lack of immediate landing options.

Perceived speed shall be assessed door-to-door. Mobilization, airport processing, transfers at both ends, weather, refuelling, and receiving-facility access may outweigh the cruising speed of an aircraft.

## 14. Transport coordination and operational readiness

- Confirm dispatch contact, vehicle/aircraft/vessel, crew, clinical escort, estimated mobilization, route, expected journey duration, and estimated arrival.
- Confirm whether a retrieval team is coming to the referring facility and what stabilization should continue while awaiting arrival.
- Establish reliable communication between the transport team, dispatch/medical control, referring clinician, and receiving facility.
- Review weather, route closures, security, civil disruption, border/airport/port opening, landing or docking access, and contingency destinations.
- Confirm safe loading and unloading arrangements, appropriate trolley or incubator, lifting/bariatric capacity, infection-control requirements, and power connections.
- Arrange return travel, accommodation, relief, meals, communication, and repatriation of staff and equipment, especially for overseas or one-way air transfers.
- Document anticipated delay and the interim care plan. The ED shall continue active monitoring and treatment while transport is being organized.
- Escalate immediately when the transport response cannot meet the clinically required timeline.

## 15. Equipment, oxygen, medications, and supplies

- Use transport-approved equipment that is maintained, charged, function-tested, securely mounted or stowed, and familiar to the escort.
- Monitoring shall match risk and normally include continuous clinical observation, pulse oximetry, cardiac rhythm, blood pressure, temperature, and end-tidal carbon dioxide for intubated/ventilated patients; additional invasive or specialty monitoring shall follow clinical need.



- Calculate oxygen for the planned journey, loading/unloading, ground legs, and foreseeable delays using the locally approved formula and reserve standard. Verify cylinder contents and compatibility before departure.
- Carry sufficient medications, fluids, blood products where approved, infusion syringes, disposables, batteries, and backup supplies for the journey plus delays.
- All medications and infusions shall be clearly labelled with patient, drug, concentration, rate, date/time, and preparer; pumps shall be locked and visible where possible.
- Carry immediate-resuscitation equipment, suction, airway backup, defibrillation capability, and condition-specific emergency supplies appropriate to the patient and escort scope.
- Maintain cold-chain, controlled-drug, blood-product, and hazardous-material requirements through the entire route.
- Do not rely on the receiving vehicle or aircraft to provide unfamiliar or unconfirmed equipment without explicit verification.

## 16. Documentation and information package

- Completed referral and transfer form with patient identifiers, reason, urgency, accepting clinician/facility, departure plan, and emergency contacts.
- Clinical summary, history, allergies, medication reconciliation, last doses, examination, observations and trends, treatment, response, procedures, and escalation limitations.
- Copies or secure electronic access to laboratory results, ECGs, imaging and reports, blood group/crossmatch information, microbiology, and relevant prior records.
- Pending investigations with named owner and clear instructions for critical-result communication after departure.
- Current medication and infusion chart, controlled-drug record, blood-product documentation, and supplies sent.
- Device details, ventilator settings, oxygen requirement, lines/drains, immobilization, infection precautions, safeguarding, and special equipment.
- Consent/capacity documentation, identity/travel documents where needed, insurance or payment authorization under local policy, and next-of-kin details.
- Transport observation and event record, including departure, arrival, interventions, communications, incidents, and handover receiver.

Original records shall remain available to the referring institution as required by law and policy. Copies and electronic transfers shall protect confidentiality and use approved secure channels.

## 17. Patient and family communication

- Tell the patient and family why transfer is required, where the patient is going, who has accepted, the expected route and timing, and what may happen on arrival.
- Explain that delays or route changes may occur and identify how updates will be provided.
- Provide receiving-facility contact information and, where possible, unit, visiting rules, travel directions, and accommodation resources.
- Clarify whether a relative may travel with the patient. Clinical and vehicle safety take priority; a separate travel plan may be required.
- Protect patient valuables, identity documents, medications, mobility aids, and essential personal items using the approved property process.
- Document information given, consent or refusal, interpreter use, questions, concerns, and family contact details.
- For overseas transfer, clarify what the health system will fund and what expenses may fall to the patient or family, without allowing financial discussions to interrupt emergency care.

