Standard Operating Procedure (SOP) – Management of Breast Cancer Referrals during COVID-19

1 Purpose of the Document

Following the COVID-19 outbreak Queen Victoria Hospital NHS Foundation Trust (QVH) has been assigned to act as a surgical referral centre for head and neck, breast and skin cancers in agreement with the NHSI/E, South East (SE) commissioners, the Kent and Medway Cancer Alliance and the Surrey and Sussex Cancer Alliance.

This Standard Operating Procedure (SOP) is designed to explain the actions, roles and responsibilities of referring Trusts and QVH in the management of breast cancer cases during COVID-19.

This document should be read in conjunction with the following documents:

Regional guidance:

- Appendix 1 - Breast Cancer Management Guidance in Response to COVID-19
- Appendix 2 - Advice on maintaining cancer treatment during the COVID-19 response

QVH SOPS and information:

- Appendix 3 - Adult transfer and discharge policy
- Appendix 4 - Breast cancer surgery referral proforma
- Appendix 5 - Breast PCR / swab process

The purpose of this document is to outline the key principles and to detail the tertiary referral processes between referring Trusts and QVH, to ensure the robust transfer of and management of patients.

2 General Principles

The aim is to ensure the provision of breast cancer surgery for patients in Kent, Surrey and Sussex during COVID-19.

QVH will be working in line with and following the Breast Cancer Management Guidance developed by COVID-19 South East cancer cell.

The SOP relates to admitted day case and in patient surgical procedures under general anaesthetic in line with clinical requirements. The SOP excludes the management of non-QVH 2ww and diagnostic requirements, which are not within scope.

The QVH will be designated as a COVID-19 free site.

Provision will be made for visiting surgeons to conduct procedures at QVH.

Referring Trusts should limit the number of surgeons undertaking operating on the QVH site, preferably to one.
3 Referral Procedure

3.1 Clinical decision making
Patients will be referred to QVH for breast cancer surgery through the Multidisciplinary Team (MDTs) in line with existing established process.

MDTs will determine patients appropriate for surgery at QVH in line with current guidance set out in the ‘Breast Cancer Management Guidance in response to COVID-19’. Pre assessment processes will ensure suitability for QVH site.

At the point of Decision to treat (DTT) referring clinicians will discuss the outcome of the MDT with the patient and advise to self-isolate for up to 14 days

3.2 Referral process
The referral to QVH should be made on the QVH referral proforma (please see appendix 4).
4 Scheduling, pre assessment and screening

4.1 Scheduling
On receipt of the referral (from the QVH referrals team) the QVH dedicated breast cancer schedulers will contact/ liaise with the referring trust scheduler and the patient by telephone to arrange a To Come In (TCI) date and pre assessment date for surgery.

The referring trust and QVH scheduler will agree the date of transfer by NHS courier of patient health records.

The referring trust scheduler will inform the patient of requirements for pre assessment and COVID-19 PCR / swab testing.

QVH schedulers will confirm, with the patient via telephone and writing, information relating to admission and pre admission screening.

If further investigations are required prior to admission, the referring trust will communicate with the QVH scheduler to rearrange TCI and pre assessment date.

The scheduler will then send a confirmation letter and information booklet to the patient.

4.2 Pre Assessment
Patients requiring an inpatient admission will complete a full pre-assessment at the referring Trust organised by the referring trust scheduler.

Patients will need to be ASA1 and ASA2 and any exceptions will require a discussion between consultant and anaesthetist for specific lists.

Where possible, patients will attend a telephone pre-assessment appointment with QVH staff. Where this is not possible, the anaesthetist will review the patient’s notes the day before admission.
4.3 Screening

In order to maintain a COVID-19 free site all patients will require screening ahead of admission including PCR/swab test, temperature check and non-contrast CT chest as follows:

**COVID-19 Elective Screening Process**

Patient contacted by the scheduling team, informing the patient of the screening process at QVH

The patient will undergo PCR swabbing at the referring trust, at least 48hrs before the admission date.

- **Positive PCR swabbing**
  - The admission will be deferred and the patient will be informed to further self-isolate for 14 days, by the scheduler. A further admission date will be arranged with the patient following the isolation period.

- **Negative PCR swabbing**
  - The patient will have a temperature check and a non-contrast CT chest on the day of admission
    - **Positive**
      - The patient will be informed to self-isolate for 14 days, by the consultant. A further admission date will be arranged with the patient following the isolation period.
    - **Negative**
      - Proceed with admission
5 Admission
On arrival to QVH, patients will report to Radiology and receive a temperature check, clinical assessment (to check the patient is asymptomatic) and non-contrast CT of chest.

If the CT of chest and temperature are normal, patients will be advised to proceed to the admitted ward areas.

If results are of concern, patients will be advised by their Consultant / Registrar that the surgery will be deferred to an alternative date. The patient will be advised to self-isolate for a further 14 days. The consultant will inform the scheduler to rearrange the TCI date.

During the patient stay, the patient will be under the care of the admitting visiting breast Consultant, out of hours care will be covered by the QVH on call Plastics Consultant / Registrar.

The patients will be supported by their local Breast Care Nurse postoperatively on discharge.

In the event of patients requiring an emergency transfer from QVH, the QVH Adult Transfer and Discharge Policy should be followed (please see appendix 3).

6 Patient follow up arrangements
Breast cancer patients will receive their follow up care at their referring Trust.

The QVH operating notes will be photocopied following the surgery, with the original documentation placed in the patients’ medical records from the local hospital and the photocopy uploaded onto QVH Evolve (EDM) system for recording purposes only.

For future access and reference purposes, all breast cancer patients admitted to QVH will be managed and reported through Patient Centre system (PAS).

If patients experience post-operative complications the patient should contact the Site Practitioner/ Trauma Coordinator team (01342 414000) to discuss further management with the on call Plastics Consultant/ Registrar and host surgeon.

The histopathology slides will be sent to and processed at the referring Trust. These will be transported via Medical Moves to the referring trust histopathology laboratory.

It is the responsibility of the local Trust to arrange appropriate follow up at the local trust.

7 MDT follow up
Following surgery the MDT co-ordinator at QVH will send across the operation notes to the relevant MDT local coordinators.

The MDT should then review the patient and agree the treatment and future care plans.
8 Transport
Patients should make their own travel arrangements to QVH where possible.
If patients require hospital transport for admission to QVH this must be arranged by the local trust or Breast Care Nurse.
Further transport options are being explored via volunteers.

