Trauma System Implementation Programme

Policy on Transfer of Care and Egress of Trauma Patients from Acute Hospitals

28 March 2023

Version 1

Trauma Care Ireland

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

HSE Policy on Transfer of Care and Egress

Document Reference	**DOC21**	Document Developed by	**The National Office for Trauma Services**
Revision Number		Document Approved By	**The National Trauma Programme Steering Group**
Approval Date	**28 March 2023**	Responsibility for Implementation	**All Health Sector Employees**
Revision Date	**28 March 2024**	Responsibility for Review and Audit	**The Trauma System Implementation Programme**

Table of Contents

Glossary of Terms

Comprehensive Geriatric Assessment	A multi-dimensional, interdisciplinary diagnostic process used to determine the medical, psychological and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up.
Multidisciplinary Team (MDT)	Consists of a range of professionals from clinical disciplines and related services, including non-clinical team members, who work with the patient in order to develop and achieve patient-centred goals.
Major Trauma Centre	Acute hospitals that provide the highest level of specialist trauma care to the most severely injured patients on a single hospital site. In the new Trauma System for Ireland, the designated Major Trauma Centres are the Mater Misericordiae University Hospital and Cork University Hospital.
Rehabilitation Needs Assessment	A standardised evidence-informed process for assessing patients' rehabilitation needs. The rehabilitation needs assessment generates a holistic, multidisciplinary rehabilitation prescription, tailored to a person's specific needs, that is designed to be used throughout the patient pathway of care.
Receiving Hospital	The hospital that the trauma patient is referred to and which will receive the patient for ongoing clinical care. Within the current framework of this policy document, this will be any hospital facility falling under the governance of HSE Acute Operations.
Referring Hospital	The hospital that is seeking to transfer the patient once the acute specialist phase of trauma care is complete. Within the framework of this policy document, a referring hospital will be any current Model 3 or Model 4 hospitals providing acute care to trauma patients. In the future state Trauma System, the scope will be reduced to Major Trauma Centres, the Trauma Unit with Specialist Services and Trauma Units.
Single Point of Contact (SPOC)	This is the person responsible for communicating and coordinating the transfer. This role may be carried out by a clinical nurse manager, bed manager, patient flow manager, trauma coordinator, hospital administrator or other designated person. The SPOC role may be standalone or in addition to other duties.
Transfer of Care	Refers to the transfer of a patient from any current Model 3 and Model 4 hospitals providing acute trauma care to any hospital facility falling under the governance of HSE Acute Operations that can meet their clinical needs and is close to the patient's home, regardless of where their care originated.

Trauma Unit with Specialist Services (TUSS)	The National Trauma Strategy recommends the development of University Hospital Galway as a Trauma Unit with Specialist Services, given the breadth and depth of services currently provided and travel distance from the nearest Major Trauma Centre. It will have additional resources and expertise above Trauma Unit status and be equipped to manage most major injuries. Within the current framework of this policy document, this refers to the candidate TUSS as the additional services needed to bring University Hospital Galway to the full TUSS standard will not be in place in 2023.
Trauma Units	A number of acute hospitals across the country will be designated as Trauma Units, which will deliver trauma care to the majority of patients who do not need the specialist expertise of a Major Trauma Centre. Within the current framework of this policy document, this refers to candidate Trauma Units as the formal Trauma Unit accreditation process to bring individual hospitals fully to Trauma Unit standard is ongoing and is expected to take three to five years.

1 Introduction

This policy covers the transfer of care and egress of trauma patients from Model 3 and Model 4 hospitals currently providing acute care to trauma patients. It does not pertain to the ingress of patients as part of an acute escalation of care into Major Trauma Centres or other trauma-receiving hospitals. The National Trauma System takes an 'inclusive' approach to the delivery of trauma care wherein a network of facilities, teams and services cooperate in managing the care of injured patients along standardised pathways.