## 18. Overseas referral and travel logistics

Overseas transfer adds clinical, legal, financial, immigration, aviation, and family risks. The following tasks shall be coordinated in parallel by clinical and administrative leads:

Domain	Minimum coordination requirement
Clinical destination	Written acceptance, named consultant, facility/unit, intervention capability, bed or admission plan, and emergency contact.
Authorization and funding	Government, insurer, employer, private-pay, guarantee-of-payment, deposit, or other approval under transparent local criteria. Record what is covered and who authorized it.
Identity and immigration	Passport or accepted travel document, visa/entry permission where required, immigration/customs notification, and documents for a guardian or escort. Escalate urgent exceptions through official channels.
Aeromedical clearance	Fit-to-fly or airline medical information, altitude/pressurization risks, oxygen and battery approval, dangerous-goods restrictions, stretcher/seating, mobility and airport assistance.
Door-to-door transport	Ambulance/ground legs to and from airport or port, loading access, receiving team arrival, estimated transit time, and contingency destination.
Clinical escort	Credentialing, scope, indemnity, passport/visa, flight safety training, accommodation, relief, return travel, and equipment repatriation.
Records and confidentiality	Clinical summary, imaging, results, medication chart, consent for disclosure, secure transmission, and language/translation needs.
Family logistics	Travel permission, accommodation, local contact, finances, child/guardian arrangements, communication plan, and psychosocial support.
Counter-referral	Plan for progress reports, discharge summary, return transfer, rehabilitation, medication continuity, and local follow-up.

**Administrative barriers should trigger executive and government liaison, not clinical abandonment. When the patient is too unstable to travel safely, this shall also trigger urgent remote specialist support, local critical-care escalation, and reconsideration of destination or retrieval options.**

## 19. Final pre-departure reassessment and safety pause

The referring clinician and transfer team leader shall complete a final pause immediately before departure and after any material delay or movement onto transport equipment.

- Confirm identity, destination, accepting clinician, urgency, route, estimated arrival, and communication contacts.
- Repeat ABCDE assessment, observations, pain, sedation, neurological status, and condition-specific examination.
- Confirm patient trajectory and that the selected destination, transport mode, escort, and equipment remain appropriate.
- Verify airway and tube security, oxygen and ventilation, vascular access, haemorrhage control, infusions, drains, splints, devices, and temperature protection.
- Confirm medications, fluids, blood, oxygen, batteries, backup equipment, documentation, imaging, valuables, and travel documents.
- Ensure transport and receiving teams have received structured handover and have had an opportunity to ask questions and repeat back critical information.

- State the deterioration plan, possible diversion points, and who has authority to stop, divert, or seek medical control.
- Document the names, date/time, and decision to proceed.

**STOP TRANSFER when: the patient has materially deteriorated; the receiver has withdrawn acceptance; required staff, oxygen, medication, equipment, communication, or documents are unavailable; transport conditions are unsafe; or the transfer benefit no longer exceeds the risk. Escalate immediately.**

## 20. Care during transport

- Secure the patient, staff, trolley, incubator, equipment, oxygen, and loose items according to transport safety requirements.
- Continue the planned monitoring and treatment without interruption during loading, movement, transit, unloading, and transition to receiving equipment.
- Document observations at the locally approved interval and whenever the patient changes or an intervention occurs.
- Maintain access to the airway, vascular lines, critical body areas, emergency equipment, and medication while minimizing pressure injury and hypothermia.
- Use seat belts and remain seated whenever possible. Ask the driver or pilot to stop or land at an appropriate location before undertaking non-immediate interventions when operationally feasible.
- Maintain infection-prevention precautions, PPE, waste control, cleaning, and exposure reporting.
- Update the receiving facility regarding departure, estimated arrival, delay, deterioration, diversion, or change in treatment.
- Do not perform beyond the escort's scope or use unsafe improvisation. Seek medical control or senior advice when uncertainty arises.