9 Key QVH Contacts

- Cancer, Access and Performance Manager:
  Victoria Worrell victoria.worrell2@nhs.net

- General Manager:
  Kathy Brasier k.brazier@nhs.net
Breast Cancer Management Guidance in Response to COVID-19

The following guidance has been produced by the COVID-19 South East Cancer Cell, 30th March 2020

1 Key Points

- For use to determine access to services when capacity is limited
- Higher priority chemotherapy will have protected access to available capacity
- Priority is determined by the absolute benefit a therapy provides to patients receiving that therapy

2 Purpose of document

The following is guidance for the provisioning of Breast cancer services during the period of the COVID-19 pandemic and its emergency management. It is intended to guide and support decisions made locally/regionally within Breast MDTs. These should not be viewed as being prescriptive, rather as a support for local decision making and should be used alongside Department of Health guidance.

3 GP referral to clinic

The emphasis is on the triage of the referral once received rather than putting off the referral. This is so that patients are logged in the system even if the decision is to defer treatment for now. Cancer cell are working on deferral codes and there will be central guidance on this to follow:


Letter to go out with breast clinic appointment stating new model of appointment and guidance regarding actions should they have symptoms of COVID-19 or live with someone who is self-isolating.

3.1 Triage of Referrals

- See only referrals where there is a higher index of suspicion of cancer, providing that there are staff to run clinics.
- Write to or phone referrals with a lower index of suspicion of cancer e.g. breast pain
- Very frail elderly patients, especially if in nursing homes, referred with suspicious lumps should not be seen in clinic until the situation has changed. If the Government introduces self-isolation for people 70 and over then consideration should be given as to whether these patients should be seen in the clinic. Older patients especially with co-morbidities are at highest risk of
death from coronavirus and they should be seen once the pandemic is over. Start on endocrine therapy empirically.

Note: potential to roll out ‘Nottingham model’ for breast demand management. This is currently being rolled out in Brighton University Hospital. Contact the relevant Cancer Alliance for more details.

4 New Cancer Patients

4.1 Surgical

4.1.1 Categorisation of Patients

Priority level 1a
• Emergency: operation needed within 24 hours to save life

Priority level 1b
• Urgent: operation needed within 72 hours

Based on: urgent/emergency surgery for life threatening conditions such as obstruction, bleeding and regional and/or localised infection permanent injury/clinical harm from progression of conditions such as spinal cord compression

Priority level 2
Elective surgery with the expectation of cure, prioritised according to:
• within 4 weeks to save life/progression of disease beyond operability based on:
  – urgency of symptoms
  – complications such as local compressive symptoms
  – biological priority (expected growth rate) of individual cancers

Local complications may be temporarily controlled, for example with stents if surgery is deferred and/or interventional radiology.

Priority level 3
Elective surgery can be delayed for 10-12 weeks if they have no negative predicted outcome.

Availability of anaesthetists and theatre staff must be considered.

4.1.2 Surgical Recommendations

• Clip put in all cancers when biopsy performed
• Aim for day case surgery in majority of patients
• If theatre space is limited, surgical priority given to ER negative patients first.
• No immediate breast reconstruction. Mastectomy and delayed reconstruction being offered at a later date
• If insufficient theatre capacity, post-menopausal ER+ patients to be commenced on primary endocrine. If not enough theatre capacity pre-menopausal ER+ patients may also have to be commenced on primary endocrine therapy
• Discuss with oncology whether all grade 3 or node positive ER+ positive patients should have genomic testing performed on the core biopsy. If a high score to have surgery as would normally need adjuvant chemotherapy.

Currently genomic testing is not reimbursed in this situation, but this will need to be re-considered.

All decisions should be clearly documented.

4.1.3 Benign Disease

• No surgery for benign disease or risk -reduction to be performed

4.2 Systemic Anti-Cancer Treatments

Treatment decisions will need to be made on a case-by-case basis with input from both patients and the MDT. The prioritisation details should be overseen by the nominated trust haematol-oncology leads at provider level.

General approach to prioritising patients on systemic anti-cancer therapy:

• Categorise patients by treatment intent and risk-benefit ratio associated with treatment.
• Consider alternative and less resource-intensive treatment regimes.
• Seek alternative methods to monitor and review patients receiving systemic therapies.

Clinicians will also need to consider the level of immunosuppression associated with an individual therapy and the condition itself, and patients' other risk factors.

4.2.1 Categorisation of Patients

Priority level 1
Curative therapy with a high (>50%) chance of success

• Adjuvant (or neo) therapy which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse

Priority level 2

• Curative therapy with an intermediate (20- 50%) chance of success
• Adjuvant (or neo) therapy which adds 20 – 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse

Priority level 3

• Curative therapy of a low chance (10 – 20%) of success
Appendix 1

- Adjuvant (or neo) therapy which adds 10 – 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse
- Non-curative therapy with a high (>50%) chance of >1 year of life extension

**Priority level 4**
- Curative therapy with a very low (< 10%) chance of success
- Adjuvant (or neo) therapy which adds less than 10% chance of cure to surgery or radiotherapy alone or treatment given at relapse
- Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension

**Priority level 5**
Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 yr life extension

**Priority level 6**
- Non-curative therapy with an intermediate (15-50%) chance of palliation/ temporary tumour control and < 1 yr life extension

Where chemotherapy is given as part of multi-modal therapy the score below reflects the contribution of chemotherapy to the whole treatment

<table>
<thead>
<tr>
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<th>Neo-adjuvant</th>
<th>Adjuvant</th>
<th>Locally advanced Chemo-RT</th>
<th>First line advanced</th>
<th>Second line advanced</th>
<th>Third and subsequent</th>
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<tr>
<td>Breast ER+ Her2-</td>
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<td>3</td>
<td></td>
<td>3</td>
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</table>

**4.2.2 Non chemotherapy SACT**
- Consider risk of immune compromise vs extended duration anti-hormone response in metastatic patients on CD4/6 inhibitors
- Consider 6 months trastuzumab rather than 12 months (persephone trial)
- No good data to show longer course better than shorter course adjuvant chemotherapy. Consider 4 courses adjuvant chemo rather than 6 to reduce time spent in immune-compromise .

**4.2.3 Patient management**
- Patients to have blood tests locally or via district nurse
- Use of telephone/virtual clinics
- Ensure patients have information leaflets/hotline numbers

**4.3 Radiotherapy**
For adjuvant breast radiotherapy 26Gy in 5 fractions is isotoxic compared with 40.05Gy in 15 fractions and may mitigate a deferred start date in patients with node negative breast cancer.

Offer omission of adjuvant breast radiotherapy to those patients with low risk breast cancer who fulfil the NICE Early Breast Cancer Guideline (2018) criteria.

4.3.1 Patient management

- Telephone clinics for new patient interviews (Planning and Pre-Treatment)
- Skin assessments conducted whilst patient attending for treatment and managed according to local protocol. All other reviews should be managed via telephone clinic.
- Patients should be provided with agreed emollient prior to treatment commencing with clear instructions for use.

