SA Health

Policy

Ambulance Transport and Handover

INFORMAL COPY WHEN PRINTED

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Government of South Australia

SA Health

1. Name of policy

Ambulance Transport and Handover

2. Policy statement

This Policy sets out the mandatory requirements to ensure patients who call triple zero and require ambulance transport are taken to the most appropriate destination with the level of clinical capability required to meet the patient's care needs, and handover of clinical care from SA Ambulance Service (SAAS) clinicians to hospital clinicians occurs in a timely manner.

3. Applicability

This policy applies to all employees and contracted staff of SA Health; that is all employees, volunteers and contracted staff of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) (including state-wide services aligned with those Networks) and SAAS.

4. Policy principles

SA Health's approach to ambulance transport and handover is underpinned by the following principles:

> We will ensure access to publicly delivered healthcare services is fair and equitable to all health consumers.

> We will discharge our duty of care to patients, ensuring their safety, wellbeing, and dignity. This includes delivering care guided by professional responsibilities, training, and expertise.

> We will work collaboratively towards improved response times to triple zero calls requiring an ambulance.

> We will ensure patients are transported in a timely manner to the most clinically appropriate destination to meet their care needs to reduce occurrence of secondary transfer.

> We will ensure efficient and effective handover of patients from SAAS clinicians to hospital clinicians to avoid delays in transfer of care.

> We share responsibility for patients in the community requiring ambulance response and will work collaboratively to expedite patient transfer of care to enable prompt release of ambulances back into the community.

> We will maximise utilisation of alternative care pathways where clinically appropriate to avoid unnecessary transport to hospital.

> We will ensure our workforce is supported with the necessary skills, knowledge, and resources to meet the healthcare needs of patients effectively and compassionately.

> We will implement measures to provide for the health, safety and wellbeing of SA Health staff, establishing a psychologically healthy workplace that promotes workers' physical and mental wellbeing.

5. Policy requirements

> **DHW, LHNs and SAAS** must:

- Ensure dashboards and online resources relevant to ambulance transport and hospital demand accurately reflect real time SAAS activity within the community and LHN capacity and occupancy, including Emergency Department (ED) and inpatient beds.

> **SAAS** must:

- Monitor risk to patients in the community awaiting an ambulance and communicate these in line with Attachment 1.

  - Determine the most appropriate destination for ambulance transports in line with this policy and as outlined in Part 1 of the Mandatory Instruction at **Appendix 1**.
- All **LHNs and SAAS** must:
  - Work collaboratively to achieve timely transfer of care and proactively manage delays in line with Part 2 of the Mandatory Instruction at **Appendix 1**.
  - Have agreed and well-defined pathways for escalating patient care from SAAS clinician to hospital clinician if the patient's condition deteriorates or changes when experiencing delays in transfer of care.
- All **LHNs** must:
  - Consider the relative risks to patients within the community (i.e., compromised community response), those waiting for transfer of care from ambulances, and those waiting for care in the ED waiting room.
  - Facilitate a whole-of-hospital approach to create capacity in ED to ensure transfer of care is not delayed and is completed in less than or equal to 30 minutes from ambulance arrival at the hospital. This includes patient triage, physical transfer, and clinical handover to hospital clinician, as outlined in Part 2 of the Mandatory Instruction at **Appendix 1**.
  - Provide up-to-date clinical service profiles upon the movement or decommissioning of any services to enable currency of the Destination Directory of Services for Specialist Review or Admission fact sheet.

6. Mandatory related documents

The following documents must be complied with under this Policy, to the extent that they are relevant:

- Clinical Communication and Patient Identification Clinical Directive
- Criteria Led Discharge Policy
- Fit to Sit Pathways Policy
- *Health Care Act 2008*
- Inter-Facility Transfer Policy
- LHN Hospital Escalation and Business Continuity Plans
- SAAS Capacity Management Plan
- Managing Transfer or Discharge of Patients Policy
- Psychosocial Safety Policy
- SAAS Escalation Review Process at Metropolitan Emergency Departments
- SA Health Fees and Charges Manual
- Statewide Demand and Escalation Policy
- Worker Health, Wellbeing and Fitness for Work Policy Directive

