Appendix 3: Emergency Department to Hyper Acute Stroke Unit Transfer Policy

This protocol is to be used when a stroke patient presents (either as a self presenter or by LAS) at an Emergency Department of a Trust that does not have a Hyper Acute Stroke Unit (HASU) and/or an Acute Stroke Unit (SU).

If a patient presents at an Emergency Department of a multi sited Trust with a HASU the Trust should have an internal mechanism for ensuring that the patient is admitted to the Trusts HASU. That internal mechanism may involve LAS as stated below.

Actions to be taken if stroke patients present at a hospital without a HASU and/or stroke unit

There are a number of scenarios under which patients with a possible stroke may present at an Emergency Department (ED) of a Trust without a HASU and/or SU. This guidance will provide an overview of the most commonly encountered scenarios and the steps to be taken to support timely and safe transfer.

1. **Patients Presenting at ED (self–presenter or patients brought in by ambulance) within the thrombolysis window (currently 4 ½ hours).**
   Patients presenting at an ED within the thrombolysis window (within 4 ½ hours of onset of stroke), should be transferred to a HASU using LAS as a **critical transfer**

2. **Patients Presenting at ED (self–presenter or patients brought in by ambulance): within 24 hours of onset of symptoms but outside 4 ½ hour thrombolysis window**
   Patients should be transferred to a HASU by LAS within 2 hours. These transfers will be arranged through the Urgent Operations Centre as per the flowchart.

3. **Patients Presenting at ED (self–presenter or patients brought in by ambulance): more than 24 hours after onset of symptoms**
   Following a clinician to clinician discussion between the medical lead at the referring trust and the lead stroke physician at a HASU, consideration should be given by the assessing clinician to transferring the patient to a HASU or in the rare circumstances that this may be considered by the assessing clinician to be appropriate to (own or nearest) stroke unit. If the assessing clinician determines the patient should go to a HASU, the HASU clinician will not refuse the patient. In the event that the HASU clinician refuses to accept the patient, the assessing clinician will escalate this to the manager on-call for the HASU host trust.

   As this transfer is unlikely to be time critical, the referring hospital's Patient Transport Service (PTS) should be used for the transfer. If advice about the transfer is required the hospital should contact the Clinical Support Unit at LAS (The hospital should be aware that any LAS PTS service for which the hospital does not hold a LAS contract is chargeable).

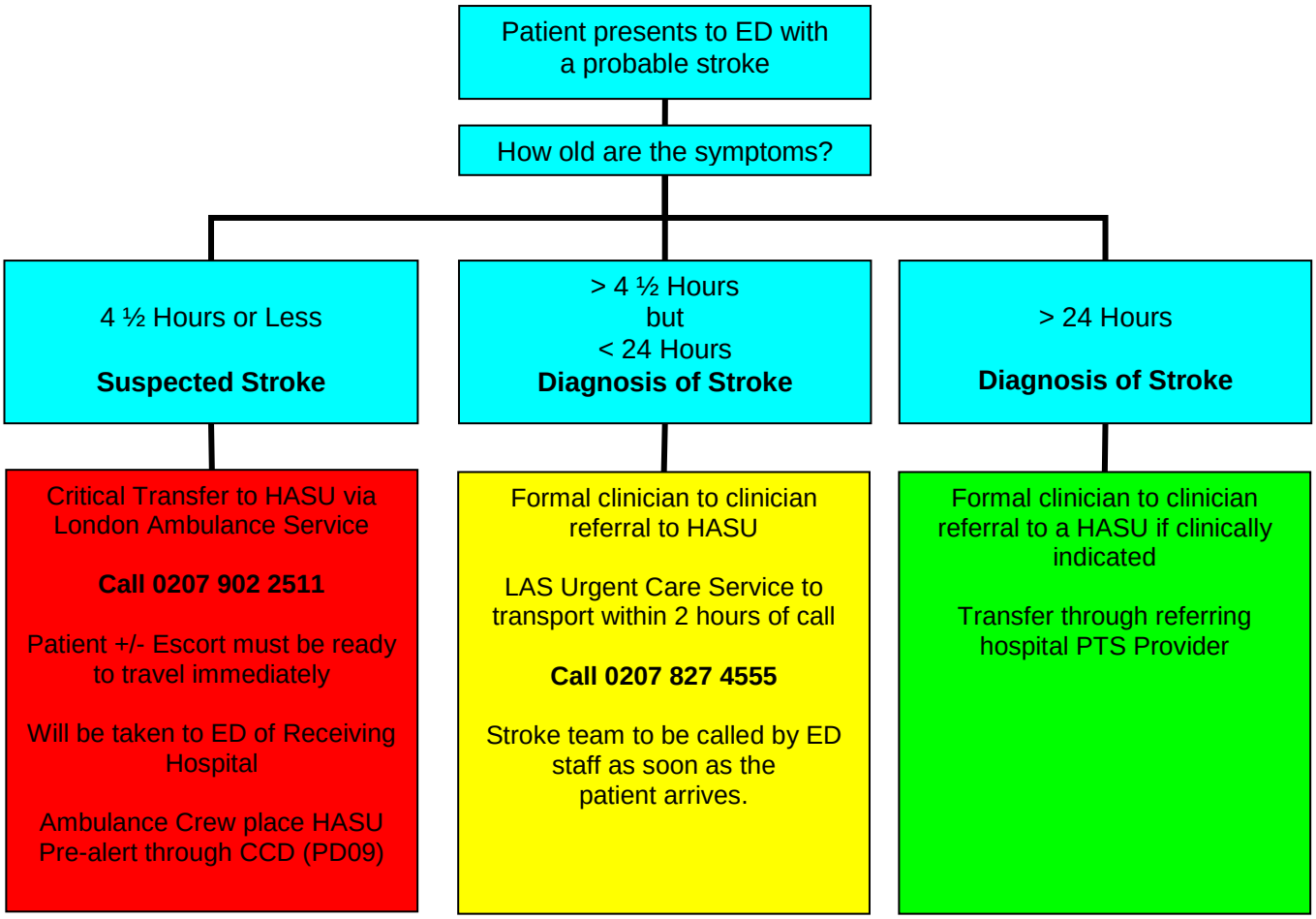
To facilitate timely transfer, a full patient history should be taken and if immediate medical management of the patient is required, the patient must be stabilised prior to transfer. Patients will receive full investigation and acute management upon transfer to a HASU. Further examination and investigation at the hospital, which may include CT scan, should be performed only where clinically indicated. This will be dictated by clinical judgement and should not delay the transfer of the patient.