5 Follow-Up of Cancer Patients

- Try to minimise the number of patients attending breast clinics for routine review. Postpone appointments where appropriate and consider introducing telephone reviews for those where review is required
- This is especially important for frail elderly patients on primary endocrine treatment.
- Consider roll out of Personalised Stratified Follow-up pathways for early stage or low risk patients. Alliance to support rapid, clinically safe roll out.

6 MDT Meetings

- Maintain weekly MDT; can be done remotely if needed. Aim to minimise the number of staff present at the MDT e.g. 1 surgeon, 1 oncologist, 1 pathologist, 1 radiologist and one breast care nurse.
- Maintain a list of patients with surgical delay on primary endocrine therapy.

7 Research Activity

It is recommended that all recruitment and screening to all clinical trials be suspended with immediate effect. No new trials should be opened.

The exceptions to this are:

- Research into COVID-19, or
- ‘The experimental treatment is essential for serious, or life-threatening conditions, and in the opinion of the treating clinician, receiving treatment in the context of the clinical trial may be very significantly advantageous to the patient concerned compared with receiving standard of care treatment. These individual cases need to be discussed with and approved by the divisional research lead’.

8 Workforce reduction plan

| Now and assuming up to - 25% Staffing loss | A - 50% Staffing loss | B - 75% Staffing loss |

5
Appendix 1

Weekly Covid-19 Status Meeting
<Insert date/time>

Team leaders

Update Huddles for all staff
<Insert date/time>

Daily
Clinic HCA to ring imaging (Ext) to ascertain cancelled imaging slots available today. These slots will be utilised for 2WW new pts with high Covid-19 risk due to age, pregnancy, co-morbidity to avoid second visit for imaging where possible.

To increase 2WW urgent capacity:
• Cancel all Family History tele-clinics.
• Keep clear records of all cancelled pts
• Postpone all 6 & 12 month F/U

To increase surgical cover:
• Cancel and defer routine endocrine clinic patients.
• Cancel and defer all routine plastic clinic patients.

All pts to be contacted by Admin team
• Cancel and defer routine endocrine clinic patients.
• Cancel and defer all routine plastic clinic patients.

All pts to be contacted by A&C team

Triage referrals:
Pts to be seen in clinic: Discrete lump or asymmetrical thickening
Pts to be offered Tele consultation in first instance: Under 25; pain, no lump, nipple discharge, nipple eczema, gynaecomastia
Admin staff to book all pts in clinic with appropriate letter sent – outcomes to be recorded as face to face or Tele consultation on local systems.

9 Other considerations
To request the national team to suspend Breast screening which could divert radiologists and radiographer
30 March 2020

Dear colleagues,

**Advice on maintaining cancer treatment during the COVID-19 response**

Thank you for all you are doing to respond to the COVID-19 emergency and, in particular, to continue to care for and support our cancer patients during these unprecedented times.

As you know, we are clear that the NHS must ensure that cancer diagnosis, treatment and care continues during the response to the COVID-19 emergency. This means:

- **Essential and urgent cancer treatments must continue.** Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time.
- Where referrals or treatment plans depart from normal practice, safety-netting must be in place so that patients can be followed up.
- Urgent consideration should be given to consolidating cancer surgery in a COVID-free hub, with centralised triage to prioritise patients based on clinical need.

We have secured the use of almost all independent hospitals across England and their capacity should be used for cancer diagnosis and treatment.

In short, given the COVID situation is likely to persist for some time, rather than deferring cancer care, continuing to provide it through ringfenced facilities and reconfigured care pathways is generally more appropriate.

In London, the spread of the virus has been ahead of many other parts of the country, and local systems have been planning how best to maintain cancer services during the response period. The purpose of this note is, based on the London experience, to provide advice to local systems on how they should continue to manage cancer referrals and cancer surgery during the COVID-19 pandemic.
2WW referrals and cancer diagnostics

All patients should be considered on the basis of clinical need, and the level of risk, both patient- and service-related.

National advice has already been issued on the management of 2WW referrals for cancer. Local systems should continue to manage referrals in line with NG12 and this additional advice wherever possible.


In primary care, where a patient meets the criteria for urgent referral under NG12 but, in view of current circumstances, the GP in discussion with the patient decides not to make a suspected cancer referral because this might be more clinically risky for the patient, the general practice should ensure the patient is appropriately safety netted, monitored and can be followed up if symptoms worsen or do not resolve.

Where a patient is referred as a suspected cancer referral and assessed virtually/by telephone, and a decision is taken not to undertake diagnostics currently due to risk to the patient, the secondary care provider should keep this patient on their patient tracking list (PTL) to ensure they can be appropriately followed up. Patients should be fully involved in reaching this decision and given advice on how to report worsening or new symptoms.

If a patient is referred as a suspected cancer referral and is not available or declines a diagnostic or other appointment due to self-isolation or shielding guidance, they should remain on the secondary care provider PTL to enable their appropriate and proactive follow-up.

Where a diagnosis of cancer is confirmed, and to minimise the patient’s overall risk they are not listed for treatment immediately, then the patient should remain on the trust PTL and a decision to treat recorded if the patient has agreed to treatment. Again, patients should be involved in reaching this decision and given advice on how to report worsening or new symptoms.

It is essential that we retain records of those people who need urgent investigation for possible cancer, so that they can be followed up and diagnosed or have cancer ruled out at the earliest opportunity.

Cancer surgery hubs

Regional offices, Cancer Alliances, local systems and providers are already making plans for the continuity of cancer services during the COVID-19 response. Each local system will have its own challenges, and many will be
different from those in London. However, based on the experience in London (which in turn has drawn on the experience of Italy), we are recommending to regional offices and local systems that, as you develop and implement your own local plans for cancer, you consider incorporating the following features:

1. **A central triage point within a local cancer system**

   All cancer patients should be considered by their MDT.

   Any patients recommended for cancer surgery should be referred to a central, clinically-led triage point. This may be placed at a regional or local cancer system (Cancer Alliance) footprint level, depending on local circumstances.

   The triage system will: prioritise patients for surgery on the basis of clinical need, and the level of risk, both patient- and service-related; and match patients with appropriate surgical specialisms and capacity across the cancer system.

2. **Consolidation of cancer surgery on ‘clean’ sites**

   Where local circumstances permit, cancer surgery should be consolidated on a ‘clean’, COVID-19-free site within the local system. This could include independent sector provision where this has been secured.

   This will require arrangements for COVID-19 testing for all potential admissions 48 hours before surgery.

   For any cancer patient found to be COVID-19 positive, clinicians will need to decide locally when that patient will be considered fit for surgery, and be considered alongside other urgent surgery within a hospital treating COVID-19 patients.

