NEO-SOP-005: Neonatal transfer to a higher level of care

Standard operating procedure (SOP) · NEO-SOP-005 · Version 0.1 · Draft for local review

Supports: 37.5

At a glance

- No neonate is moved to a higher level of care until the receiving unit has accepted the transfer and confirmed it can provide the care needed.
- The baby is stabilised before transfer and sent with a trained transport team, the right equipment and a written handover.
- The parents are told about the transfer, consent is recorded, and they are given the receiving unit's contact details.
- Every transfer is recorded with times, team members, equipment and the handover details, and reviewed for any problem.
- Stop and escalate if: the receiving unit cannot confirm acceptance, the baby is not stable enough to move, or the transport team does not have the right equipment.

1. Purpose

To make sure a neonate who needs care at a higher level is transferred safely, at the right time, with the right team and equipment, and with a complete handover, so that the receiving team can continue care without a gap (37.5).

2. Scope

Item	Coverage
Applies to	Neonatal and maternity staff, the neonatal transport team, the referring and receiving teams
Patients	Neonates (birth to 28 days) and infants who need transfer to a unit with a higher level of neonatal care, for surgery, intensive care or specialist services
Types of transfer	Inter-hospital transfers by ambulance or transport team, and internal transfers between units within the facility

3. Definitions

Term	Meaning in this SOP
Higher level of care	A unit with greater staffing, equipment or specialist services than the referring unit, as set out in the national neonatal level of care criteria
Acceptance	The receiving consultant or senior doctor agrees to take the baby, and confirms the bed, the team and the time of arrival
Stabilisation	Measures taken before transfer to keep the baby's breathing, circulation, temperature, blood sugar and other key functions within safe limits
Transport team	Clinicians and equipment trained for neonatal transport, who travel with the baby
SBAR handover	A structured handover: Situation, Background, Assessment, Recommendation

4. Background

Transfers of sick neonates carry risks of hypothermia, hypoglycaemia, hypoxia, equipment failure and loss of information. Most transfer-related harm comes from delays in deciding, from unplanned transfers, from incomplete handovers and from poor preparation of equipment.

This SOP follows the principle that the receiving unit accepts the baby before transfer, and that the baby is stable and documented before departure.

5. Responsibilities

Role	Responsibility
Referring consultant or senior doctor	Decides that transfer is needed, requests acceptance, and agrees the plan and timing with the receiving consultant
Receiving consultant or senior doctor	Confirms acceptance, the bed and the team, and the time of arrival, and records the acceptance
Referring registered nurse	Stabilises the baby, prepares the notes and the handover, and checks the equipment with the transport team
Transport team	Travels with the baby, monitors the baby, and completes the transfer record
Receiving registered nurse	Receives the baby, checks identity and the handover, and confirms the arrival to the referring unit
Unit manager	Keeps the transfer agreements and transport equipment in place, and audits transfers
Medical director or chief executive	Approves this SOP and the transfer agreements, and receives audit results and serious incidents

6. Materials and equipment

- Transport incubator, or transport cot with heat control, checked before each transfer.
- Portable ventilator, oxygen and suction, checked and charged.
- Infusion pumps and syringe drivers with the medicines needed for the journey, labelled and checked.
- Monitoring: heart rate, oxygen saturation, blood pressure and temperature, with spare batteries.
- Emergency equipment and drugs for the transport team, including resuscitation equipment sized for neonates.
- Transfer record, SBAR handover sheet, copies of the notes, the medicine chart and the parents' consent form.

7. Safety

Before any transfer, the baby must be stable enough to travel in the judgement of the transport team and the referring consultant. The baby is kept warm, the airway is secured, glucose and oxygen levels are checked, and the equipment is tested before the journey.

> If the baby is not stable enough to travel, do not move the baby to meet an arrival time. Discuss with the receiving consultant whether the baby should be stabilised further or whether the receiving team should travel to the baby.

8. Before you start

1. Confirm the decision to transfer with the referring consultant and record the clinical reason.
2. Request acceptance from the receiving consultant. Record their name, the time of acceptance, the bed and the expected arrival time.
3. Check the baby's identity, the parents' identity and the consent for transfer.
4. Check that the transport team is available and that its equipment has been checked and recorded.

9. Procedure

9.1 Decision and acceptance

1. The referring consultant assesses the baby and decides on transfer, with the reason and the urgency recorded.
2. The referring team requests acceptance by telephone and, where the unit's system allows, in writing.
3. The receiving consultant accepts the baby and confirms the level of care, the bed, the team and the arrival time.
4. If no bed is available, the referring team asks the regional coordination service for an alternative unit, and records each request and response.

9.2 Preparation and stabilisation

1. Stabilise the baby, and record the baseline observations: heart rate, respiratory rate, oxygen saturation, blood pressure, temperature and blood glucose.
2. Secure the airway, the vascular access and the feeding route, and record the medicines given and the time of each.
3. Inform the parents about the transfer in person where possible. Explain the reason, the destination, how they can travel to the receiving unit, and who to call. Record their agreement.
4. Prepare the transfer record, the copy of the notes, the medicine chart, the imaging and the results.

