Hyper-Acute Stroke Services Review

Repatriation Policy

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Repatriation Policy

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1 Aim

• To support effective patient flow and the efficient use of hyper-acute stroke bed capacity, particularly where hospital bypass policies are in place;
• To provide equitable access to comprehensive stroke care in a timely manner, delivered as close to home as possible;
• To facilitate the equitable delivery of tertiary treatments for acute stroke;
• To provide guidance on timely and appropriate repatriation of all patients including those who are “stroke mimics”.

2 Scope

Patients with stroke who require transfer to a hospital closer to their home having received hyper-acute stroke unit (HASU) or tertiary level stroke care or, if having been assessed, are found to have a non-stroke diagnosis following admission onto a HASU.

3 Monitoring

The following will be monitored on a regular basis:

• HASU length of stay (LoS) for patients who are to be repatriated to their closest Trust;
• Any delays in transfer and LoS in dedicated stroke units for stroke patients who are to be repatriated to their closest Trust;
• The number of stroke mimics, LoS, transfer destinations and issues around repatriation.

4 Underpinning Principles of the Protocol

• Patients who require repatriation are identified by a stroke / tertiary care consultant and the decision communicated to the patient, carers and receiving unit as soon as possible;
• Once the decision has been made it must be supported by the appropriate documentation and communicated to the staff who will organise the safe transfer for the patient, in accordance with the relevant transfer guidelines;
• Transfer of a patient to another Trust, closer to their home, to continue specialist care or re-enablement following specialist hyper-acute or tertiary care should occur within 48 hours of the decision to transfer;
• Prompt escalation of issues by both the referrers and receiving Trusts is to be made in line with the protocol, 7 days per week, 365 days a year;
• When escalation is due to there being no available bed for the transfer, the checklist of activities should be completed and verified to confirm the internal escalation process has been exhausted;
• If the two respective directors agree a plan which is outside of the 2 calendar day standard, then the safe transfer must be organised (ambulance transfer booked, etc.) shortly after the agreement is made. It is then the responsibility of the Clinical Service Unit to ensure that the plan is carried out and to escalate to the senior manager responsible, if for any reason the plan cannot be carried out.
5 Operating Protocol

5.1 Stroke admissions to HASU and tertiary care beds (TCB)

A patient is to be repatriated as soon as their treatment on the HASU or in a TCB is completed and a medical decision has been made that it is safe to transfer them. The 3 stage process below should be followed for the transfer:

1. Pre-notification: When a patient is admitted to HASU or a TCB, the stroke / tertiary care team should ascertain whether they are potentially eligible for transfer to their closest acute/rehabilitation stroke service (‘the service’) following treatment on the HASU / TCB. The stroke nurse in charge should contact the service immediately to inform them. This should include communication of the patient details and an expected discharge date (EDD). The patient and patient’s relatives/carers should also be informed of the intention to transfer the patient to the acute/rehabilitation stroke unit following completion of treatment on the HASU / TCB.

2. Daily updates: The HASU / tertiary care ward should update the receiving service every day (including weekends) on the progress of ‘their’ patients (including MRSA status and special requirements (e.g. mattresses), along with the expected date and time of repatriation. An electronic file of patients could be shared between HASU services on a daily basis.

3. Discharge: Once the HASU or tertiary phase of care is over, the HASU / tertiary care medical team will decide if the patient is medically stable for transfer. The HASU / tertiary care medical team should contact the stroke team at the receiving service to discuss any issues and ongoing care needs. This should be pre-empted and acted on quickly.

The receiving service should have arrangements in place to ensure that the relevant medical team is informed; during the out of hours period this may be the on-call medical team covering the wards. Reasons for this include:

- Repatriated patients will need an immediate medical assessment when they arrive at the receiving service since they may still be in an early stage after their stroke at the time of repatriation, and therefore this differs from most inter-hospital transfers;
- The receiving Trust would have accepted the patient in the first place had they not been diverted to the HASU for hyper-acute care, or would have transferred the patient for tertiary treatment, so this arrangement does not impose any additional workload on the on-call team;
- Transport delays could cause a patient referred during normal working hours to arrive out of hours. Handover of medical care to the on-call medical team will ensure their review by a senior physician on arrival, something that the local stroke team may not be able to guarantee out of hours.

The transfer should be organised in the same way that inter-facility transfers are usually handled, (and are planned not emergency transfers) Appendix 1. It is good practice for the transfer of patients to take place between 9 am and 4 pm, 7 days a week. It is the responsibility of one of the HASU/tertiary care nurses to ensure that copies of all relevant patient notes (medical, nursing and therapies) accompany patients repatriated to the receiving dedicated stroke unit. Radiological images should be made available on PACS. The MRSA status of patients should not delay transfer. It remains the responsibility of HASU/tertiary care staff to forward any outstanding results regarding the MRSA status.
5.2 Non-Stroke HASU Admissions

The experience of centres providing HASS is that approximately 30% of patients attending for assessment have not had an acute stroke. These patients fall into 2 broad categories:

- **TIA’s**: Patient’s symptoms are consistent with an ischaemic cerebrovascular event, but have resolved by the time of assessment. Patients enter the TIA pathway and are currently triaged according to their ABCD2 score into high-risk and low-risk categories. At present high-risk patients should be assessed within 24 hours whilst low-risk patients should be assessed within 7 days. HASS with bypass arrangements need to have an SOP for the timely management of these patients.