3. **Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer**

   Advice has been published to support clinicians in treatment decision-making and prioritisation, and to inform conversations about treatment with patients:


   We will share with Cancer Alliances details of the structures put in place in London to assist with your local planning.
Cancer Alliances and national support

In many local systems, Cancer Alliances will be well placed to lead or support work to organise the configuration of local cancer services and manage patient flows, particularly for those patients for whom the clinical risk of delay is high. Regional teams will Cancer Alliances to help them deliver these arrangements.

All current advice on handling cancer patients is available on the NHS England and NHS Improvement website:


The national cancer team and national specialised commissioning team will work with regional offices and Cancer Alliances to monitor preparations across the country, and will offer more intensive support where requested in areas where plans are not as advanced. This may be of particular relevance in the context of rarer cancers where there are relatively small number of providers.

If you have any questions or you feel the national cancer team can provide any particular support, please don’t hesitate to contact us at: england.cancerpolicy@nhs.net.

Kind regards,

Dame Cally Palmer  
National Cancer Director

Professor Peter Johnson  
National Clinical Director

Professor Steve Powis  
National Medical Director for Cancer
Adult Transfer & Discharge Policy

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<tr>
<td>AUTHOR</td>
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Executive Summary

- All admissions, transfers and discharges will be planned with the involvement of the family, close friends or carer.
- Transfer and Discharge are essential to equip patients and carers with the knowledge, understanding and support to prevent or minimise further episodes of ill health.
- Discharge Planning will begin in Pre Assessment Clinic prior to Admission or on Re-admission as required. The Estimated Date of Discharge (EDD) must be identified by the multidisciplinary team within 24 hours of admission.
- For the purpose of this policy, adult refers to any person 17 years and over.
- For adults with Acute Mental Health needs please refer to Section 10 as well as following all general principles and other related policies.
- The following minimum information must be provided (where applicable) to either the receiving hospital, GP, or community nurse on discharge of the patient:
  
  - name
  - date of birth
  - address
  - unique identifier (where possible this must be the NHS number)
  - Emergency contact details (Next of Kin)
  - Presenting condition, treatment received and investigations performed
  - records of care
  - known preference and assessed needs
  - previous medical history including GP’s contact details
  - any infection requiring ongoing management, with current plan included
  - medicines
  - any medication changes
  - Known allergies
  - key contact person from the Trust
  - reason for transfer if appropriate
  - Any unresolved issues or known risks
  - Future appointment details
  - Comments on patient’s dependency levels
  - Any psychological issues identified or risk of harm to self or others.

- Information provided to the department must be documented in the patient’s health
records for any inpatient transfer.

- Information provided to the patient and healthcare provider on discharge must be documented in the health records in the form of an Electronic Discharge Notification (EDN).

- Paediatric patients are covered in the separate Paediatric Admission, transfer and discharge policy.

1 Introduction

- This policy is designed to standardise and provide a safe co-ordinated approach to the management of Transfer and Discharge for all adult patients at the Queen Victoria Hospital NHS Foundation Trust (QVH). The whole process must be seen as a multi-professional approach involving input and effective communication from all healthcare staff.

1.2 The Transfer and Discharge are important components of a patient’s healthcare journey and must be achieved to ensure the transition is completed without undue stress to the patient providing all the information required to ensure continuity of care in the receiving hospital or department, community services or with the family and or carer. There are four distinct stages which combined together complete the patient experience. These may be defined as:

Inpatient episode
Process of discharge
Transfer / Handover of Care – Internal transfer and external transfer including Emergency (out of hours)
Outpatient Follow up

Patient groups

Inpatient – any adult receiving overnight care
Outpatient – any adult using hospital services on an appointment basis
Day Case – any adult who is admitted and discharged on the same day

1.3 This policy aims to clarify the support and information required along with the responsibilities of all staff involved in the adult Transfer and Discharge process. All clinical staff will along with appropriate managers and administration staff be involved at some stage with the requirements of this policy.

1.4 Throughout this document the title Ward Matron /Deputy/ Discharge Coordinator is used to denote the registered health care professional (i.e. Nurse) with overall responsibility for planning the assessment and discharge of patients.

1.5 Unless defined otherwise the term “movement” will include the Transfer and Discharge of a patient.

1.6 Unless defined otherwise, an ‘Outlier’ will be an adult patient waiting to come into the
Trust from another hospital and/or waiting to return.

1.7 This policy will apply for transfer and discharge at all times of the day or night.

**Definitions**

- Handover of care is the exchange of quality documented information provided to the receiving department/hospital detailing the treatment and important factors relating to the care and safety of the patient being transferred. The transfer of patients is the same as handover of care.

- Electronic Discharge Notification (EDN) (appendix 1) – This is an electronic form used to document patient discharge information such as medication and treatment that can be sent to the General Practitioner (GP) electronically and printed for the patient or other healthcare providers.

2 **Scope**

This policy applies to all staff involved with the transfer/handover of care or discharge of adult patients.

3 **Duties**

*All staff* – responsible for adhering to this policy

*Chief Executive* – overall responsibility for all movement of patients involving the Trust.

*Ward Matron/Deputy* – The Ward Matron or Deputy is responsible and accountable for ensuring all the information necessary to plan and manage movement arrangements is communicated and used in the patients’ best interests. They must ensure all the processes outlined in the policy are followed enabling a safe and timely high quality outcome. To ensure the elective bed booking system is always kept up to date and to complete a DATIX report in the event that something untoward occurs in relation to transfer or discharge.

*All Clinical Staff must ensure the following:*

4

- documentation is completed, up to date and accurate prior to following the transfer of a patient
- relevant people involved in the process have been informed
- all equipment required for the transfer is available and ready for use
- arrange a competent escort for the patients’ movement if required
- accurate and timely information regarding the infection status to the receiving area is provided
The policy is adhered to and any deviations must be safe and in the patients best interest. Liaise with external Multidisciplinary Team (MDT) to ensure a safe discharge process.

Completion of the EDN, ensuring that the patients GP has received a copy within 24 hrs of discharge.

Patients and their GP’s are given full information on medication changes including medication prescribed at the time of discharge, reason for medication changes and any adverse reactions or allergies to medicines experienced by the patient during admission. To assist discharge, doctors must ensure that take home medications (TTO) are written up before patients leave Recovery to ensure safe and effective discharge can take place.

Site Practitioner - responsible for first line site management decisions out of hours.

Head of Nursing - to provide support for the processes within the policy and ensure any operational problems encountered with any patient movement are resolved.

Infection Prevention and Control Team – to provide support and advice to staff for a patient with a possible or known infection.

Administration Staff – to provide accurate and timely information regarding the patient to the relevant areas, particularly in relation to patient transport or the need for step down/HDU or ITU beds.

Multi Disciplinary Team (MDT) A group of healthcare professionals with shared responsibility for care – to facilitate the safe discharge of patients from the Trust by ensuring they receive effective assessment, treatment and if required necessary equipment to overcome the problems that may affect their ability to carry out essential daily activities of living once at home.