## 21. Deterioration, delay, diversion, and emergency events

- Immediately reassess ABCDE and begin indicated emergency treatment within the capabilities and safety of the transport environment.
- Notify transport control/dispatch and the receiving facility; seek remote clinical support when available.
- Stop at or divert to the nearest appropriate facility when continued travel creates greater risk than diversion.
- For air or sea transport, follow the captain/pilot's operational authority while communicating the clinical urgency and required response.
- Document the event, observations, interventions, decisions, communication, route change, and patient response.
- After transfer, report equipment failure, medication error, communication breakdown, injury, exposure, crash, major delay, unexpected resuscitation, or death through the incident system.
- Ensure psychological support and debriefing for staff and family after a major event.

## 22. Arrival, handover, and transfer of responsibility

- Confirm the receiving team and clinical space before moving the patient from transport equipment.
- Continue monitoring and treatment until transition to receiving equipment is complete and safe.
- Provide face-to-face SBAR/ISBAR handover to identified medical and nursing staff, including changes and events during transport.
- Hand over medications, infusions, controlled drugs, blood products, equipment, documents, images, valuables, identity/travel documents, and pending results.

- State current observations, airway/ventilator settings, oxygen, infusions, lines/drains, treatment limitations, infection precautions, safeguarding, and immediate actions due.
- Allow questions and read-back of critical information. Resolve discrepancies before leaving where possible.
- Record the receiver's name, role, date/time, patient status, and formal transfer of responsibility.
- Notify the referring facility and dispatch that the patient has arrived, including stable/unstable status and any significant outcome or feedback.

## 23. Special populations and circumstances

Population / circumstance	Additional safeguards
Neonates and children	Use age/weight-specific equipment, medication, monitoring and thermal care. Prefer specialist retrieval. Ensure guardian consent/status, safeguarding, paediatric airway capability, and destination readiness.
Pregnancy and postpartum	Assess maternal and fetal risk, gestation, labour likelihood, haemorrhage, eclampsia, fetal monitoring, delivery contingency, neonatal support, and receiving maternity/neonatal capability.
Mental-health or behavioural emergency	Confirm legal authority, capacity, risk of self-harm/violence/absconding, least-restrictive measures, safe vehicle, trained escort, medication monitoring, security role, and receiving acceptance.
Highly infectious disease	Coordinate IPC, PPE, isolation route, ventilation, cleaning, waste, exposure management, and public-health notification. Avoid unnecessary exposure during transfer.
Major trauma / spinal injury	Maintain haemorrhage control, immobilization only as indicated, temperature control, analgesia, trauma destination, blood/airway contingency, and direct transfer to definitive care.
Bariatric or mobility-limited patient	Confirm lifting plan, trolley/vehicle/aircraft limits, pressure care, dignity, restraint compatibility, and additional staff/equipment.
Palliative or treatment-limited care	Transfer only when consistent with goals and likely benefit. Hand over resuscitation status, symptom plan, advance directives, family wishes, and medications.
Prisoner / security risk	Separate clinical from custodial decisions; preserve confidentiality and dignity; coordinate restraints, officers, route and receiving security without obstructing clinical access.
Deceased patient or death in transit	Follow local law, death certification, coroner/police, family communication, infection-control, property, transport, and documentation procedures.

## 24. Capacity transfers, repatriation, and counter-referral

- A transfer undertaken primarily because of bed or staffing capacity shall occur only after senior clinical and executive review confirms that local alternatives have been exhausted and the destination is clinically appropriate.
- Capacity pressure shall not justify transfer to a lower or unsuitable level of care.
- Repatriation shall be planned during the specialist admission, with clear criteria for stability, receiving acceptance, medication continuity, equipment, rehabilitation, and follow-up.
- The overseas or receiving facility shall provide a discharge/transfer summary and relevant results before return whenever possible.
- The referring institution shall identify who will receive counter-referral information and resume responsibility after return.