Therefore, this policy will support the transfer of trauma patients out of Model 3 and Model 4 hospitals. This is to ensure efficient patient flow throughout the Trauma System so that patients continue to receive the right care in the right place at the right time - in keeping with the philosophy of an inclusive trauma system. Additionally, the policy places the patient at the centre by enabling two aspects of care: patients retain access to specialist trauma services as required throughout their care pathway, and patients can access care closer to their home. Both patient-centric aspects of the policy are underpinned by patients retaining immediate access to care on a no-refusal basis.

1.1 Aims and objectives

The aims and objectives of the Transfer of Care and Egress Policy are:

- To reduce variations in practice across the Trauma System and provide a standardised process for the referral, acceptance and transfer of care and egress of trauma patients from Model 3 and Model 4 hospitals
- To support hospitals and teams within the Trauma System to work effectively and efficiently by providing a clear procedure for escalation and response in relation to any delay in or deviation from this process
- To provide greater assurance to receiving hospitals about both the process for transfer of care and escalation, and the controls in place surrounding appropriateness of trauma referrals out of Model 3 and Model 4 hospitals
- To ensure the efficient and safe flow of trauma patients from Model 3 and Model 4 hospitals to an appropriate care setting for ongoing care close to home or where support is available from those important to the patient. In some instances, this may be an interim step while awaiting definitive post-acute rehabilitation
- To improve care pathway clarity, assist patients in their care journey and increase patient satisfaction by streamlining processes, optimising pathways and improving communication surrounding transfer of care.

The purpose of this Transfer of Care and Egress Policy document is to outline the principles of, and procedure for, the transfer of care and egress of trauma patients from Model 3 and Model 4 hospitals. It will introduce key concepts, policy components, and detail the advised steps for transfer of care.

1.2 Scope

The scope of this policy covers the transfer of care and egress of trauma patients out of Model 3 and Model 4 hospitals currently providing acute care to trauma patients, to other acute care settings - i.e. all hospital facilities under the governance of HSE Acute Operations. In the future

Trauma System, the scope will be reduced to the transfer of care and egress of trauma patients out of Major Trauma Centres, the Trauma Unit with Specialist Services (TUSS) and Trauma Units as these will be the only trauma-receiving acute hospitals in the future state Trauma System, as envisioned in the National Trauma Strategy.

To note, this includes:

- The transfer out of a trauma patient from a Model 3 or Model 4 hospital to another Model 3 or Model 4 hospital, provided it is not part of an acute escalation of care.
- The transfer out of a trauma patient from a Model 3 or Model 4 hospital to any hospital under the governance of HSE Acute Operations.

A detailed process for the transfer of trauma patients out of Model 3 and Model 4 hospitals to a hospital that is deemed appropriate for their ongoing care needs has been set out in section 2 of this document. This process may be amended and/or supplemented in future.

The escalation process, developed for managing delayed transfers at the time that they occur, will be implemented through the governance structure of the Trauma System supported by HSE Acute Operations. The escalation process is detailed in section 3.

To note, this policy does not pertain to the ingress of patients as part of an acute escalation of care into Major Trauma Centres from other care settings. Similarly, the transfer process and escalation pathway set out in this document does not currently extend to units outside of the governance of HSE Acute Operations. However, this policy will be revised to include units and other facilities in the community setting and elsewhere as the Trauma System incrementally develops and the Sláintecare proposal of Regional Health Areas is progressed.

1.3 Principles

The following principles guide the transfer of trauma patients out of Model 3 and Model 4 hospitals:

- When the treatment needs of a patient who requires a higher or specialist level of care are completed, they will either be transferred to a hospital that can meet their immediate ongoing clinical needs or be discharged home directly.
- It is desirable that the patient receives their treatment and care in a hospital that can cater for their needs as close as reasonably possible to the patient's home or where support is available from those important to them. This drives better outcomes, accelerated recovery and higher satisfaction for patients.
- Within a proactive approach to ensuring efficient and appropriate patient flow, planning for transfer of care and egress will commence as soon as possible after the patient is admitted to the Model 3 or Model 4 hospital.
- A concept of automatic acceptance will apply to the transfer of patients out of Model 3 and Model 4 hospitals, to include access to all acute hospitals that can manage the patient's ongoing needs, regardless of where the patient's care originated.
- Without effective processes for transfer of care, automatic acceptance to Major Trauma Centres is jeopardised due to the risk of capacity problems developing. Effective processes for transfer of care and egress support the maintenance of adequate capacity and preparedness in Major Trauma Centres, and for the TUSS and Trauma Units in the future state Trauma System, to receive the patients that would benefit from their specialist care.