7. Supporting information

- Aboriginal Health Care Framework 2023-2031
- Fact Sheets:
  - Booking SAAS Patient Transport Service
  - Destination Directory of Services for Specialist Review or Admission
  - Patient Transport Decision Making Matrix
  - Responsibility for Costs Associated with Transport and Assistance Options

8. Definitions

- **Ambulance clearance:** means the ambulance must be available for further tasking within 20-minutes from transfer of care. If more time is required to ensure operational readiness of the ambulance is not compromised (e.g., cleaning, restocking, complex documentation and/or clinical/operational debriefing), authorised clearance codes must be obtained.
- **Ambulance turnaround time:** means the total time from ambulance arrival at the hospital ambulance bay to the time the ambulance is ready and available for another emergency dispatch (less than or equal to 50 minutes). The Patient Transfer of Care Time (less than or equal to 30 minutes) is the responsibility of the LHN, and the Ambulance Clearance Time (less than or equal to 20 minutes) is the responsibility of SAAS.
- **Australasian Triage Scale (ATS)**: means the clinical tool used in ED to establish the recommended waiting time for medical assessment and treatment of a patient. The ATS is only used to describe clinical urgency.
- **Clinical Priority:** means the clinical judgement of ED clinicians to prioritise patient treatment within the same ATS categories by considering individual patient circumstances, medical history, risk factors, dynamic clinical changes, and wait time.

  While the ATS provide structured guidelines, clinical judgment balances urgency with accuracy to ensure patients receive the right level of care based on both objective and subjective assessments of their condition.
- **Compromised Community Response:** means there is a risk to patients in the community who require an ambulance. The risk may be related to one or more of the following:
  - Outstanding priority 1 (≥ 1) and/or 2 (≥ 5) cases in the community.
  - Extensive transfer of care delays in one or more LHNs (≥ 1,000 minutes).
  - Significant percentage of ambulance resources at metropolitan, peri-urban or regional hospitals (≥ 50%).
  - SAAS escalation level of Opstat Red or White as per SAAS Capacity Management Plan.
- **Deterioration**: means a patient who has significant fluctuations in clinical presentation, despite standard pre-hospital interventions.
- **Involuntary patient:** means patients under an Inpatient Treatment Order or Section 56 (Care and Control) of the *Mental Health Act 2009*.
- **Local Health Network**: means an incorporated hospital under the *Health Care Act 2008*, comprising a range of public hospitals and health care sites and services.
- **Transfer of care**: means handover from SAAS clinician to hospital clinician for ongoing clinical care, and the SAAS clinician and their equipment is no longer required.
- **Treatment Space:** means any designated area within an ED where a patient could be safely and effectively assessed and treated by a hospital clinician.
- **Triage:** means the formal process used to immediately assess all patients arriving in an ED to determine the urgency of their care requirements.

9. Compliance

This policy is binding on those to whom it applies or relates. Implementation at a local level may be subject to audit/assessment. The Domain Custodian must work towards the establishment of systems which demonstrate compliance with this policy, in accordance with the requirements of the Risk Management, Integrated Compliance and Internal Audit Policy.

Any instance of non-compliance with this policy must be reported to the Domain Custodian for the Services, Planning and Programs Domain and the Domain Custodian for the Risk, Compliance and Audit Policy Domain.

10. Document ownership

Policy owner: Domain Custodian for the Services, Planning and Programs Policy Domain.

