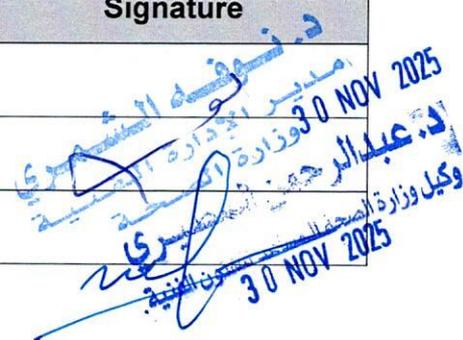


Policy Title: Patient interhospital/intrahospital transfer policy.	
Policy Owner: MOH committee on hospital clinical services and policies.	Policy Code: A-ADM-005
Section location: General and specialized health care facilities in MOH and Non-MOH health care facilities.	Version: V3
	Effective Date: 01/12/2025
Applies to: General and specialized health care services in MOH and Non-MOH health care facilities.	Revision date: 30/11/2027
Approvals	Signature
Approved by: MOH Committee on Hospital Clinical Services and Policies.	
Approved by: MOH Technical Directorate.	
Approved by: MOH Assistant Undersecretary of Technical Affairs.	

1. Purpose:

1.1 The purpose of this policy is to provide the necessary guide and standards for the safe and efficient transfer of patients (stable, unstable and critical) within the different departments of the same hospital (intrahospital) and between hospitals (interhospital) with the most structured multidisciplinary approach aiming to avoid critical incidents and/or complications en route. It is also aimed at averting unnecessary transfers and providing alternatives.

2. Definitions:

- 2.1 **Repatriation:** return of the patient to his/her respective hospital/catchment area (ward to ward, ICU to ICU and clinic to clinic).
- 2.2 **Index:** same, original, first facility/hospital patient.
- 2.3 **MRP:** Most Responsible Physician.
- 2.4 **ERP:** Emergency Room Physician.
- 2.5 **ICU:** Intensive Care Unit.
- 2.6 **CCU:** Cardiac Care Unit.
- 2.7 **ER/ED:** Emergency Room/Emergency Department.
- 2.8 **PCI:** Percutaneous Coronary Intervention.
- 2.9 **STEMI:** ST Elevation Myocardial Infarction.
- 2.10 **MOH:** Ministry Of Health.

3. The Transfer procedures:

3.1 Intrahospital Transfers:

- 3.1.1 **Intrahospital** Transfers are aimed to transfer patients **within** the same hospital for investigations, interventions or transfer of care from one respective service/specialty/ward to another.
- 3.1.2 **Unstable/critical patients** whose hemodynamic/physiological status render the risk of transfer more than the benefit of bedside care who are nevertheless in need of investigations (e.g., ultrasound, echocardiography etc.) and/or interventions

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(ultrasound guided drainage of collections) that are amenable to be provided bedside, **should** be provided with those investigations/interventions bedside if available and sufficient.

- 3.1.3 The **transferring service/specialty/ward** planning an intrahospital transfer aimed to transfer patients within the same hospital (for investigations, interventions or transfer of care) should ensure the **receiving service/specialty/department/ward** are aware, **accepting** and expecting the transfer.
- 3.1.4 It is the responsibility of the **transferring service/department** responsible for the patient's care to inform the **receiving service/specialty/department/ward** about the clinical status of the patient being transferred and the necessary requirements for his/her care at the recipient location.
- 3.1.5 It is the responsibility of the **transferring service/department** responsible for the patient's care to ensure the safe transfer of their respective patients **to the receiving service/specialty/department/ward** and/or back.
- 3.1.6 It is the responsibility of the **transferring service/department** responsible for the patient's care to follow the guides set forth in this policy to stratify the patients according to their medical/clinical status and their medical supportive requirements to ensure the safe transfer of their respective patients **to the receiving service/specialty/department/ward** and/or back.

Chart 1: The NEWS scoring system

Physiological parameter	Score						
	3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO ₂ Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO ₂ Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Transfer Risk Assessment

NB Risk assessment is to some extent subjective and other factors not listed may influence the perceived risk. The risk tool is provided for guidance only. It is the referring consultants responsibility to ensure that the transfer is appropriate and that the transferring team have the necessary skills required.

