Guidelines on the Repatriation of Adult and Paediatric Burn Injured Patients within the South West Burns Clinical Network

NHS South West Burns Clinical Network

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This document provides a framework for the repatriation of adult and paediatric burn injured patients in the South West Burns Clinical Network (SWBCN).

The framework provides a number of criteria that burn services should follow to ensure a safe and timely repatriation of paediatric and adult burn injured patients within the SWBCN and also for inter-network transfers.

1. Key Principles

1.1 Adult patients with complex burn injuries within the SWBCN will be treated in The Welsh Centre for Burns and Plastic Surgery in Morriston Hospital, Swansea as per the National Burn Care Referral Guidance[1].

1.2 Paediatric patients with complex burn injuries within the SWBCN will be treated in The SW UK Children's Burn Centre at the Bristol Royal Hospital for Children as per the National Burn Care Referral Guidance[1]

1.3 Patients with less serious burn injuries will be treated in their local burns service up to the level of injury to which their service is designated[1].

1.4 Patients from outside the SWBCN requiring Burn Centre level care may be transferred to Swansea (adults) or Bristol (paediatrics) if no appropriate level of burn bed is available within their own Network area.

1.5 A number of patients may have been transferred some distance for their definitive burn care. These patients, at an appropriate stage in their management, must have an opportunity to have their care transferred to a Burn Unit or Burn Facility closer to their place of residence.

1.6 All the Burn Care Service Providers within the SWBCN have been designated as a Centre, Unit or Facility and are deemed to be able to deliver the level of care and rehabilitation appropriate for their designation.

1.7 Complex discharge planning is better done by a burn service closer to where the patient lives.

1.8 Care pathways will be in place to ensure on-going care is not diminished by transfer from a Centre to a Unit or transfer from a Centre or Unit to a Facility.

1.9 The following criteria for repatriation/transfer to another burn service must be followed.

2. All Transfers

2.1 The transfer of care between burn services should only occur when clinically appropriate and when decided by the Consultant in charge of the patient following input from the multi-disciplinary team (MDT).

2.2 Within normal circumstances, the transfer of care to another service should occur with the patient's agreement and the support of their family or carer(s) as appropriate.

2.3 Contact between the transferring and receiving burn services should be by verbal and written communication at Consultant level in the first instance to ensure that the appropriate care input can be delivered at the service to which the patient is being transferred. A named Consultant should be identified in the receiving burn service to maintain sole or shared care of the patient in respect of further surgical management once the patient has transferred.

2.4 Prior to transfer, all disciplines within the referring burn service (for example, medical, nursing, therapy, psychology/psychiatry, infection control and, in the case of children, paediatricians) should have communicated with their corresponding discipline in the receiving service to ensure seamless transition of care.

2.5 The referring burn service should set up an MSTeams videoconference with the receiving burn service at least once prior to transfer to ensure members of the receiving MDT are aware of the patient's on-going holistic care requirements.

2.6 A rehabilitation prescription of planned on-going care will include:

- A rehabilitation programme;
- Wound dressing requirements;
- Psychology input;
- Microbiological information;
- Appropriate discharge information (to be sent to the accepting service and the patient's GP). A copy of this documentation should also be given to the patient.

NB: This is not an exhaustive list and other agencies, when appropriate, will need to be informed (for example, safeguarding issues).

2.7 Appropriate documentation from all disciplines involved in the care of the patient should accompany the patient (ideally using the *SWBCN Patient Transfer Information Document).* In addition to the above information, this should include a detailed drug history and planned timeframe over which various drugs need to be continued.

2.8 The receiving Burn Care Service must ensure that there will be a bed available to receive the patient (subject to their care requirements being met).

3. CENTRE to UNIT Transfers

3.1 **ITU/HDU** - Transfer of care from a Centre to a Unit should be at a stage when the need for ITU/HDU management is complete and the patient is medically stable and does not require respiratory support. Ward level care that is appropriate for the patient's needs should be instigated at the centre prior to transfer.

3.2 **TBSA** - TBSA unhealed <10%.

3.3 **Surgical Management** - Transfer of care from a Centre to a Unit should be when complex surgical management of the patient is complete.

