Guideline for transport of critically ill patients
Background Paper

1. Purpose of review

The transport of critically ill patients had previously been divided into two separate documents, one for intrahospital transfers and one for interhospital transfers (P04/PS39 Minimum Standards for Intrahospital Transport of Critically Ill Patients and P03/PS52/IC-10 Minimum Standards for Transport of Critically Ill Patients). Both documents were last reviewed in 2003. Following the establishment of the College of Intensive Care Medicine (CICM), formerly the Joint Faculty of Intensive Care Medicine, as an independent entity in 2010, the documents were republished. The 2013 review is part of the usual review cycle to ensure that the guidelines reflect contemporary knowledge and are based on current evidence.

Although there are some significant differences between intrahospital and interhospital transfers there is sufficient overlap to warrant combining the previously separate documents into a single document.

2. Background

Critically ill patients are at particular risk associated with reduced or exhausted physiological reserves. Transporting such patients requires the services of highly trained and skilled practitioners to manage these patients as they are exposed to additional risks during transport.

As part of the process of continuing improvement in college professional documents each document is considered from the perspective of the intended end-users and stakeholders, with a view to simplification and usability, as well as the intention of the document. In that context this document has been classified as a “guideline”.

The guidelines associated with this background paper are intended for medical practitioners and apply to all stages of critical patient transport be that prehospital, interhospital or intrahospital.

The goal of this document is to assist medical practitioners and hospitals develop and implement strategies and protocols that reduce risks of transporting critically ill patients and maximise their safety.

3. Discussion of issues

In view of the spectrum of practitioners involved in transporting critically ill patients the document development group (DDG) was formed with representation from each of the colleges of emergency medicine, intensive care medicine, and anaesthesia. This ensured that the expertise and experience of each specialty contributing to the management of critically ill patients was incorporated.

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The principal issues considered include staffing, training, equipment, monitoring, transport, and governance.

While the guidelines strive for excellence it is recognised that transport services provided by non-medical practitioners, such as the ambulance services, have their own standards and protocols. However, these guidelines apply whenever medical practitioners are involved.

Where differences exist between intrahospital and interhospital transport, they have been identified and separately addressed.

There is evidence1-4 that in specific cases involving blunt trauma and those requiring procedures such as thoracostomy or hysterotomy physician involvement had a significant impact on improving outcomes and decreasing mortality (see item 7.1).

4. Summary

Transport of critically ill patients exposes them to additional risks, which require the expertise of highly trained and skilled medical practitioners to mitigate these transport risks. The goal of this document is to assist medical practitioners and hospitals develop and implement strategies and protocols that reduce risks of transporting critically ill patients and maximise their safety.

References

1. Bloomer R, Reid C, Wheatley R. Prehospital resuscitative hysterotomy. Eur J Emerg Med. 2011 Aug;18(4):241-242.

2. Davies GE, Lockey DJ. Thirteen survivors of prehospital thoracotomy for penetrating trauma: A prehospital physician-performed resuscitation procedure that can yield good results. J Trauma. 2011 May;70(5):E75-78.

3. Garner A, Rashford S, Lee A, Bartolacci R. Addition of physicians to paramedic helicopter services decreases blunt trauma mortality. Aust N Z J Surg. 1999 Oct;69(10):697-701.

4. Lockey D, Crewdson K, Davies G. Traumatic cardiac arrest: Who are the survivors? Ann Emerg Med. 2006 Sep;48(3):240-244.

Process of document review

In accordance with a memorandum of understanding agreed to in 2010, a document development group (DDG) was established with representation from the three colleges, as follows:

Dr Peter Roessler (chair), FANZCA, ANZCA Director of Professional Affairs (Professional Documents)

Associate Professor Paul Forrest, FANZCA, ANZCA

Dr Stefan Mazur, FACEM, Australasian College for Emergency Medicine

Associate Professor Peter Morley, FCICM, College of Intensive Care Medicine

Dr Roessler chaired proceedings, ensuring the process of review aligned with that detailed in ANZCA professional document A01 Policy for the Development and Review of Professional Documents.

The DDG amalgamated P04/PS39 Minimum Standards for Intrahospital Transport of Critically Ill Patients and P03/PS52/IC-10 Minimum Standards for Transport of Critically Ill Patients. The following stakeholders were invited to provide feedback on a preliminary draft, prior to endorsement of the final draft by each college's governance body:

- ACEM Pre-Hospital and Retrieval Medicine Committee
- ANZCA Council
- ANZCA national/regional committees
- Faculty of Pain Medicine Board and regional committees
- ANZCA Trainee Committee
- Anaesthesia and Critical Care in Unusual and Transport Environments Special Interest Group (SIG)
- Cardiothoracic, Vascular and Perfusion SIG
- Diving and Hyperbaric Medicine SIG
- Neuroanaesthesia SIG
- Obstetric Anaesthesia SIG
- Rural SIG
- Trauma SIG
- CICM Board

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the College website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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