Low Risk

NEWS 1 - 4
Maintaining airway
FiO₂ < 0.4 / Base deficit < -4 mmol/l
Not requiring inotrope / vasopressor support
GCS ≥ 14
Normothermic

Nurse / Practitioner with appropriate competencies only

Medium Risk

NEWS 5 - 6
Maintaining airway
FiO₂ < 0.4 - 0.6 / Base deficit -4 to -8 mmol/l
low dose inotrope / vasopressor support < 0.2ug/kg/min
GCS 9-13 (Consider elective intubation)
Hypo / Hyperthermic

Doctor accompanied by Nurse / Practitioner with appropriate competencies if potential to deteriorate then doctor should have critical care and advanced airway competencies

High Risk

NEWS 7 or more
Intubated / Ventilated
FiO₂ > 0.6 Base deficit > -8mmol
CVS unstable and / or
requiring inotrope / vasopressor support < 0.2/kg/min
Hypo / Hyperthermic
Major Trauma e.g Head / chest / abdominal / pelvic injury

Doctor with critical care and advanced airway competencies accompanied by Nurse / Practitioner with appropriate competencies

Before Moving The Patient Consider:

Reason: Can the patients needs be met within the existing hospital
Timing: Does this transfer need to be done at this time
Team: Are the right people available to conduct the transfer safely
Transport: Booked and reference number documented
Risk: What are the predictable risks & will the base hospital be exposed whilst the team are deployed

Preparing For Transfer:

E	EQUIPMENT	Establish on transfer ventilator and secure patient on trolley	<input type="checkbox"/>
		Full monitoring to ICS standard	<input type="checkbox"/>
		Emergency drugs, oxygen and fluids available	<input type="checkbox"/>
		Transfer bag checked (including battery back up)	<input type="checkbox"/>
		Consider spinal immobilisation if necessary	<input type="checkbox"/>
		Specialist equipment e.g. balloon pump, warming blankets	<input type="checkbox"/>
S	Systematic	Full ABCDE assessment	<input type="checkbox"/>
		Confirm airway secure	<input type="checkbox"/>
		2 Working and accessible intravenous access points	<input type="checkbox"/>
		Confirm patient stable and suitable of transfer	<input type="checkbox"/>
C	Communication	Inform patient (if not sedated) and family	<input type="checkbox"/>
		Confirm transfer, requirements and ETA with receiving unit	<input type="checkbox"/>
		Mobile telephone available	<input type="checkbox"/>
O	Observations	Commence inter-hospital transfer charting	<input type="checkbox"/>
		Full set of observations recorded	<input type="checkbox"/>
		Confirm patient stable and suitable of transfer	<input type="checkbox"/>
R	Recent Investigations	Handover documentation completed	<input type="checkbox"/>
		Recent investigation results including arterial blood gas	<input type="checkbox"/>
		Confirm radiological images transferred electronically	<input type="checkbox"/>
T	Team	Skill mix of transfer team appropriate	<input type="checkbox"/>
		Protective clothing / high visibility jackets available	<input type="checkbox"/>
		Is the unit safe to leave?	<input type="checkbox"/>

3.1.7 It is the responsibility of the **transferring service/department** responsible for the patient's care to provide the necessary personnel and medical support (equipment etc.) set forth by this policy to ensure the safe transfer of their respective patients **to the receiving service/specialty/department/ward** and or back.

Suggested contents list for Transfer bags⁷:

<p>Advanced Airway Equipment</p> <ol style="list-style-type: none"> 1. 1x ET Tube 6 2. 1 x ET Tube 7 3. 1 x ET Tube 8 4. 1 x ET Tube 9 5. 2 x laryngoscope Handles , Bulbs Batteries 6. 1 x Laryngoscope Blades 3 7. 1 x Laryngoscope Blades 4 8. 2 x Endotracheal ties 9. 1 x Magill Forceps 10. 1 x Tape for securing ET 11. 3 x Lubricant gels 12. 1 x Stylet 13. 1 x Gum Elastic Bougie 14. 1 x Tracheal dilator 15. 1 x Scalpel size 22 16. 1 x 10ml syringe 17. 1 x Torch 18. 2 x face masks 19. 1 x ETCO2 indicator 20. 1 x Waters circuit <p>Self-ventilating Equipment</p> <ol style="list-style-type: none"> 1. 1 x Gudel airways size 2 2. 1 x Gudel airways size 3 3. 1 x Gudel airways size 4 4. 1 x Nasopharyngeal airways 6 5. 1 x Nasopharyngeal airways 7 6. 1 x Oxygen Mask-non rebreathe size 4 7. 1 x Oxygen Mask-non rebreathe size 5 8. 2 x Oxygen tubing <p>Inside pouch on side of bag</p> <ol style="list-style-type: none"> 1. 2 x Clinical waste bags 2. 1 x Sharps box (to be sourced locally) 3. 1 x Hand-held portable suction 4. 3 x IV Fluids (crystalloid) 500ml 5. 1 x Pressure bag 	<p>Breathing Equipment</p> <ol style="list-style-type: none"> 1. 1 x I-gel size 3 2. 1 x I-gel size 4 3. 1 x I-gel size 5 4. 1 x Airway HME Filter 5. 1 x Catheter Mount 6. 1 x Sterile scissors 7. 1 x Anaesthetic mask size 4 Green 8. 1 x Anaesthetic mask size 5 Orange 9. 1x Stethoscope 10. 1 x Wave form capnograph <p>Suction Equipment</p> <ol style="list-style-type: none"> 1. 2 x Yankauer suckes 2. 2 x Suction catheters (10F) 3. 2 x Suction catheters (12F) 4. 2 x Suction catheters (14F) 5. 2 x Suction tubing <p>External Equipment</p> <ol style="list-style-type: none"> 1. 1 x self-inflating bag and mask with oxygen reservoir and tubing (BVM) 	<p>Circulation Equipment</p> <ol style="list-style-type: none"> 1. 2 x IV cannula size 14G 2. 2 x IV cannula size 16G 3. 2 x IV cannula size 18G 4. 2 x IV cannula size 20G 5. 2 x IV cannula size 22G 6. 10 x Pairs of non sterile gloves 7. 5 x Luer lock syringes 20ml 8. 4 x Luer lock syringes 50ml 9. 3 x Chloraprep skin wipes 10. 10 x Alcohol wipes 11. 2 x Blood./Colloid fluid giving sets (Gravity) 12. 5 x Infusion device giving sets 13. 5 x infusion device extension sets 14. 4 x 3-way taps (or equivalent) 15. 10 x Obturators (Red and/or white bungs) 16. 1 x Micropore tape 17. 4 x Gauze 18. 5 x Cannula dressings 19. 12 x ECG Electrodes 20. 1 x Trauma shear scissors 21. 10 x Labels 22. 10 x Sodium Chloride ampoules (flush) <p>Interventional circulation Equipment</p> <ol style="list-style-type: none"> 1. 1 x EZ-IO Intraosseous Device 2. 3 x EZ-IO Needles 3. 5 x Needles Green 4. 5 x Needles Blue 5. 5 x Needles White 6. 5 x Drawing up needles 7. 2 x Tourniquets
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3.1.8 It is the responsibility of the **transferring service/department** responsible for the patient's care **to consult the anesthesia/ICU physician** (or any physician with critical care and advanced airway competency) to accompany the respective patient deemed -by the guide set forth in this policy- to require such advanced level of expertise, to ensure the safe transfer of their respective patients **to the receiving service/specialty/department/ward** and or back.

3.1.9 It is the responsibility of the **transferring service/department** responsible for the patient's care to decide, according to the patient's medical status, the need to be accompanied, by the treating physician and/or anesthesia/ICU physician only. This decision should be documented in the file by the senior registrar (or an above rank) of the treating unit transferring the patient.

3.1.10 It is the responsibility of the **anesthesia/ICU physician** (or any physician with critical care and advanced airway competency) who is consulted or delegated to accompany a patient deemed -by the guide set forth in this policy- to need advanced airway and critical care support, to ensure that the required medical equipment and support is available at hand, functional and ready for the transfer.