- **“Stroke mimics”**: Many patients with conditions that simulate acute stroke (e.g. migraine, seizures) do not require admission, in which case once a clinical decision is made, they may be discharged directly home, with advice to their GP to arrange local outpatient follow-up (e.g. neurology) if appropriate.

- **Patients admitted but subsequently found not to have had a stroke**: These patients should either be discharged home directly or should be transferred from HASU to their closest Trust within 48 hours of a non-stroke diagnosis being made, once they are stable enough to be transferred. The bed manager should arrange with their counterparts at their closest trust to alert them that a non-stroke patient requires repatriation to a non-stroke bed.

6 HASU / TCB Discharge Policy

**On admission to HASU / TCB:**

- Admitting clinician to stipulate EDD;
- HASU / TCB consultant to decide whether patient is fit for transfer to dedicated stroke unit of Trust closer to home;
- Receiving stroke unit to be contacted immediately (within 12 hours) to inform them of EDD (including weekend and Bank Holiday);
- Stroke mimics to be identified, and appropriate destination specialty decided upon and contacted via bed manager.

**Daily Update:**

- HASU / TCB team to update receiving stroke unit of EDD, MRSA status and special requirements for patients;
- Potential discharges (home, transfer to receiving stroke unit, transfer to other team) to be identified and fitness for transfer confirmed.

**Discharge Home:**

- Inform the receiving stroke unit that patient will not be transferred;
- Produce a comprehensive discharge summary;
- Arrange the follow-up under receiving Stroke Consultant Physician.

**Transfer to receiving Stroke Unit:**

- HASU / TCB team to contact receiving stroke unit to inform the patient is safe to transfer;
- HASU / TCB nurse in charge to arrange transfer;
• HASU / TCB nurse responsible for copies of all patients notes accompanying patient.

Transfer to Other Teams:
• Stroke / TCB team to contact appropriate on-call team to accept transfer;
• HASU / TCB nurse in charge to confirm and arrange impending transfer;
• HASU / TCB nurse responsible for copies of all patient’s notes accompanying the patient.

7 Escalation Policy

It is imperative that stroke patients are transferred from HASU / TCB to a designated stroke unit, within a stroke service. In the event that the patient is transferred to a bed that is not on a dedicated stroke unit this should be reported as a ‘Never Event’.

The admitting HASU / TCB should notify the receiving dedicated stroke unit of the planned transfer of the patient. Ideally, this request should take place before 11am on the day of the proposed transfer (after the HASU / TCB ward round). Escalation of non-transfer should involve the following 4 levels:

**Level 1** - In the unlikely event that the receiving stroke unit does not accept the patient for a medical reason, the HASU / TCB consultant will discuss the case with the receiving stroke team consultant immediately or within 2 hours of notification of transfer. If the receiving stroke unit does not accept the patient for a non-medical reason, the HASU / TCB ward manager should contact the receiving stroke unit ward manager immediately or within 2 hours of notification.

**Level 2** - If repatriation is still delayed 6 hours beyond the notification time, this should be raised to the matron and bed manager on call for both sites.

**Level 3** - If this has still not been resolved 8 hours after the notification, the case should be escalated to the next level to the general manager or the managers on-call for both sites by the HASU / TCB.

**Level 4** - If this has not been resolved 12 hours after the initial notification of transfer, the designated senior manager should be informed. At the weekends the issue should be escalated to the designated senior manager, e.g. on-call manager.

A record should be kept of the number of times the escalation policy is used and the level (levels 1 to 4 above) to which it was invoked. Responsibility for record-keeping should be clearly defined. Where level 4 of the escalation policy has been reached this should be reported as a ‘Never Event’.

8 Stability for Repatriation

The NEWS (National Early Warning System) tool is a scoring system based on physiological variables, similar to that used in ‘early warning scores’ to flag up potentially sick patients on medical or surgical wards. NEWS provides guidance only and the consultant should use their discretion when assessing whether a patient is medically stable for transfer.

The patient’s GCS should not be per se the criterion for delaying transfer, so long as it has not deteriorated significantly within the previous 24 hours. For other physiological variables the following scoring system is agreed:

Patients discharged home from HASU will normally score 0 and have a GCS of 15 (unless dysphasic). Contraindications for transfer to a receiving stroke unit include:

• Any single score of 3;
• A total score of ≥3;
• An increase in score of ≥2 in the preceding 24 hours;
• A decrease in GCS of ≥2 in the preceding 24 hours.

Patients should not be transferred with feed running in their NG tubes.