Transfers relating to paragraph 1 above should be arranged as per the flow chart below (red box). LAS Emergency Operations Centre (EOC) will coordinate conveyance to the most appropriate HASU based on real time review of capacity and demand. Capacity issues at the receiving trust will not affect patient transfer. The receiving trust is responsible for actively managing capacity to accommodate new transfers.

Transfers relating to paragraph 2 above should be arranged per the flow chart below (yellow box). The ED clinician will contact the local HASU (normally the HASU local for the patient) to refer the patient and the ED staff will contact LAS to arrange the transfer.

NOTE: All transfers of patients from HASU's to SU's or to other Emergency Departments are not covered by this protocol. They are separately covered by the HASU to SU protocol and are the responsibility of the HASU hospitals' PTS except for critical transfers which will continue to be managed by the LAS. This includes patients brought to the ED of a HASU and subsequently found to not be suitable for a HASU bed.

EMERGENCY DEPARTMENT TO HASU TRANSFER PROTOCOL
(July 19th 2010)



Notes:

1. Requests for critical and immediate transfers must be made by a healthcare professional with knowledge of the patient's condition.

2. LAS will undertake these transfers without an escort where no clinical intervention is required en route. An appropriately trained healthcare professional will be required for any patient with airway compromise, fitting or on essential infusions or monitoring, as a paramedic crew cannot be guaranteed for any journey. The decision as to whether an escort is required lies with the attending LAS crew.

3. The patient and healthcare professional must be ready for transfer when the crew arrive. If they are not ready within fifteen minutes the call will be cancelled and will need to be re-booked.

4. If an assessing clinician determines that the patient should go to a HASU, the HASU clinician should accept the patient. Transfer to a stroke unit is only likely to be appropriate in rare circumstances.

5. In the event of LAS invoking extreme overcapacity plans to manage demand, there can be no guarantee that the two hour transfers will be done within this time frame.

6. The Clinical Support Desk can be contacted on **0207 922 8657** for advice on transfers

4. Patients Presenting at ED: palliative care

Where a stroke patient presents at an A&E, but where further acute management is deemed to be of no benefit to the patient, the clinical team at the hospital may decide to admit a patient onto an inpatient ward for palliative care. The patient spell should have a primary code to cover the patient's palliative needs, not management of stroke. Consideration should be given to admitting the patient to a SU for their end of life care. SUs and HASUs should not exclude patients with severe acute stroke, even if it looks like they will not survive.

5. Inpatient Stroke: on the ward at a hospital

There are too many potential scenarios in which inpatient strokes might occur to make a single protocol advisable. A medical assessment should be made by the responsible medical team and/or local stroke physician, including consideration of transfer to a HASU if thrombolysis is possible, and if the patient is medically fit for transfer. LAS should be informed in such cases and the patient should be taken to the nearest HASU and a transfer will be arranged as per the thrombolysis critical transfer guidelines. If HASU care is not required or the patient is unfit for transfer, management should be undertaken in the Hospital, and the patient transferred to a local SU when safe to do so. Care at a SU, will focus on post hyper acute medical management and provision of MDT inpatient rehabilitation.

For inpatient strokes in a hospital without a stroke unit it is advisable and preferred that a direct clinician to clinician discussion takes place (between the Hospital and HASU) to agree the best course of medical management. If the assessing team wish the patient to be transferred for stroke care and the patient is fit for transfer, they must be accepted by a HASU. This is the only way to ensure that they enter the appropriate patient pathways in a timely manner. Transfer of these patients should be arranged according to the flowchart.

If patient transfer to SU is the agreed course of action, the London SU Lookup table should be used to identify the most appropriate stroke unit to transfer the patient to. SU's must accept patients within their defined catchment If in the very unlikely scenario that the SU is unable to provide a bed the issue will be escalated to the manager on-call of the SU host trust and then the manager on-call of the SU host PCT.

http://www.londonsulookup.nhs.uk/