Title: Ambulance Transport and Handover Policy

Objective reference number: A2563469

Review date: 31/03/2030

Contact for enquiries: Health.HSPUnplannedCare@sa.gov.au

11. Document history

Version	Date approved	Approved by	Amendment notes
3.0	10/04/2025	Chief Executive, Department for Health and Wellbeing	Reviewed and updated in line with feedback received from stakeholder consultation 2024/2025. Information related to transport between facilities, discharge to the community, transport costs, and transport assistance has been transferred to the Inter-Facility Transfer Policy. Information in the Statewide Demand and Escalation Policy related to ambulance handover, Attachment 2: Escalation for Compromised Community Response and Transfer of Care Delays, and Attachment 3: Ambulance Rapid Offload Process, have been transferred into the Ambulance Transport and Handover Policy.
2.0	28/07/2023	Chief Executive, DHW	Reviewed and updated in line with SA Health Policy Framework. Previously named Ambulance Distribution for Demand Management Policy Directive.
1.4	03/07/2020	Executive Director, Health Services Programs and Funding	Minor updates to reflect LHN and SAAS feedback.
1.3	28/02/2020	Executive Director, Health Services Programs and Funding	Updates to reflect changes to escalation during delays in transfer of care (as agreed by HSP Strategic Oversight Group).
1.2	16/12/2019	Executive Director, Health Services Programs and Funding	Minor updates to reflect strengthened escalation processes for ambulance transfer of care delays, department name and other staff title changes.
1.1	01/04/2019	Executive Director, Operational Service Improvement and Demand Management	Minor updates to reflect LHN feedback.
1.0	18/05/2017	Executive Director, Operational Service Improvement and Demand Management	Original approved version.

12. Appendices

1. *Ambulance Transport and Handover Mandatory Instruction*

Appendix 1: Ambulance Transport and Handover Mandatory Instruction

The following Instruction must be complied with to meet the requirements of the *Ambulance Transport and Handover Policy*

1. Destination Decision Making

1.1. Where ambulance transport is required, patients must be taken to a suitable alternative care pathway if appropriate (including as an early assessment or pre-admission destination for relevant complex cases) or the most appropriate and geographically closest public hospital, with consideration to:

a) Patients who are suitable for established clinical pathways (e.g., stroke, STEMI, Major Trauma), including specialised pathways with the private sector (e.g., SALHN chest pain and long bone fracture).

b) Patients with complex and/or emergency needs who require review by, or admission to, a specialist service. This cohort must be transported to a destination with the appropriate level of clinical capability outlined in the Clinical Services Capability Framework, and in line with the Destination Directory of Services for Specialist Review or Admission.

c) Patients with mental health conditions under care and control of an authorised officer must be transported to an approved treatment centre or another appropriate place for medical examination. Patients subject to an inpatient treatment order must be transported to an approved treatment centre or authorised community mental health facility in line with the *Mental Health Act 2009*.

d) Patients who are suitable for peri-urban public hospitals, or care in place with support from a secondary service or appropriate specialist clinical advice and guidance.

e) Patients who have been discharged from an ED or public hospital in the previous 72 hours for a related issue. For metropolitan patients, every effort must be made to transport the patient to a hospital within the same LHN. For regional or remote patients, every effort must be made to transport the patient to a facility geographically close to their home location in the first instance.

f) Major emergencies or incidents (e.g., bushfire, pandemic, State Alert / Statewide Escalation in line with Statewide Demand and Escalation Policy) where ambulance or command roles direct patient distribution in conflict with existing policies and procedures as part of an overall incident management approach, including the use of temporary medical facilities.

g) Peak travel times and periods of interruptions to travel flows (e.g., motor vehicle crashes, hazmat incidents etc) when it may be more appropriate to minimise travel time, transporting the patient to a hospital that is outside of the local area.

1.2. Where clinically appropriate, activity levels (ambulance and hospital) and available ambulance resources must be considered by SAAS in determining the destination.

1.3. The SAAS clinician must consider the patient's clinical needs and the hospital's capability to meet those needs when determining hospital destination. Patient preference is to be considered when appropriate, in line with circumstances outlined in Table 1, however the final decision resides with the SAAS clinician.

Table 1: Criteria for Transport to Patient's Preferred Destination

Circumstance	Criteria
Clinical Trial	• Patients who are entered into an approved clinical trial at a particular site where the presentation may be related to that trial.
Known Patient	• Patients who have a significant history and/or existing relationship at a particular site.
Patient Safety	• Domestic or family violence risk.
Private Health Insurance	• Patients with private health insurance must be offered the option to attend a private hospital with the level of clinical capability required to meet the patient's care needs.

2. Transfer of Care

2.1. SAAS must present to triage upon arrival to ED. Patients arriving via ambulance must be assessed and triaged as per usual ED triage procedures. Following triage, the LHN assumes overall responsibility for patient care.

2.2. While awaiting transfer of care:

a) The SAAS clinician must be provided with an appropriate hospital clinician to contact for escalation.

b) The SAAS clinician must continue to monitor the patient's condition, provide necessary care, and escalate any concerns or deterioration in the patient's condition to the appropriate hospital clinician.