- Transfer of care of trauma patients will be achieved within 48 hours of notification. This will allow for enough time to make arrangements to facilitate the patient transfer, including confirming the availability of a bed in the receiving hospital and relaying all relevant clinical information. If the transfer is delayed beyond 48 hours, the escalation process will commence.
- Clinical governance and responsibility for the patient remains with the referring hospital or transferring team until the patient arrives at the receiving hospital.
- Transfer of care must be carried out in a collaborative manner with the appropriate involvement of the patient, those important to them, local services and specialist input.
- It is accepted that in some cases transfer of care will be an interim step pending the availability of a bed in a post-acute rehabilitation setting. Where this is the case, the Model 3 or Model 4 hospital will commence the referral process to the rehabilitation facility immediately. The responsibility for completing the referral process to the rehabilitation facility remains with the hospital with current clinical governance and responsibility for the patient, whether that is the Model 3 or Model 4 hospital, or any other hospital under the governance of HSE Acute Operations.

2 The Process for Transfer of Care

To achieve an effective, safe, and standardised transfer of care process, the Transfer of Care and Egress Policy must reflect certain considerations involved in completing the transfer of care and egress of trauma patients from Model 3 and Model 4 hospitals. These considerations revolve around planning care pathways and ongoing engagement with the patient and those important to them, reaching clinical agreement on transfer of care, the logistics of arranging and completing the transfer, and other transfer considerations including timelines and clinical governance throughout the process. These considerations are detailed in the following sections.

2.1 Planning

2.1.1 Care pathways

Care pathways will follow proven evidence-informed protocols with input from a multidisciplinary team (MDT) of professionals and include specific provisions for transfer of care and/or discharge date targets for patients. The appropriate pathway of care will be identified by the trauma team, supported by information from the Rehabilitation Needs Assessment and/or Comprehensive Geriatric Assessment.

2.1.2 Patient transfer

A proactive approach to transfer planning should prevail, with the aim of having the right patient in the right place at the right time. Such a proactive approach for managing a patient's ongoing care will commence from the time of initial admission to the Model 3 or Model 4 hospital and will assist in optimising both their short- and long-term clinical and functional outcomes. When the treatment needs of a patient who requires acute or specialist trauma care are completed, they will be transferred to a hospital that can meet their immediate ongoing clinical needs, as close as reasonably possible to the patient's home or where support is available from those important to them.

2.1.3 Engagement with the patient and those important to them

Engagement with the patient and those important to them is an essential component of trauma care. Patients and those important to them must be supported throughout the patient's clinical care pathway, including during onward transfer of care. Trauma clinicians must engage with patients and those important to them as early as possible to describe the trauma care pathways. Explaining the rationale for transfer of care or egress from a Model 3 or Model 4 hospital will help ensure that the patient and those important to them understand the process and are prepared for their care journey.

2.2 Clinical agreement

Clinical agreement centres around the determination of a patient's readiness for transfer of care. A trauma patient is ready for transfer from a Model 3 or Model 4 hospital when:

1. A clinical decision has been made that the patient is medically ready and safe for transfer to the receiving hospital, and
2. An MDT has reviewed the patient, and all identified ongoing medical, nursing and rehabilitation needs will be detailed in an individualised management plan that will be provided to the receiving hospital.