Pharmacy Department – to ensure prescriptions are checked and medication dispensed according to the information within the Electronic Discharge Notification form

Discharge Coordinator – to ensure complex patient discharges are managed in a safe and timely manner liaising with relevant members of MDT to facilitate effective transfer of care.

4 Patient Groups

Patient groups can be categorised as follows:

- **Discharge** - Adult patient being discharged from QVH to their home or place of care. The discharge process is the same for all adult patients however there are additional requirements to specific categories of patients detailed in section 10 below. (These special groups are mental health, elderly patients from Minor Injuries Unit (MIU), homeless, Self-discharge against medical advice and patients with learning disability needs).

- **External transfer/ handover of care** (transfer out) - Adult patients transferred to another hospital. This can be either:
5 Minimum Patient Information for all External Transfer and Discharges

All patients being transferred out or discharged regardless of circumstance will have as a minimum the following information:

- Name
- Date of birth
- Address
- Unique identifier (where possible this must be the NHS number)
- Emergency contact details
- Presenting condition, treatment received and investigations performed
- Known preference and assessed needs (transfer)
- Any infection requiring ongoing management, with current plan included
- Medicines given
- Any medication changes
- Known allergies
- Key contact person from the Trust
- Reason for transfer if appropriate
- Any unresolved issues or known risks
- Previous medical history including GP’s contact details (for transfers)
- Future appointment details if arranged
- Comments on patient’s dependency levels
- Any psychological issues identified or risk of harm to self or others.

6 Internal Transfer / Handover of Care (including out of hours)

6.1 Transfer / handover from one ward to another ward (giving and receiving information)

The Lead Nurse or Ward Matron/ Deputy, together with the Site Practitioner and surgical team will discuss and finalise the plan for transfer. The level of care must be
discussed with the nurse of the receiving department to ensure the staff have the required expertise and facilities to continue to provide the appropriate level of care;

The following needs to be completed prior to transfer:

- The transferring department must document in the patient health record the transfer confirming the following;
- The surgical team have reviewed the patient, agree the transfer and have documented this in the medical notes;
- The risk of the transfer has been assessed prior to the movement to ensure emergency equipment is provided where necessary;
- The patient’s infection control status has been confirmed. If there is a risk, the receiving ward has been notified and an appropriate environment allocated.
- All relevant notes (this contains the minimum information detailed in section 5 above), charts, medication, dressings and patient's belongings have been provided for the transfer;
- A qualified nurse familiar with the patient’s history will accompany the patient and provide a handover to the receiving department;
- The relatives have been informed of the transfer.

6.2 Transfer handover of care to and from theatres and recovery (giving and receiving information)

All patient notes (including the prescription chart and risk assessment booklet but excluding other nursing documentation) must accompany the patient to theatre and on return post surgery.

The WHO Checklist will record the handover between the ward and theatre (including recovery) and on return. The following sections must be completed and signed at each stage by the person handing over responsibility of care to ensure the appropriate information has been handed over to the receiving department;

- Prior to transfer to theatre
- Sign in before induction of anaesthesia
- Time out before skin incision
- Sign out on completion of surgery
- Recovery handover and discharge (back to the ward/ department)

7 External transfer / handover of care – non-emergency transfer to another hospital

The Discharge Coordinator in conjunction with the nurse caring for the patient and the surgical team must finalise arrangements for the patient to be transferred once the decision has been made. This includes communication with the receiving hospital, the patient and their relatives ensuring the appropriate paperwork is completed. The following must be completed and confirmation written in the nursing notes prior to transfer:

- The surgical team has documented in the medical notes / EDN that the patient
Appendix 3

has been referred to and accepted by the receiving hospital, the names of individuals concerned should be highlighted in the medical notes. The name of the accepting Consultant must be clearly written within the medical notes.

- Correct transport arranged, with appropriately trained staff available for the escort if required;
- The patient’s property is packaged and ready to go with them and the Patient Property Book is completed.
- Specialist equipment is available for the transfer as required;
- The relatives or carers have been informed;
- The receiving hospital staff have all the necessary information and are aware of the estimated time of arrival;
- The minimum patient information detailed in section 5 is provided to the receiving hospital by ensuring the Transfer letter is inserted in the Extra Section of the EDN which is printed and sent with the patient and a copy sent to the patient’s GP. If for any reason the EDN cannot be printed the information in section 5 must be included and documented within the handover process.
- Photocopies of medical notes, drug charts, latest and/ or relevant test results, transfer letters and medical photographs may be sent in a post-safe envelope for the journey and the hospital informed if photographs are deemed to be distressing. Patients will not have access to their notes or photographs during transfer.

8 External transfer / handover of care – emergency transfer out from the QVH (this is also the out of hours process)

The Site Practitioner and a senior clinician must be involved in the transfer process. The actions detailed below must be documented in the patient’s nursing notes by the nurse responsible for care;

- The patient’s condition is stabilised
- Correct transport arranged e.g. Paramedic Ambulance;
- The receiving hospital has been contacted and has all the necessary information for patient transfer;
- Adult Critical Care Network Transfer Form (Appendix 2) is completed and copy sent with patient if applicable;
- The minimum patient information detailed in section 5 above, is provided to the receiving hospital; by ensuring the EDN is printed and sent with the patient and a copy sent to the patient’s GP. If for any reason the EDN cannot be printed the information in section 5 above must be included and documented within the handover process.
- Appropriately trained staff are available for the escort if required eg: nurse/ anaesthetist;
- Photocopies have been made of the medical notes including drug charts, latest and/ or relevant test results, operation notes, history sheets and medical photographs. These should be in a post-safe envelope for the journey and the receiving hospital informed if photographs are deemed to be distressing;
Appendix 3

- The Consultant has been informed of the transfer;
- The patient’s property is sealed and ready to go with them and the Patient’s Property book has been completed;
- The relatives or carers have been informed and given travel instructions if following in a car;
- Specialist equipment is available for the transfer. E.g. tracheostomy kit, portable suction, listed and returned to QVH after a safe transfer.
- Clinical handover by a competent individual to the ward/ departmental staff and relevant members of the team at the receiving hospital.
- Complete a DATIX.

9 Discharge – general process for all adult discharge from the QVH (see section 10 for additional requirements)

9.1 Pre assessment Clinic (PAC) must flag up post-operative care needs which may arise on discharge. Discharge planning begins as soon as the patient is admitted to the ward area. The estimated date of discharge is identified within 24 hours of admission. The MDT has a shared responsibility for ensuring a discharge date and plan is implemented within 24 hours. The Ward Matron/ Deputy has ultimate responsibility to ensure the discharge process has been commenced. Prior to the day of predicted discharge, the nurse allocated to the patient must ensure all elements of the discharge process are completed. It is critical any equipment or community service requirements are arranged at the earliest opportunity to avoid delays to the patient discharge.