## 25. Cancellation or postponement

- Reassess the patient immediately when transport is delayed, cancelled, or postponed.
- Notify the patient/family, receiving facility, dispatch, referral coordinator, and relevant senior clinicians.
- Document the reason, expected delay, revised clinical risk, interim treatment and monitoring plan, and next escalation time.
- A transfer shall be cancelled when the indication no longer exists, the patient no longer consents with capacity, the receiver cannot provide the required service, the transport risk becomes excessive, or a better local/remote option becomes available.
- Cancellation for financial or administrative reasons in a clinically urgent case shall be escalated to the Medical Director or designated executive immediately.

## 26. Documentation standards

- Decision and rationale: indication, benefit-risk assessment, alternatives, urgency, senior clinician, and time.
- Referral and acceptance: clinicians, facilities, advice, destination, date/time, and contingencies.
- Consent/capacity, interpreter, family communication, financial information, and refusal or disagreement.
- Risk category, transport mode, escort names/competencies, equipment, oxygen, medications, route, and estimated times.
- Stabilization, final reassessment, observation trends, treatment, devices, and readiness decision.
- Departure, transit observations, interventions, events, communications, delay, diversion, and arrival.
- Receiving handover, receiver, status, transfer of responsibility, confirmation to referring facility, and counter-referral plan.
- Incidents, equipment failures, staff injury/exposure, complaints, and learning actions.

## 27. Quality indicators and audit

Indicator	Suggested measure
Acceptance before departure	Percentage of transfers with named receiving clinician/facility and documented acceptance.
Risk assessment	Percentage with senior documented risk category and escort/equipment plan.
Pre-transfer stabilization	Percentage with final ABCDE reassessment and completed checklist.
Critical information	Percentage with referral form, medication list, results/imaging, and pending-result ownership.
Transport monitoring	Percentage with complete observation/event record appropriate to risk.
Handover completion	Percentage with named receiver, arrival time, and verbal/written handover.
Timeliness	Decision-to-referral, acceptance, transport request, departure, and arrival intervals by priority.
Adverse events	Deterioration, cardiac arrest, unplanned airway intervention, medication/equipment incident, diversion, injury, death, and major delay.
Equity	Transfer authorization, destination, delay, and outcomes reviewed by clinical need, funding route, age, sex, residence, disability, and other locally lawful equity variables.

Indicator	Suggested measure
Patient/family experience	Understanding, communication, dignity, financial transparency, and support.
Counter-referral	Percentage of overseas transfers with discharge summary, return plan, and local follow-up documentation.

## 28. Education, competency, and implementation

- All clinicians, nurses, dispatch staff, referral coordinators, and transport providers shall receive orientation to the transfer pathway, SBAR, risk assessment, checklists, and stop-transfer authority.
- Clinical escorts shall have documented role-specific competence in resuscitation, transport equipment, monitoring, oxygen, infusions, communication, patient packaging, and emergency procedures.
- High-risk transfer competence should include simulation of airway failure, oxygen depletion, pump failure, haemodynamic deterioration, seizure, obstetric delivery, paediatric deterioration, behavioural crisis, infection exposure, and diversion.
- The hospital shall maintain an updated directory of referral facilities, services, consultants, transport providers, airports/ports, immigration contacts, funders, and escalation authorities.
- Standard forms, referral templates, observation records, equipment packs, and checklists shall be available in the ED and transport service at all times.
- Implementation shall begin with local configuration, multidisciplinary tabletop testing, baseline audit, pilot transfers, review of near misses, and formal approval.
- The protocol shall be reviewed after any serious transfer incident, change in overseas referral arrangements, transport contract, law, national policy, or major clinical guidance.