2.3. The patient must be moved from the ambulance to either a suitable treatment space in the ED or the waiting room (per the Fit to Sit Pathways Policy) as soon as possible, as determined by the hospital clinician.

2.4. Transfer of care should be completed within 30-minutes of arrival to:

a) Hospital, and must not exceed 60 minutes; if this occurs, escalation must be enacted in line with Attachment 1.

b) Alternative care service providers, who are obligated to accept suitable patients in line with their service agreement.

2.5. Whenever and wherever two patients are assessed of equal clinical priority (refer to Definitions), the patient arriving by ambulance must be given priority for placement within ED to enable release of the ambulance to respond to needs within the community.

2.6. Following transfer of care, the SAAS clinician must immediately call 'handover' via radio to the SAAS Emergency Operations Centre (EOC) and prepare for ambulance clearance (refer to Definitions).

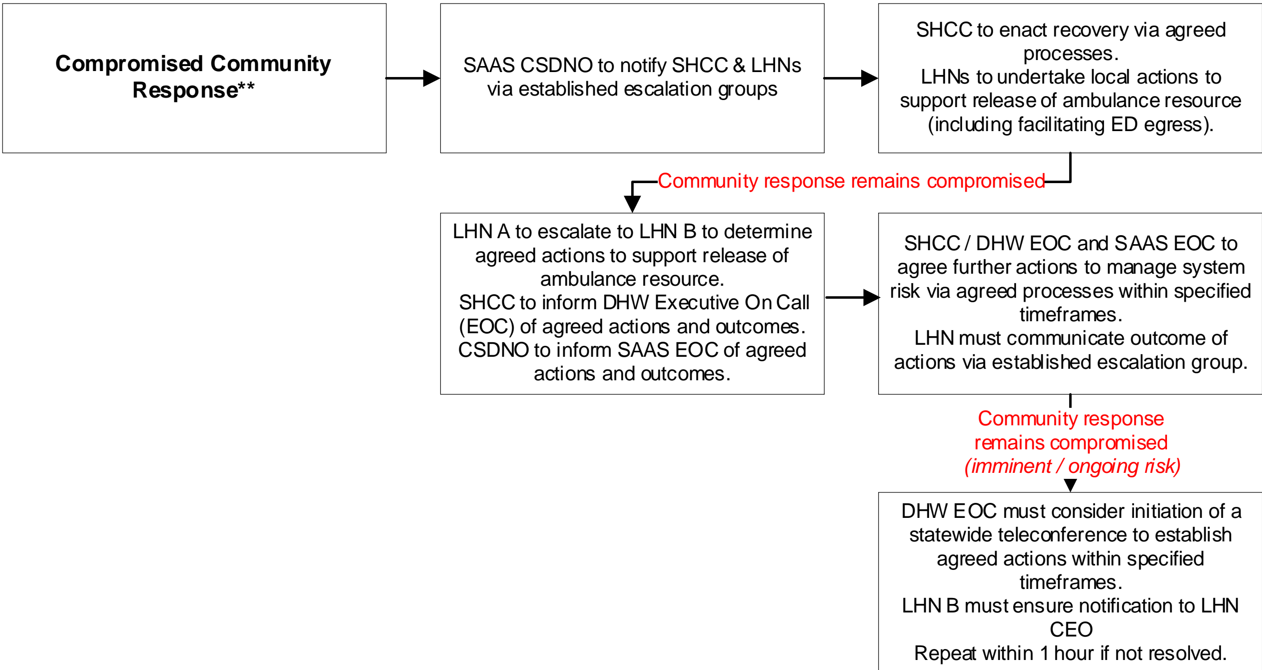
2.7. If ambulance capacity to respond to cases in the community is compromised, and SAAS and the State Health Coordination Centre (SHCC) have exhausted all available escalation actions in line with Attachment 1, ambulance rapid offload must be requested in line with Attachment 2.