9.2 The EDD is recorded and reviewed on a daily basis by the MDT following the surgical ward rounds.

9.5 Patients, relatives and carers are informed during admission that they will be discharged from the ward as early as possible on the day of discharge, once deemed medically fit by the surgical team;

9.6 Patients are fit for discharge when physiological, social, functional and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate;

9.7 One day prior to discharge, the nurse needs to ensure that the patient’s EDN has been completed and checked by the pharmacist and appointments have been requested for their follow up;

9.8 On the day of discharge, the nurse is responsible for ensuring that written and verbal advice (where required) has been given to the patient, relatives or carers regarding their medications/ dressings/ equipment required.

9.9 The following documentation will accompany the patient on discharge:
- Copy of Electronic Discharge Notification Form (Appendix 2) (please ensure all the minimum data in section 5 above is included)
- Appointments Information;
- Written information regarding treatment where required;
- Contact details of ward
9.10 The minimum information provided to any receiving healthcare professional (District Nurse, GP, Nursing Home) on discharge is the following;

- Copy of Electronic Discharge Notification Form (Appendix 2) (please ensure all the minimum data in section 5 above is included)
- Additional information sent as required

9.11 The recording of the information provided on discharge is documented by the nurse responsible for the patient who must ensure the Discharge Checklist/ Complex Discharge Planner (See page 22, adult admission booklet) is completed.

9.12 Discharge out of normal working hours should follow the same process as above.

9.13 **Discharge between 21.00 and 06.00 is required to follow the standard processes but must be at the patients request and not the request of QVH.**

10 **Additional Discharge requirements for Patients with Specific Requirements**

10.1 **Patients with Psychiatric illness**

Refer to the Trust policy, Care of Patients with Acute mental Health Needs located on the Qnet/ policy and procedures/ clinical policy folder. Patients suffering from a psychiatric illness must be discharged to the relevant mental health team under the direction of a consultant psychiatrist if required. This must have been agreed prior the admission of the patient to the hospital. If patients are discharged directly to their home, the psychological therapy team within the Trust need to be consulted to ensure appropriate follow-up in the community has been organised.

10.2 **Discharge of the elderly from the Minor Injuries Unit (MIU)**

Patients must be assessed on general health/ social factors. These must include the adequacy of home arrangements. Elderly frail patients should receive priority for transport and their GP informed of their discharge within 24 hours of this taking place. Prior to discharge of any patient from MIU it must be ascertained whether that patient requires a full community assessment following discharge, this should be instigated by the practitioner looking after the patient in conjunction with the patient’s GP.

10.3 **Self Discharge against medical advice**

The decision that a patient is fit for discharge can only be made by the Consultant responsible for the patients care or someone to whom the Consultant has delegated authority. Every effort should be made to persuade the patient to stay and complete their treatment. Self-discharge against medical advice usually falls within the following categories:

- **The patient understands the risks they are taking in leaving hospital** – in this instance the patient has the right to refuse treatment and leave.

- **The patient is unable to understand the risks associated with discharge** due to their medical condition (i.e. confusion, shock, pain etc) or due to mental health problems – In this situation the surgical team will need to act in the patient’s best interest and
should involve psychology at the earliest opportunity following both the Mental Capacity Act (MCA) and Deprivation of Liberty guidance (DOL’s) available on the Qnet.

If a patient wishes to self-discharge, the Ward Matron/Deputy should contact:

- A member of the Surgical Team
- Site Practitioner
- Social Services if it is felt necessary, in and out of hours following a risk assessment
- Psychological therapies if appropriate
- A DATIX should be completed

The self-discharge form (Appendix 3) should be signed by the patient and the doctor and filed in the patient’s medical notes.

In the event of the patient refusing to sign the self-discharge form, this must be recorded in the patient’s medical/nursing notes. The doctor/nurse must inform the patient’s General Practitioner within 24 hours.

10.4 **Discharge needs of people who are homeless**

It is vital that consideration is given to the housing situation of patients to ensure that patients are not discharged to inappropriate places, or become homeless as a result of their stay in hospital. Appropriate risk assessments must be carried out and passed on to primary care staff or other service providers as appropriate.

It is usually the role of Social Services to facilitate the care of people over 65 in liaison with the local homeless unit. The needs for those under 65 are covered by the local homeless unit. All Social Services have a homeless department attached to them. Patients should be referred back to the area they have come from, if safe and agreeable, and if any concerns refer to the local homeless unit. Referrals should be made within office hours as early in the day as possible to ensure that accommodation can be found. Information and resources can be found on the internet under Homeless Pages and Homeless UK.

10.5 **Discharge of patients with specific care needs**

Where patients experience difficulties in understanding and agreeing with the discharge care planned for them, it is the responsibility of all staff to ensure that they have access to the services of an interpreter or access support to ensure the patient or carer has a full understanding of the plan. In this context an interpreter may include a signer or Braille contact for hearing and visually impaired patients respectively. Additional written information appropriate to the level of understanding may be sourced.

Additional planning by the senior clinician in charge of the patient and nursing team may be needed for the following specific care needs on a case by case basis:

- Patients who are living alone, who are frail, elderly or live with a carer who may have difficulty coping. People living in sheltered housing or other warden assisted accommodation should be treated as living alone, as wardens will only assist in emergencies and cannot provide continuing care;
Appendix 3

- Vulnerable Adults at Risk;
- Terminally ill patients;
- People with a continuing disability, including those discharged from long stay hospitals to return to the community, and those with sensory impairment;
- For patients requiring community care, it is the responsibility of the Lead Nurse to give a minimum of 24 hrs notice of discharge to community agencies and inform carers or relatives (with the patient’s permission). Should a longer period of notice be requested this will be negotiated between the Trust and the agency/individuals concerned.

10.6 Any additional discharge issue detailed in section 10 must be documented in the patient notes.

11 Medication on Discharge

11.1 Medication process on discharge for in-patients

Any medication required for the patient must be documented on the EDN by the clinician responsible for the care of the patient. This must be sent to the pharmacy department during normal working hours for screening prior to dispensing either from ward stock or by the pharmacy department who will arrange delivery of patient's medication to the ward.

Out of normal working hours the doctor must complete the EDN and the nurses on the ward will provide a TTO pack as available on the ward. In exceptional circumstances following discussion with Site Practitioners the patient will be given a completed FP10 prescription form for any drug not available as a TTO pack if it has not been prepared previously by the pharmacy department.

Patient’s own medications must be returned to them including CD's.

11.2 Medication process for day case patients

The EDN is completed by the doctor and the medication is dispensed by the nurse in charge of the patient’s care. Any drug that is not within the ward stock must be obtained from pharmacy.