3.4 **Wound Care** – The patient should ideally not require general anaesthetic or IV sedation for dressing changes and are at a level that can be managed by experienced ward based burns nursing staff. Infection control status +/- MDROs, MRSA/MRC status should be communicated.

3.5 **Rehabilitation (Therapy/Psychology/Social/Scar Management)** - The transfer of care from a Centre to a Unit should occur at a stage when the patient's continuing rehabilitation requirements can be met by the Burns Unit. Patients do not need to be fully mobile before repatriation to a Burns Unit. The patient may be transferring from bed to chair with assistance of two or three people or could be using a standing hoist. Their rehabilitation could also involve using a tilt table. Decisions will be based on specific case needs after consultation with each discipline.

3.6 **Outpatient provisions** – If the level of therapy/wound care can be offered as an outpatient at point of transfer, this process needs to be discussed and agreed with the receiving Burns MDT.

3.7 If there is to be a care level insufficient for the patient's needs within the receiving service, then this is highly likely to result in a delayed transfer.

4. CENTRE to FACILITY or UNIT to FACILITY Transfers

As for Centre to Unit transfer detailed above, but <u>in addition</u>:

4.1 **TBSA** - TBSA unhealed < 5%, but depends on co-morbidities.

4.2 **Surgical Management** - Transfer of care from a Centre or Unit to a Facility should be when surgical management of the patient is complete.

4.3 **Wound Care** – The patient should not require general anaesthetic or IV sedation for dressing changes and required burns dressings. Infection control status +/- MDRO's, MRSA/MRC status should be communicated.

4.4 **Rehabilitation (Therapy/Psychology/Social/Scar Management) –** The transfer of care from a Centre or Unit to a Facility should occur at a stage when the patient's continuing rehabilitation requirements can be met by a Burns Facility or a local rehabilitation hospital. The patient may be walking a few steps with a Zimmer or gutter frame and would be offered at least once daily physiotherapy and/or occupational therapy intervention, and access to psychology services, dependent on their needs. Significant collaboration between services will be required to decide when the patient is transferred to ensure that the patient has access to the physical and psychological rehabilitation required to meet their needs.

4.5 If the patient is to be transferred to a local rehabilitation hospital within the South West Burn Care ODN area, then there must be appropriate provision for the above described burn wound care and ongoing support of the non-specialist service by the local burns service.

4.6 **Outpatient provisions** – If the level of therapy/wound care can be offered as an outpatient at point of transfer, this process needs to be discussed and agreed with the receiving Burns MDT.

4.7 If there is to be a care level insufficient for the patient's needs within the receiving service, then this is highly likely to result in a delayed transfer.

4.8 Patients and their families and/or carers should be offered the choice of outreach support to access ongoing specialist advice and wound/scar management, once clinically appropriate, following discharge from inpatient care. This can be in-person or by electronic/remote means and in collaboration with local community healthcare professionals.

5. Infection Prevention and Control

5.1 All hospitals delivering a specialised burn care service within the South West Burns Clinical Network have Infection Prevention and Control (IPC) policies. These policies will need to be factored into the planning of repatriation of burn patients to another burn service. In some circumstances this may delay their transfer. All microbiology results and treatment need to be discussed as part of the handover between Teams. However, if the patient has a multi-drug resistant organism (MDRO), then it will be necessary for the Infection Prevention and Control Team (IPCT) from the referring burn service to discuss with the receiving burn service's IPCT prior to transfer.

5.2 All patients can expect enhanced infection prevention and control precautions, including isolation. The isolation will be dependent on the individual services IPC policies. Microbiology tests will need to be updated by the referring service prior to transfer. This is necessary to protect the hospital population as a whole when transferring between services.

5.3 Repatriation Transfer videos are a useful aid for reducing patient anxiety and managing expectations when transferring between two burn services.

6. Delayed Repatriations

Local System Repatriations

6.1 Repatriation to other acute hospitals is for when patients no longer need specialist intervention and/or require continuation of acute level care closer to their place of residence. Patients who require repatriation to a ward bed within a local system are the responsibility of that Integrated Care System (ICS) working with NHS Trusts. These patients should remain high priority in line with the terms of the mutual aid agreements and local trusts have a responsibility to accept and place the patient for repatriation within 72 hours of referral.