Attachment 1: Escalation for Compromised Community Response and Delayed Transfer of Care

Escalation for Compromised Community Response

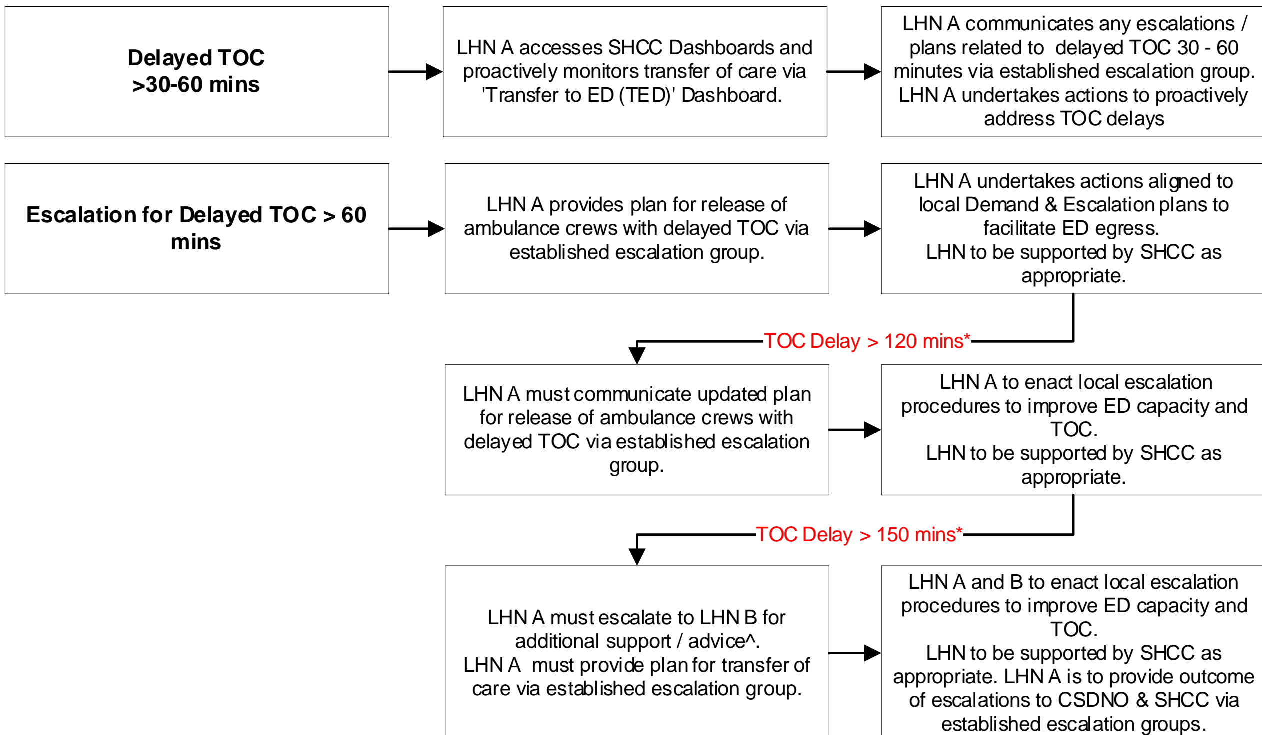
Escalation for Compromised Community Response should only be enacted when there is a risk to patients in the community who require an ambulance. The risk may be related to one or more of the following:

There are outstanding Priority 1 (Trigger: ≥ 1) and / or Priority 2 (Trigger: ≥ 5) cases.	There are extensive Transfer of Care (TOC) delays in one or more LHN (Trigger: ≥ 1,000 mins, excl. TED occurred)	A significant percentage of total ambulance resource is at metropolitan / peri-urban or regional hospitals** (Trigger: ≥ 50%)	SAAS escalation level of Opstat Red or White as per SAAS Capacity Management Plan.



**Compromised community response in regional areas must be escalated through established local processes to restore ambulance capacity and ensure timely emergency response for regional communities.

Escalation for Delayed Transfer of Care



* CSDNO / SHCC may request LHN communication, plans or timeframes for offload of prolonged TOC delays where not communicated.