5. The transport team checks the equipment and the battery levels, and confirms that the spare equipment is with them.

9.3 Journey

1. Check identity at departure against the identity band and the transfer record.
2. The transport team monitors the baby continuously and records observations at least every 15 minutes.
3. If the baby deteriorates, the transport team follows its emergency protocol and informs the receiving team immediately.
4. Keep the baby warm and avoid unnecessary handling. Record any problem during transport.

9.4 Arrival and handover

1. Identity is checked on arrival against the identity band and the transfer record.
2. The transport team gives an SBAR handover to the receiving team, covering the baby's diagnosis, the treatment given, the current status, the plan and the risks.
3. The receiving team repeats back the key points, and both teams sign the handover record.
4. The receiving team confirms arrival to the referring unit, and the referring unit records the time.

9.5 After transfer

1. The referring unit confirms the outcome of the transfer within 24 hours and records it.
2. The receiving unit informs the parents of the baby's arrival and the plan, and provides contact details.
3. Any problem during the transfer is recorded as an incident and reviewed under INC-SOP-001.

10. Decision points

Situation	Action
Receiving unit cannot accept	Ask the regional coordination service for another unit. Continue stabilisation and treatment at the referring unit, and record each decision.
Baby becomes unstable before departure	Postpone the transfer and stabilise. Discuss with the receiving consultant whether the receiving team should travel to the baby.
Transport equipment fails or is missing	Do not depart until the equipment is replaced or repaired, and the receiving consultant is informed of the delay.
Parents cannot be contacted	Continue with the transfer if it is urgent and the baby would be harmed by delay. Record all attempts and inform the parents as soon as possible.
Parents refuse transfer	Explain the risks and benefits again. If they still refuse, record their decision, the information given, and inform the consultant and the unit manager.

11. Special situations

- Surgical transfers: the surgical team confirms the operating plan and the time before transfer, and the receiving team is informed of the surgical need.
- Maternal transfer with a baby still in the mother: follow the maternity transfer policy, and check that the baby's transfer and the mother's transfer are coordinated.
- Transfer of a baby on a ventilator or with a chest drain: the transport team must include a clinician trained in the equipment used.
- Transfer across a border or to a facility in another region: check the agreement, the licence and the consent process.

12. Escalation

- No acceptance within the time the unit sets: the consultant escalates to the medical director and the regional coordination service.
- Deterioration during transfer: the transport team follows its emergency protocol and informs the receiving consultant immediately.
- Serious incident during or after transfer: report under INC-SOP-001 and inform the unit manager within 24 hours.

13. Monitoring

The unit manager audits all transfers each quarter and reports to the neonatal governance meeting. The audit records the time from decision to acceptance, the time from acceptance to departure, the completeness of the handover record, and any adverse event.

Measure	Target
Transfers with a documented acceptance before departure	100 percent
Transfers with a complete SBAR handover record signed by both teams	100 percent
Transport equipment checked and recorded before departure	100 percent
Parents informed of the transfer and given contact details	100 percent
Median time from decision to departure for urgent transfers	Set locally and reviewed each quarter

14. Records

- Transfer decision and acceptance record, with names and times.
- Transfer record with observations, medicines and equipment.
- SBAR handover sheet, signed by both teams.
- Parents' information and consent record.
- Equipment check record for the transport team.
- Incident reports for any problem during transfer.

15. Training

Transport team members complete a neonatal transport course and a practical assessment at least every year. Referring and receiving staff complete training in the SBAR handover and the transfer procedure at induction and every two years, and take part in a transfer simulation at least once a year.

16. Related documents

Code	Document
NEO-SOP-002	Weight-based medicine dosing for neonates and infants
NEO-SOP-003	Family information and presence in the neonatal unit
NEO-SOP-004	Child protection and safeguarding in the neonatal unit
NEO-POL-001	Neonatal level of care
NEO-REG-001	Neonatal staffing against level of care register
INC-SOP-001	Root cause analysis of serious incidents

17. Evidence

This SOP is based on the reference sources listed below, the requirement of criterion 37.5 of the ASF standards, and the national neonatal transfer agreements, which must be checked at each review.

E-learning for this document

- No course linked yet. Request a neonatal transfer and handover course from the academy (see the Standard 37 request list).

References

1. World Health Organization. Pocket book of hospital care for children: guidelines for the management of common illnesses with limited resources. Second edition. 2013.
2. Haig KM, Sutton S, Whittington J. SBAR: A shared mental model for improving communication between clinicians. Joint Commission Journal on Quality and Patient Safety. 2006.
3. National neonatal level of care criteria and national neonatal transport guidance (to be inserted by the unit at adoption).

Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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