11.3 Medication information for the patient

The patient must be given the medication along with relevant information for each drug in addition to a medicines helpline card. The nurse or pharmacist dispensing the medication for the patient must ensure they have the correct information.

12 Joint Discharge Planning and Delivery

12.1 When a patient has been identified through screening as needing a community care assessment or community care, the Discharge Coordinator must liaise with the MDT to plan, coordinate and manage the care of the patient. When care needs are identified to enable a safe transfer of care, a notice request for assessment must be
completed and sent to the relevant Social Services. Consent must be obtained prior to this process being completed.

12.2 It is the Ward Manager/ Deputy responsibility to ensure all service providers participating in the planned community care are kept fully informed of the plans, status and their contribution to it. The allocated social services care manager and the nominated multi disciplinary team member is responsible for notifying the Ward Matron/ Deputy of the progress and the outcome of their discharge planning.

12.3 Disputes between the Trust and other agencies participating in the assessment and discharge planning process will be handled in accordance with the principles and procedures laid down in the appropriate Clinical Commissioning Group (CCG)/ Social Services department resolution of disputes document. These can be obtained from the relevant Social Services department. Complex issues should be discussed with the Trust’s legal department.

13 Home Assessment Visits Prior to Discharge

13.1 Where it is considered necessary, and appropriate, a home assessment visit and the fitting of home equipment, adaptations or individual aids, the needs and wishes of the patient and their carers must be assessed by an Occupational Therapist and / or Physiotherapist, possibly in conjunction with the Social Services in the patient’s home locality where possible. However, this is a rare situation.

13.2 Where it is determined that the patient’s ability to cope at home will be aided by the fitting of appropriate equipment, the patient and their carers must agree and be involved in the choice, understand its purpose, be trained in its use, and be fully informed of the costs involved. Discharge planning procedures must accommodate the identification of essential adaptations required to the place of discharge.

13.3 It is the responsibility of the therapists to ensure that any essential home equipment, adaptations, individual aids/ orthotics have been installed, provided, or arranged before the patient is discharged.

14 Training and Awareness

New staff will be introduced to the policy if relevant during their local induction process.

15 Equality

This policy and protocol will be equality impact analysed in accordance with the Trust Procedural Documents Policy, the results of which are published on our public website and monitored by the Equality and Diversity team.

16 Review

This policy will be reviewed in 3 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

17 Monitoring Compliance with this Policy
<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual or dept. responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group/committee which will receive the findings/monitoring report</th>
<th>Committee/individual responsible for ensuring that the actions are completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The handover/transfer requirements between care settings for giving and receiving information. Recording of handover /transfer Out of hours handover / transfer process</td>
<td>Compliance in Practice (CiP) and ad hoc audit</td>
<td>Discharge Coordinator</td>
<td>Monthly audit</td>
<td>Nursing Advisory Group (NAG)</td>
<td>Head of Nursing, Matrons and Director of Nursing and Quality to review compliance and subsequent actions monitored and communicated to directorate meetings or taken to ward meetings.</td>
</tr>
<tr>
<td>The discharge requirements for all patients The discharge information to be given to the receiving healthcare professional The information to be given to the patient on discharge How a patients medicines are managed on discharge Recording of information to the receiving healthcare professional and patient Out of hours discharge process</td>
<td>Compliance in Practice (CiP)</td>
<td>Discharge Coordinator</td>
<td>Monthly audit</td>
<td>Nursing Advisory Group (NAG)</td>
<td>Head of Nursing, Matrons and Director of Nursing and Quality to review compliance and subsequent actions monitored and communicated to directorate meetings or taken to ward meetings.</td>
</tr>
</tbody>
</table>

18 References

**Adult Critical Care Transfer Form**

To be used for all adult patients transferred to Critical Care - this is a legal record of transfer.

### Patient Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postcode</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td>Male ☐ Female ☐</td>
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</table>

### Admission Details

<table>
<thead>
<tr>
<th>Transferring Hospital</th>
<th>Receiving Hospital</th>
<th>Transferred to ICU ☐ HDU ☐ Theatre ☐ Ward ☐ Other ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level of care: Level 1 ☐ Level 2 ☐ Level 3 ☐ Vent ☐</td>
<td></td>
</tr>
</tbody>
</table>

### Staff Arranging Transfer

#### At Transferring Hospital: Referring Consultant

<table>
<thead>
<tr>
<th>Name</th>
<th>Speciality i.e. A/C, ITU, Med, Surg, Other</th>
</tr>
</thead>
</table>

#### At Receiving Hospital: Receiving Consultant

<table>
<thead>
<tr>
<th>Name</th>
<th>Speciality i.e. A/C, ITU, Med, Surg, Other</th>
</tr>
</thead>
</table>

### Checklist — Must be completed before transfer

- Decision made by consultant ☐
- Formal referral letter complete ☐
- Patients health records photocopied ☐
- Results/X-rays/3dars present/transferred ☐
- Relatives aware of transfer ☐
- Home/relationship ☐
- Fracture Precurations, Spinal, Long Bone, Cervical, Thoracic, Pelvis ☐
- Informed Receiving Hospital of Departure ☐
- Neuro checklist if appropriate ☐

### Ambulance Details

<table>
<thead>
<tr>
<th>Time contacted</th>
<th>Ambulance Reference number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated arrival time</td>
<td>Time arrived at unit</td>
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<tr>
<td>Time left until</td>
<td></td>
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</tbody>
</table>

### Pre Transfer – Ventilation, Monitoring & Lines

#### Ventilation

- Spontaneous, mechanical, bag ☐
- T/ET Size ☐ Lip Level ☐
- Ventilator Mode ☐
- Tidal Volume (Vt) ☐
- PEEP ☐
- PIP ☐
- Peak Inflation Pressure ☐
- Resp Rate ☐
- Saturation ☐

#### ABGs

- PO₂ ☐
- PCO₂ ☐
- HCO₃ ☐
- PH ☐
- SPO₂ ☐
- Post intubation CA arithmetic mean ☐
- Other ☐

#### Monitoring & Lines

- Please circle monitoring, lines required for journey ☐
- ECG ☐
- A3P ☐ NBP ☐
- Temperature ☐
- SPO₂ ☐
- ETCO₂ ☐
- CVP ☐
- Peripheral lines ☐
- Urinary Catheter ☐
- NGT/OGT ☐
- Balloon Pump ☐
### UNDER OBSERVATION CHART for use during transfer

<table>
<thead>
<tr>
<th>TIME</th>
<th>HRS</th>
<th>MINS</th>
<th>UNIT</th>
<th>AMB</th>
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</table>