## 29. References and source frameworks

1. World Health Organization. Prehospital emergency care: operational guidance for ambulance systems. 2025.
2. World Health Organization. Emergency Care Toolkit and Standardized Clinical Forms.
3. World Health Organization. Acute Transfer Checklist for sending health facility teams.
4. World Health Organization. Acute Referral Form.
5. World Health Organization. Interfacility Acute Transfer Checklist for transport teams.
6. World Health Organization. SBAR Handover Tool.
7. World Health Organization. Infection prevention and control during transfer and transport of patients with suspected or confirmed COVID-19. Updated 2022; principles applied to transmissible infections generally with local IPC guidance.
8. World Health Organization and International Committee of the Red Cross. Basic Emergency Care: approach to the acutely ill and injured. 2018.
9. Faculty of Intensive Care Medicine and Intensive Care Society. Guidance on the Transfer of the Critically Ill Adult. 2019.
10. Faculty of Intensive Care Medicine and Intensive Care Society. Guidelines for the Provision of Intensive Care Services, Version 3. 2026.
11. Local legislation, professional standards, overseas referral policy, ambulance/aeromedical contracts, infection-control policy, controlled-drug rules, aviation/maritime requirements, immigration rules, and funding authorization procedures.

## Annex A. One-page interfacility and overseas transfer workflow

Step	Action	Minimum requirement
1	Need	Identify unavailable service/capability and expected benefit.
2	Urgency	State clinical deadline and consequences of delay.
3	Stabilize	Address ABCDE threats and complete non-transportable interventions.
4	Accept	Named receiving clinician, facility, unit, advice, and bed/admission plan.
5	Risk	Assign transfer risk; match escort, mode, monitoring, equipment, oxygen, and contingency.
6	Coordinate	Dispatch, route, weather/security, overseas authorization, immigration, funding, ground legs, family.
7	Prepare	Records, results, imaging, medication, devices, supplies, valuables, travel documents.
8	Pause	Final reassessment and pre-departure checklist; stop if unsafe.
9	Transport	Monitor, treat, document, update receiver, divert if required.
10	Handover	SBAR verbal + written transfer, transition equipment, named receiver.
11	Confirm	Notify referring facility/dispatch; record arrival and patient status.
12	Follow through	Counter-referral, equipment reconciliation, incident review, family support.

## Annex B. Transfer decision and benefit-risk checklist

Decision point	Record
Required care unavailable locally	Yes / No / Uncertain
Expected benefit exceeds risk of transfer and delay	Yes / No / Uncertain
Alternative local, remote, or visiting-specialist option considered	Yes / No / Not applicable
Clinical priority and latest safe departure stated	Priority: ____ Deadline: ____
Receiving facility and named clinician accepted	Name / facility / date-time: _____
Destination can provide required intervention/level of care	Confirmed by: _____
Patient/representative informed and consent/capacity documented	Yes / No / Emergency exception
Senior clinician authorizes transfer	Name / signature / date-time: _____

## Annex C. Transfer risk and escort matrix - local approval required

Risk domain	Low	Moderate	High
Physiology / trajectory	Stable; low deterioration risk	Recent abnormality or active treatment	Unstable, deteriorating, or organ support
Airway / breathing	Self-maintained; simple O2	Significant O2/NIV risk or airway concern	Intubated/ventilated or likely airway intervention
Circulation	No active bleeding or vasoactive support	Fluid/infusion needs or recent instability	Active bleeding, shock, vasoactive support
Neurology / behaviour	Alert/cooperative	Altered, seizure risk, agitation	Severe impairment, refractory seizure, high restraint/sedation risk
Journey	Short, predictable, easy access	Longer, limited access, weather/route risk	Air/sea, prolonged, remote, difficult diversion
Suggested escort	Approved clinician	Advanced clinician +/- second escort	Specialist retrieval/critical-care team

*Final category and escort selection are clinical judgments. Complete the locally approved risk tool and record rationale, competencies, and contingency plan.*