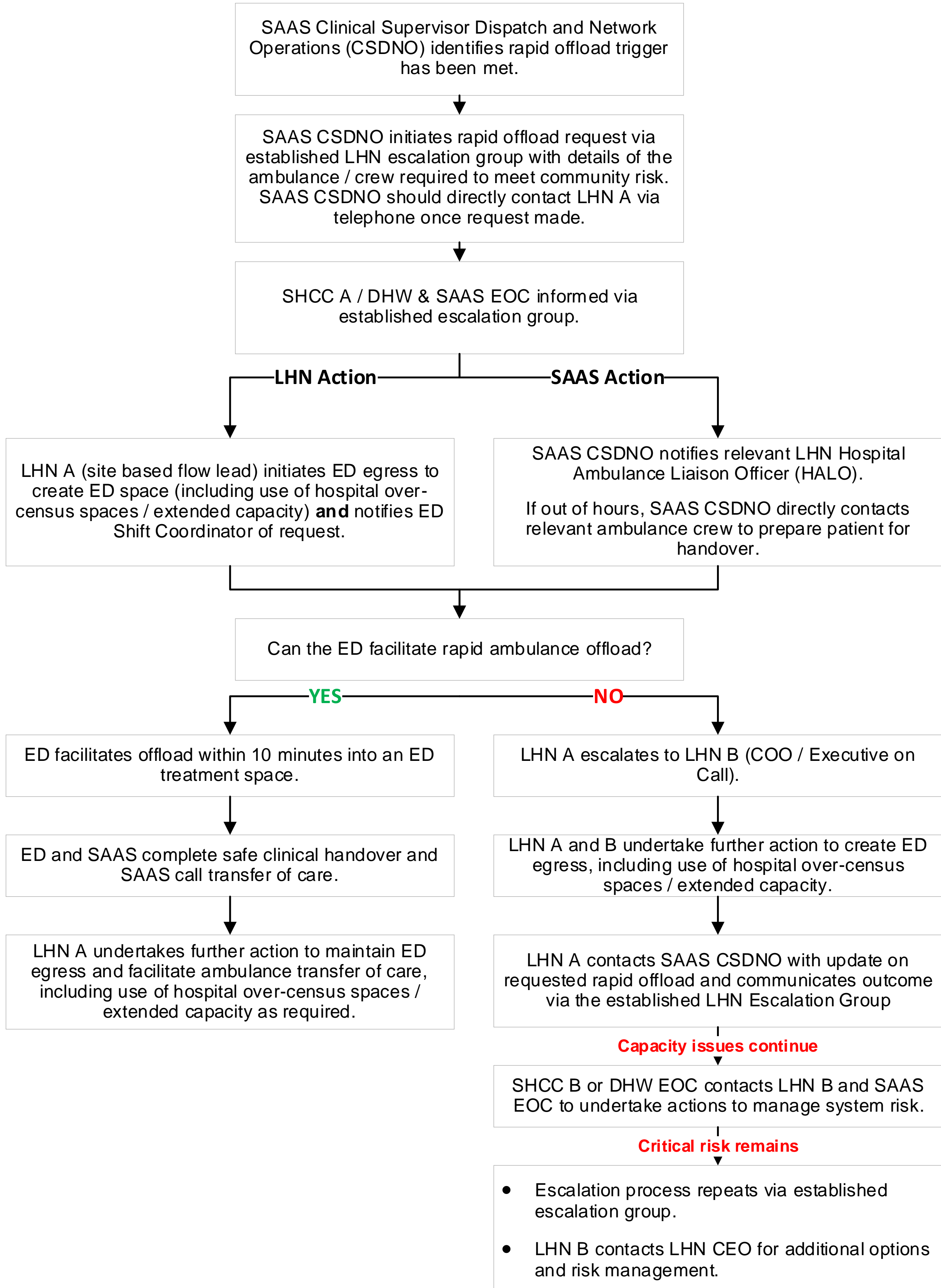
^Automated text notification commences when delayed TOC exceeds 150mins to relevant LHN CEO (0800 - 2200hrs) and is repeated every 30 minutes until resolved.

Attachment 2: Ambulance Rapid Offload Process

A Rapid Offload request should only be enacted when:

1. There is no available or appropriate ambulance resource to meet demand and there is an ongoing imminent risk to community response; **AND**

2. SAAS and the State Health Coordination Centre (SHCC) have exhausted all available escalation actions.



All requests, actions planned, and outcomes must be communicated via the established LHN escalation group.