**Drugs/Fluids**

**Tidal Volume**

**Peak Inflation Pressure**

**PEEP**

**FiO₂**

**Respiration Rate**

**SpO₂**

**ETCO₂**

**Temp**

**Rhythm**

**Pupils Reaction/Size**

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<th>L</th>
<th>R</th>
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</table>

**GUIDE CHART FOR PUPIL SIZE**

- 9mm
- 8mm
- 7mm
- 6mm
- 5mm
- 4mm
- 3mm
- 2mm

**URINE OUTPUT**

<p>| |</p>
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**OTHER FLUID OUT**

**ANY PROBLEMS - Equipment, Clinical or Organisational**

**This is the legal record of transfer and must be dated, signed & returned**

**ESCORTING PERSONNEL**

<table>
<thead>
<tr>
<th>Doctor</th>
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<tbody>
<tr>
<td>Name...</td>
</tr>
<tr>
<td>Grade... Spec...</td>
</tr>
<tr>
<td>Transfer Course Attended</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurse/ODP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name...</td>
</tr>
<tr>
<td>Grade... Spec...</td>
</tr>
<tr>
<td>Transfer Course Attended</td>
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</tbody>
</table>

**Signature of Escorting Doctor + bleep no...**

**Date...**
### Adult Critical Care Referral Letter

**(to be completed by referring Doctor)**

<table>
<thead>
<tr>
<th><strong>PATIENT DETAILS</strong></th>
<th><strong>ADMISSION DETAILS</strong></th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>Referring Hospital</td>
</tr>
<tr>
<td>Address</td>
<td>Consultant</td>
</tr>
<tr>
<td></td>
<td>Referred by: Sleep No:</td>
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<tr>
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<td>Date and time referred:</td>
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<tr>
<td>Postcode</td>
<td>Accepted by: Sleep No:</td>
</tr>
<tr>
<td>DOB</td>
<td>Date and time accepted:</td>
</tr>
<tr>
<td></td>
<td><strong>Male</strong> [ ] <strong>Female</strong> [ ]</td>
</tr>
</tbody>
</table>

**HISTORY** (including date and time of incident and cranial/spinal injuries)

**PAST MEDICAL HISTORY**

**USUAL MEDICATION**

**NEURO-ASSESSMENT** (non-ventilated patient)
### Neuro patients only

Have the following parameters been achieved?

<table>
<thead>
<tr>
<th>Parameter</th>
<th>PaO₂ ≥ 13 kPa</th>
<th>PaCO₂ ≤ 4.5-5 kPa</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAP ≥ 80</td>
<td></td>
<td>Sedated and paralysed</td>
</tr>
</tbody>
</table>

### RESULTS

<table>
<thead>
<tr>
<th>Drug/IV fluids given</th>
<th>Dose/volume infused</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus toxoid</td>
<td></td>
<td></td>
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<tr>
<td>Mannitol</td>
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<tr>
<td>Phenytoin</td>
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<tr>
<td>Crystalline</td>
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<tr>
<td>Colloid</td>
<td></td>
<td></td>
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<tr>
<td>Blood</td>
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</table>

### SUMMARY OF CARE/INTERVENTION

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Date/Time</th>
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</tbody>
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<tr>
<th>Next of kin:</th>
<th>Tel No:</th>
<th>Notified:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Transfer with the patient:** Observation chart | Medical notes | X-rays | CT scans

Adult Critical Care Transfer Form

Signed: Print: Grade:

Date:

JP/AL March 2010
Dear Dr,

Discharge Notification

The patient was admitted under the care of Mr. [Speciality:] into Ward at [Address:].

Patient:
D.O.B.:
NHS No.:
Hospital No.:

Clinical Assessment

Mode of Admission:
Presenting Problems:
Diagnosis:
Past Medical History:
Procedures / Investigations:
Complications / Problems During Stay:
Patient Status:
Summary and recommendations to GP:

Allergies

Allergy: Nature of reaction.

Medication on Discharge

Clinician: Designation: Date: Bleep:

Comments: Free text

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Duration</th>
<th>Supply</th>
<th>Ward TTO Pack</th>
<th>GP continue?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td></td>
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</tbody>
</table>

Notes

Management
Primary Care Plan
Destination on Discharge:
GP to Review On Discharge:
Care Arrangements Made:
Information Given to Patient and Relatives:
Secondary Care Plan
Future OP Appointment Booked:
Appointment Details:
Certificate Given:
Further Report:
OPD Plan:
Copy to Patient/Family:

Completed By:
SELF DISCHARGE FORM FOR PATIENTS

I confirm that I have decided to discharge myself from the Queen Victoria Hospital against medical advice and that I fully understand the consequences of that decision and the risks I am taking for myself and my health. These have been explained to me by the responsible health professional. I take full responsibility for this decision and its consequences.

Signed..............................................

Witness .........................................

Date................................................

In the event of a patient refusing to sign a form, a note to this effect must be made in the patient’s medical records.
QVH Breast Surgical Treatment Referral Proforma

Please email to tqv-tr.Referrals@nhs.net – with email subject ‘URGENT CANCER’

<table>
<thead>
<tr>
<th>Queen Victoria Hospital NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Patient Name:</td>
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<tr>
<td>Patient DOB:</td>
</tr>
<tr>
<td>Patient NHS Number:</td>
</tr>
<tr>
<td>Patient Address:</td>
</tr>
<tr>
<td>Patient Contact Details:</td>
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<tr>
<td>Date of Referral:</td>
</tr>
<tr>
<td>Referring Hospital:</td>
</tr>
<tr>
<td>Operating Surgeon:</td>
</tr>
<tr>
<td>Key Worker:</td>
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<tr>
<td>Diagnosis:</td>
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<tr>
<td>Latest MDT Outcome:</td>
</tr>
<tr>
<td>Planned Surgery (including estimated LOS):</td>
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<tr>
<td>Estimated Length of Operation:</td>
</tr>
<tr>
<td>Urgency of Surgery &lt; 2 weeks, 2-4 weeks or &gt;4 weeks:</td>
</tr>
<tr>
<td>Comorbidities (including performance status/medications/allergies):</td>
</tr>
<tr>
<td>PAC Date:</td>
</tr>
<tr>
<td>Scheduling Contact at Referring Trust:</td>
</tr>
</tbody>
</table>
COVID-19 PCR Swabbing – Breast Flow Chart

Inpatient Admissions – performed at local trust
Breast

The referring trust will arrange and perform the PCR swabbing at the local trust, liaising with the QVH scheduler regarding admission date.

The PCR swab will be performed, at the local trust, at least 48hrs ahead of the date of admission at QVH.

The referring trust will monitor the results.

A decision with the made, by the referring consultant to either proceed to admission or defer admission and advise the patient to self-isolate for a further 14 days.

The referring trust will contact the QVH scheduler with the results and decision to admit or defer.