3.1.11 It is the responsibility of the physician /nurse of the **transferring service/department** responsible for the patient's care who are delegated to accompany a patient deemed -by the guide set forth in this policy- to be low risk to ensure that the required medical equipment and support is available at hand, functional and ready for the transfer, and to ensure continuous observation and assessment of the respective patient en route to and/or from their destination.

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- 3.1.12 It is the responsibility of the **receiving service/ward/department** to ensure its readiness and capabilities to accept, receive and continue to provide the necessary care/management/support of the transferred patient prior to receiving the transfer.
- 3.1.13 With regards to patients in the **emergency department** who are to be transferred for imaging (or any other location) but have **not** been admitted by a service (or consulted) it is the responsibility of the **ERP** (emergency room physician) to follow the above guide set in this policy for the respective patients transfer.
- 3.1.14 With regards to patients in the **emergency department** who are to be transferred for imaging (or any other location) but have **not** been admitted by a service (or consulted), the decision to consult the anesthesia/ICU physician for transfer of moderate to high risk patients (as per the above guide) is left to the **ERP** discretion, their level of critical care /airway competency and department workload.
- 3.1.15 If an **ERP with** critical care/airway competency, is delegated to the transfer of a moderate or high-risk patient (as per the guide above), it is his/her responsibility to follow the rules set in article 3.1.9 and 3.1.10 of this policy.
- 3.1.16 In situations where a patient clinically deteriorates and a code blue is to be initiated, the responsibility of the transferring service/department resides with the patient they accompany. The patient should never be expected or accepted to be left alone (to call for help or initiate code blue by the transferring team). The initiation of the code blue should be delegated to members of the recipient destination, or surrounding personnel (orderly, technicians, public relations etc.). The transferring service/department should initiate the basic life support/ACLS measures to the patient until the code blue team arrives and takes over the care and intervention.
- 3.1.17 **Transferring and receiving services** should ensure proper documentation of sign/hand over of the transferred patient.

3.2 **Interhospital Transfers:**

- 3.2.1 **Interhospital** Transfers are aimed to transfer patients **between** hospitals for investigations, interventions or transfer of care from one respective service/specialty/ward to another.
- 3.2.2 Patients in one hospital should **not** be transferred to another hospital for an intervention, clinical assessment or outpatient follow up services that may be provided in the index hospital. The consulted specialist should follow the tenants of consults set by the MOH and continue care, management plan and intervention in the index hospital if the appropriate necessary set up and care is available in the index hospital (e.g., orthopedic surgery, vascular surgery, neurosurgery, interventional radiology etc.).
- 3.2.3 If the consulted specialist requires the patient transfer for an intervention (e.g., neurosurgery for management of AVM or SAH), the patient is transferred to a receiving ward and admitted under that specialist for the care, management and follow up until deemed fit for repatriation (return of the patient to his/her respective index hospital/catchment area - ward to ward, ICU to ICU and clinic to clinic) at which point they should request the transfer to the hospital and follow the transfer standards set in this policy.
- 3.2.4 Interhospital transfers are subject to the same policy set above as intrahospital transfers.
- 3.2.5 Transfers from the emergency department of one hospital to another (or ward) should be arranged by the consulted most responsible physician requesting the transfer (ED

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physician, consulted general surgeon on-call, internal medicine on-call, orthopedic surgery on-call etc.).

**N.B. If a physician is deemed necessary to accompany the patient, the criteria above should be followed, and the ED physician is exempted from accompanying patients to other hospitals.

- 3.2.6 **Unstable, critical patients** should not be transferred to other hospitals for intervention, unless the referring hospital or facility is not equipped to definitively manage or temporarily stabilize the patient and the patient is best served by the receiving hospital (e.g. PCI for STEMI in a facility lacking an interventional coronary care unit). The transfer is arranged after the receiving hospital acceptance and the signed consent of the procedure and transfer denoting risks and benefits should be acquired.
- 3.2.7 Unstable, critical and emergency (walk-in or code orange triaged) patients presenting to hospitals out of their catchment area should be managed and stabilized accordingly, and admitted if deemed necessary with repatriation to their catchment hospital once deemed stable and necessary by the treating MRP.
- 3.2.8 Repatriation of patients to their catchment area MOH Hospital is left to the discretion of the receiving team of the index hospital (first to receive and treat); once deemed stable and resources/beds in the MOH hospital of the patient's catchment area are available.
- 3.2.9 Transfers of traumas and subspecialties should follow the policy set by the MOH for the diagnoses specified. (MOH Medical and Surgical Emergency Admission Designation policy A-ADM-003).
- 3.2.10 Transfers of **admitted** patients should be:
- 3.2.10.1 Ward to ward.
- 3.2.10.2 CCU/ICU to CCU/ICU, unless agreed upon to transfer otherwise (E.g. CCU to repatriated ward).