## Annex D. Referral and acceptance record (SBAR/ISBAR)

Field	Information
Identification	Patient identifiers, age, sex, weight, location, referring clinician/contact
Situation	Reason for transfer, diagnosis/syndrome, urgency, required intervention, clinical deadline
Background	History, comorbidities, allergies, medications, pregnancy, baseline function, key investigations
Assessment	ABCDE, observations/trends, severity, trajectory, treatment and response, current support
Recommendation	What is requested, destination/unit, pre-transfer advice, contingency if delayed
Acceptance	Receiving clinician/service/facility, date-time, contact, bed/admission plan
Read-back	Key information repeated and uncertainties resolved: Yes / No

## Annex E. Pre-departure transfer checklist

Check	Required confirmation
Identity / destination	Two identifiers; receiver; facility/unit; route; priority; contacts
Patient	ABCDE optimized; observations; pain/sedation; glucose; temperature; pressure care
Airway / breathing	Device secured; ventilator trial; suction; oxygen; backup; chest drains



Check	Required confirmation
Circulation	Bleeding controlled; access secured; fluids/blood/infusions; pump and spare
Neurology / safety	GCS/mental state; seizures; restraints; immobilization; falls/absconding risk
Equipment	Monitor, defibrillator, suction, airway kit, batteries, charging, secured/stowed
Medications	Journey supply + delay reserve; labels; controlled drugs; antidotes; cold chain
Documents	Referral form; summary; results; imaging; medication chart; consent; pending results
Overseas	Passport/visa/entry; payment authorization; fit-to-fly; airline/air ambulance; ground legs
Communication	Transport team and receiver handover; ETA; family informed; contingency agreed
Final pause	Senior clinician and transfer leader agree benefit > risk and conditions remain safe

## Annex F. Equipment, oxygen, medication, and power worksheet

Item	Requirement / calculation	Checked by
Oxygen	Device flow/consumption: ____ Estimated door-to-door duration: ____ Locally required delay reserve: ____ Total available: ____	
Ventilator / monitor	Settings, battery life, mains/vehicle compatibility, spare battery, mounts, alarms	
Infusions	Drug/concentration/rate, volume needed for journey + delay, spare syringe/bag, pump battery	
Emergency medication	Condition-specific and resuscitation medications; expiry; temperature/security	
Airway / suction	Primary and backup airway, suction, bag-mask, filters, humidification as applicable	
Other devices	Defibrillator, incubator, splints, chest drain, pumps, blood warmer, PPE, waste	
Communication	Charged phone/radio, numbers, charger/power bank, dead-zone contingency	

## Annex G. Transport observation and event record

Date/time	Location / phase	HR	BP	RR	SpO2	O2 / ventilation	Neuro	Temp	Treatment / event / response

Date/time	Location / phase	HR	BP	RR	SpO2	O2 / ventilation	Neuro	Temp	Treatment / event / response

*Record observations at the locally approved interval, after every intervention, and whenever condition changes. Include communication, delay, diversion, equipment issue, medication, and handover.*

## Annex H. Overseas transfer coordination checklist

Domain	Completed / details
Clinical acceptance	Facility, consultant, unit, intervention, bed/admission plan, contacts
Funding authorization	Funder, authorization number, guarantee/deposit, exclusions, family informed
Travel documents	Patient passport/visa/entry; guardian/escort documents; urgent immigration liaison
Transport	Air ambulance/commercial/sea; booking; fit-to-fly; oxygen/battery approval; stretcher/seating
Ground transfers	Referring hospital to port/airport; destination port/airport to receiving hospital
Escort	Names, competencies, credentialing, indemnity, flight safety, accommodation and return
Clinical package	Summary, imaging, results, medication, blood data, consent, secure transmission
Family	Contact, travel companion, accommodation, communication, child/dependent arrangements
Contingency	Weather/delay/diversion, alternative facility, medical control, extra supplies
Counter-referral	Progress contact, discharge summary, return transport, local receiving clinician

## Annex I. Patient and family information prompts

- Why transfer is needed and what care is unavailable locally.
- Receiving hospital, clinician/service, route, expected timing, and contact details.
- Expected benefits, material risks, alternatives, and what may happen if transfer is delayed or refused.
- What the patient may take; handling of valuables, medicines, passport, mobility aids, and equipment.
- Whether a relative may travel and what separate travel/accommodation arrangements are needed.
- What costs are covered, possible out-of-pocket costs, and whom to contact about funding.
- How updates will be provided and whom to call if plans change.
- How return, counter-referral, rehabilitation, and local follow-up will be arranged.