Other SW Region System Repatriations

6.2 Patients who require repatriation to a ward bed outside of a local system should follow the process as detailed below.

<u>Referring Trust responsibility:</u>

- Facilitate clinician to clinician referral when the patient is clinically fit for repatriation.
- Details of the onward care needed for the patient to be repatriated are included in the referral and followed up by email.
- Provision of information to patients and relatives to gain assent/support for transfer.
- Handover (written and verbal) – patients should not leave until verbal handover complete.
- Appropriate transport for transfer should be arranged at the earliest opportunity.

Receiving Trust responsibility:

- Receiving Trust should aim to repatriate the referred patient within 72 hours, or 48 hours in the case of major trauma or after receiving treatment at a specialist centre.
- All transfers should aim to reach destination during normal working hours (8.00 am and 5.00 pm).

Referring ICS responsibility:

- Act as an escalation point of contact for repatriations where internal escalation has failed to resolve any delays.
- Escalation to receiving ICS for resolution.

Receiving ICS responsibility:

- Work with Trusts to understand any escalated delays and facilitate repatriation at the earliest opportunity.
- Keep the referring ICS informed of any updates and monitor the situation until the delay is resolved.

Dispute resolution & escalation:

- For delays beyond 72 hours, escalate to provider Chief Operating Officer (COO) of receiving Trust for resolution.
- Failure of COO to COO resolution to be escalated to provider Chief Executive Officer (CEO) of receiving Trust for resolution within 4 days of referral.
- Failure of provider CEO to CEO to be escalated to provider ICS CEO of receiving Trust for resolution within 5 days of referral.
- Failure of ICS to ICS CEO to be escalated to the Regional Operations Centre (ROC) at england.sw-roc21@nhs.net.

Inter-regional escalation:

- Ensure the escalation process above has been followed and documented in the template at Appendix 2 (or similar local version of this template).
- Failure of process above to be escalated via the ROC to receiving regional discharge and hospital flow leads copying in Regional Operations Centre (ROC) at england.sw-roc21@nhs.net for resolution within 24 hrs.
- Failure of regional discharge and flow lead to facilitate repatriation to be escalated to GOLD command arbitration in both regions within 24 hrs for binding determination.

7. Resources

1. Bristol Adult Burns Unit (Southmead Hospital) Repatriation Transfer video. Burns service at Southmead Hospital - YouTube

2. Salisbury Burns Unit (link to follow)

8. References

1. National Burn Care Referral Guidance. National Network for Burn Care (NNBC),Version 1, Approved February 2012

https://www.britishburnassociation.org/wp-content/uploads/2018/02/National-Burn-Care-Referral-Guidance-2012.pdf

2. British Burn Association National Standards for the Provision of Adult and Paediatric Burn Care (2nd Edition, June 2023) https://www.britishburnassociation.org/wp-content/uploads/2023/08/BBA-Burn-Care-Standards-2023.pdf#:~:text=The%20%E2%80%98National%20Standards%20for%20the%20Provision%20of%20Adult,and%20the%20clinical%20network%20in%20which%20they%20operate .

3. NHSE South West Region Acute Trust Patient Repatriation SOP V.1 2022.

Trust / ICS Checklist for Patients Delayed Awaiting Repatriation

South West Region Urgent and Emergency Care Delayed Repatriation Escalation Checklist - required patient information for successful escalation and support

Patient Details			
Patient's Initials		NHS N°	
Swab results maximum 48 hours prior to referral?			
Referring Trust and Site			
Referring Speciality and Ward			
Receiving Trust and Site			
Receiving Speciality and Ward if known			
Date declared fit for repatriation by referring Trust			
Date first notified to receiving Trust			
Name of person accepting referral			
Date site expected to receive patient			
Escalation Details			
Name of referring Consultant			
Name of referring COO			
Name of referring CEO			
Name of referring ICS CEO			
Name of receiving Consultant			
Name of receiving COO			
Name of receiving CEO			
Name of receiving ICS CEO			
Date of COO to COO escalation call			
Date of CEO to CEO escalation call			
Date of Trust escalation to ICS			
Date of ICS CEO to ICS CEO escalation call			
Date of escalation to NHSEI SW ROC			
Any additional information			