3.3 Transfers from Non-MOH health care facilities to MOH hospitals:

- 3.3.1 The ministry of health hospitals provide health care, support and coverage for **all patients** in the state of Kuwait including those in the non-MOH health care facilities.
- 3.3.2 When it is decided by the treating team of a respective non-MOH health care facility (or the patient him/herself or legal guardians) that the patient under their care is best served and cared for in an MOH hospital/health care facility they should request transfer to the catchment area hospital of the respective patient from the respective specialty unit on call in that hospital.
**** (unless it's inconsistent with the previous MOH rules and regulations).**
- 3.3.3 If the catchment area MOH hospital is unable to accept the patient's transfer due to lack of resources and/or beds, the treating team of the respective non-MOH health care facility should contact the next closest MOH hospital and request transfer of the patient from the respective specialty unit on call in that hospital. (Refer to the attached MOH-designated back up hospital scheme).
- 3.3.4 if the on-call specialty/unit/department in an MOH hospital, accepts the transfer of a patient **NOT** from its catchment area under its care from a non-MOH health care facility due to lack of resources and or beds in the MOH hospital of the patient's catchment area, repatriation of the patient to his/her catchment area MOH Hospital is left to the discretion of the receiving team of the first hospital ; once deemed stable and resources/beds in the MOH hospital of the patient's catchment area are available.

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3.3.5 Transfers from non-MOH health care facilities to MOH should follow the same rules/regulations/policies set above. It is the responsibility of the transferring treating team of the non-MOH health care facility to adhere to this policy and ensure acceptance of the patient from the receiving MOH hospital and patient safety during transfer.

4. Monitoring procedure:

- 4.1 MOH committee on hospital clinical services and polices will monitor the above policy.
- 4.2 Senior doctor of the related team can email the above-mentioned committee, in case of any incidence.
- 4.3 The email address will be: incident@moh.gov.kw

**Ambulance priorities for patient repatriation/interhospital transfer:

Priority	Description
Priority-1	Within 0- 60mins (e.g., STEMI for PCI in another facility)
Priority-2	Within 6 hours (e.g., stable patient planned for urgent intervention)
Priority-3	Within 12 hours (e.g., stable patient planned for intervention, or repatriation from tertiary center)
Priority-4	Within 12-24 hours (e.g., repatriation of stable or institution dependent patient)

5. References:

- 5.1 MOH Emergency Admission Policy A-ADM-002.
- 5.2 MOH Medical and Surgical Emergency Admission Designation policy A-ADM-003.
- 5.3 Medical practice law 70/2020.
- 5.4 Ministry of health code of ethics for medical and allied health care professionals' decree 209/2022.
- 5.5 West Yorkshire Adult Critical Care Transfer Guidelines, 2017.
- 5.6 Views-Towards a national early warning score for detecting adult inpatient deterioration.
- 5.7 Prytherch DR, et al. Resuscitation. 2010.
- 5.8 Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardizing the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

6. Attachments:

- 6.1 MOH-designated backup hospital scheme.

HOSPITAL	FIRST BACK-UP	SECOND BACK-UP
FARWANIYA	SABAH	JAHRA
JAHRA	FARWANIYA	SABAH
ADAN	MUBARAK	FARWANIYA
AMIRI	MUBARAK	ALSABAH
MUBARAK	AMIRI	ADAN
SABAH	AMIRI	FARWANIYA
JABER	MUBARAK	FARWANIYA
SABAH ALAHMAD CENTER	ADAN	MUBARAK

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