## Annex J. Arrival, handover, and completion record

Field	Record
Arrival	Date/time: ____ Receiving facility/unit: ____ Patient status: Stable / Unstable / Deceased
Medical receiver	Name / role / signature / date-time: _____
Nursing receiver	Name / role / signature / date-time: _____
Handover	Verbal SBAR completed; documentation/imaging/medication/property transferred; questions resolved
Equipment transition	Oxygen, ventilator, monitor, infusions, devices and drains safely transitioned
Referring facility notified	Person notified / date-time / patient status: _____
Feedback / incident	None / details / incident number: _____

## Annex K. Transfer incident, delay, diversion, or cancellation record

Field	Record
Event type	Delay / cancellation / deterioration / diversion / equipment / medication / injury / exposure / other
Date/time and phase	_____
Clinical and operational circumstances	_____
Actions and communication	_____
Patient outcome	_____
Immediate escalation	_____
Incident report / review lead	_____
Learning and corrective action	_____

## Annex L. Transfer audit tool

Audit item	Result
Clinical need and benefit-risk documented	Yes / No / N/A
Priority and latest safe departure recorded	Yes / No / N/A
Named receiving clinician/facility accepted	Yes / No / N/A
Senior risk assessment and escort match	Yes / No / N/A
Final ABCDE reassessment and checklist	Yes / No / N/A
Required oxygen/equipment/medication/power verified	Yes / No / N/A
Complete referral, results, imaging and medication information	Yes / No / N/A
Consent/capacity/family communication documented	Yes / No / N/A
Transport observations and events complete	Yes / No / N/A

Audit item	Result
Arrival, named receiver and responsibility transfer documented	Yes / No / N/A
Overseas authorization/travel/counter-referral complete if applicable	Yes / No / N/A
Delay, incident or equity concern reviewed	Yes / No / N/A

## Annex M. Local configuration table

Local element	Approved configuration
Transfer clinical lead	[Name / role / contact]
Executive escalation authority	[Name / role / 24-hour contact]
Ambulance/dispatch contacts	[Local numbers and priority definitions]
Aeromedical and maritime providers	[Providers, contracts, contacts, capabilities]
Approved referral facilities	[Service matrix, consultants, acceptance routes]
Overseas referral authorization	[Clinical and financial decision pathway]
Immigration / airport / port liaison	[Contacts and urgent exception process]
Transfer priority response targets	[Complete after agreement with transport providers]
Risk tool and escort standards	[Attach approved tool and competency matrix]
Oxygen reserve calculation standard	[Approved formula and reserve]
Equipment and medication packs	[Location, owner, check frequency]
Communication / medical control	[Phone/radio channels and escalation]
Incident reporting and audit owner	[System / lead / review schedule]
Counter-referral and repatriation process	[Responsible office / clinician]

## Annex N. Approval and sign-off

Review / approval role	Name	Signature	Date
Emergency Department Lead			
Nursing Director / ED Nurse Manager			
Medical Director / Clinical Governance			
Ambulance / Transport Service Lead			
Anaesthesia / Critical Care Lead			
Paediatric / Maternity Lead			
Overseas Referral / Finance Lead			
Infection Prevention and Control			
Hospital Executive Approval			

Implementation note: This draft becomes operational only after completion of all local configuration fields, approval of priority and responsibility models, confirmation of referral and transport agreements, validation of equipment and escort standards, staff education, simulation, and publication of the current contact directory.