9 Guidance on Transport for Transfers (Appendix 1 p7)

Repatriations from HASU are not time critical emergencies the majority can be planned through non-emergency transfer teams. If on day transfer required follow the Inter Facility Transfer Guidance (Appendix 1 page 7) to support staff the list below highlights the skills of YAS staff. Paramedic skills are required for the undiagnosed 999 population and if requested will delay any transfer request. See table below for skill set in pre-hospital care.
## Guidance on Transport for Transfers

All ambulance staff below are equipped to defibrillate, monitor and recognise and initially manage a patient in arrest (YAS clinical skill set 2015).

<table>
<thead>
<tr>
<th>Can respond to emergency incidents</th>
<th>Paramedic (PARA)</th>
<th>Emergency Medical Technician 1 (EMT1)</th>
<th>Emergency Medical Technician 2 (EMT2)</th>
<th>Advanced Emergency Medical Technician (AEMT)</th>
<th>Emergency Care Assistant (ECA)</th>
<th>Assistant Practitioner (AP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Primary &amp; secondary assessment: LOC, BP, BM, P, R, Temp, ABCDE, NEWS, GCS</td>
<td>All</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>3 and 12 lead ECG placement</td>
<td>All</td>
<td>YES verification of trace</td>
<td>YES</td>
<td>YES Interpretation</td>
<td>YES Interpretation</td>
<td>YES Verification of trace</td>
</tr>
<tr>
<td>Intubation: <em>Use suction, BVM, AED Airway Management</em></td>
<td>All</td>
<td>All in bold</td>
<td>All in bold</td>
<td>All in bold</td>
<td>All in bold</td>
<td>All in bold</td>
</tr>
<tr>
<td>Maternity</td>
<td>All</td>
<td>Recognition of Normal Birth</td>
<td>Management</td>
<td>Management</td>
<td>Recognition of Normal Birth</td>
<td>Recognition of Normal Birth</td>
</tr>
<tr>
<td>Drugs:</td>
<td>JRCALC drugs</td>
<td>Oxygen and Entonox</td>
<td>Anaphylaxis; Glucagon; Ventolin; O₂; Aspirin; Entonox; GTN</td>
<td>Anaphylaxis; Glucagon; Ventolin; O₂; Aspirin; Entonox; GTN</td>
<td>Oxygen and Entonox</td>
<td>Oxygen and Entonox</td>
</tr>
<tr>
<td>Transportation after immediate drug therapy</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

*Intubation: Use suction, BVM, AED Airway Management*
10 Transfer Documentation

For safe and high quality transfers, comprehensive discharge documentation is crucial. Details of the requirements for this are set out below for HASU patients:

<table>
<thead>
<tr>
<th>For Stroke HASU Patients – Discharge Documentation</th>
<th>For Stroke HASU Patients – Transfer Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Team</strong></td>
<td><strong>Nursing and Therapy</strong></td>
</tr>
<tr>
<td>Date of stroke;</td>
<td>MRSA status;</td>
</tr>
<tr>
<td>History and examination findings;</td>
<td>Communication issues (e.g. language, hearing</td>
</tr>
<tr>
<td>NIHSS score;</td>
<td>aids);</td>
</tr>
<tr>
<td>Bamford classification;</td>
<td>Continence status (e.g. reason for urinary</td>
</tr>
<tr>
<td>Tests and results including scans;</td>
<td>catheter);</td>
</tr>
<tr>
<td>Thrombolysis decision, outcome and adverse</td>
<td>Pressure areas and wounds (incl. Waterlow</td>
</tr>
<tr>
<td>events;</td>
<td>score);</td>
</tr>
<tr>
<td>Medication;</td>
<td>Nutrition status (incl. weight, BMI, NG tube);</td>
</tr>
<tr>
<td>Follow-up arrangements.</td>
<td>Swallowing issues;</td>
</tr>
<tr>
<td></td>
<td>Mobility and other nursing needs;</td>
</tr>
<tr>
<td></td>
<td>Social circumstances;</td>
</tr>
<tr>
<td></td>
<td>Details of referrals (e.g. district nurse).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Team</th>
<th>Nursing and Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of stroke;</td>
<td>MRSA status/whether side room required;</td>
</tr>
<tr>
<td>History and examination findings;</td>
<td>NEWS score;</td>
</tr>
<tr>
<td>NIHSS score;</td>
<td>Communication issues (e.g. language, hearing</td>
</tr>
<tr>
<td>Bamford classification;</td>
<td>aids);</td>
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<tr>
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<td>events;</td>
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</tr>
<tr>
<td>Medication;</td>
<td>score);</td>
</tr>
<tr>
<td>Follow-up arrangements.</td>
<td>Nutrition status (incl. weight, BMI, NG tube);</td>
</tr>
<tr>
<td>Advice regarding suggested further investigation</td>
<td>Swallowing issues;</td>
</tr>
<tr>
<td>and management.</td>
<td>Mobility and other nursing needs;</td>
</tr>
<tr>
<td></td>
<td>Social circumstances;</td>
</tr>
</tbody>
</table>

For Non-Stroke HASU Patients

- Diagnosis;
- History and examination findings;
- Tests and results;
- Medication chart;
- Advice regarding further follow up.
Appendix 1

IFT Guidelines V2.pdf