It is the responsibility of the referring team to identify the most appropriate receiving hospital, which is defined as having the capability to deliver the required care appropriate to the patient's needs and is as close as reasonably possible to the patient's home or where support is available from those important to them. The Rehabilitation Needs Assessment and Rehabilitation Prescription, designed to identify the ongoing medical, nursing and rehabilitation needs of the patient, are completed by the patient's MDT in the referring hospital and will accompany the patient as they move along their care pathway. A complete Rehabilitation Needs Assessment and Rehabilitation Prescription provide the receiving hospital with a plan to support the management of the patient's ongoing needs.

2.2.1 Patients with more complex and/or ongoing needs

If a patient requires an admission to an inpatient rehabilitation facility but is unable to access a bed in the facility at that time, they will be transferred to a hospital that can cater for their clinical needs as close as reasonably possible to the patient's home or where support is available from those important to them. This will assist in preserving acute specialist capacity within Model 3 and Model 4 hospitals whilst providing the patient with appropriate high-quality care close to their home; the care to be provided in the receiving hospital is equivalent to the care provided in the referring hospital.

The referral to the interim hospital is to be completed in tandem with the referral to the recommended rehabilitation facility. The responsibility for completing the referral process to the rehabilitation facility remains with the hospital with current clinical governance and responsibility for the patient.

Early engagement between referring and receiving hospitals is essential with regard to patients with more complex needs to support the planning process and ensure a successful transfer of care.

2.3 Notification and coordination of patient transfer

Coordination of patient transfers will be facilitated through a nominated single point of contact (SPOC) who will act as the central point of communication for the transfer process. This role may be fulfilled by a Trauma or Rehabilitation Coordinator or Patient Flow Manager/ Bed Manager/ Clinical Nurse Manager. Each acute hospital must nominate a SPOC; the SPOC must be available to send and receive trauma patient referrals at a minimum from 9am to 5pm, 7 days per week.

The physical transfer of the patient should also normally take place between 8am and 8pm, with acknowledgement that while the policy does not intend for there to be unreasonable out-of-hours transfer, this may not always be possible. Patient transfers must be managed by appropriately-trained staff and adhere to the Inter-Facility Patient Transfer Standards published by the Pre-Hospital Emergency Care Council, due to the complexities of care requirements that exist for trauma patients. Up-to-date contact details of the SPOC must be available at switchboards in all hospitals.

There are two recommended stages of communication in the transfer of care process:

1. The referral 'notification' - this is the official recorded notice of referral and is completed by the SPOC in the referring hospital. The SPOC in the referring hospital must relay the key information required for referral as outlined in section 2.4. The receiving hospital must

identify the receiving clinical team, name the responsible Consultant and confirm bed availability to the SPOC in the referring hospital.
2. Once the accepting Consultant is confirmed by the SPOC in the receiving hospital, the clinician-to-clinician handover can take place - this is required for continuity of care and must involve all pertinent clinical information as outlined in section 2.4.

The SPOC in the referring hospital will coordinate transport arrangements and clinical handover. The SPOC in the receiving hospital is responsible for confirming acceptance of the patient's care.

The referring hospital will provide a clear plan for ongoing patient management to the receiving team, supported by documentation and full clinician-to-clinician handover. Both hospitals will maintain effective communication on the patient's needs and condition for the duration of the transfer process. The referring hospital will be available to support the receiving hospital with advice on the management of the patient when required. This availability for support and advice will be on an ongoing basis and will facilitate smooth transfers back up the line of care if complications arise in a patient's care.

2.4 Process for the transfer of care

The following sequential steps must be followed to complete the transfer of care process:

1. Clinical agreement on the determination of a patient's readiness for transfer of care must be reached internally by the MDT at the referring hospital.
2. The referring hospital must issue a referral to the receiving hospital:
    a. The referral will be communicated between SPOCs in the referring and receiving hospitals; this may be done via telephone in the first instance but must be supported by a written referral. Once the referral notification is sent by the referring hospital to the receiving hospital, the 48-hour timeline for completion of transfer commences. **Clock starts.**
    b. Required referral information includes patient demographic details, address, date of original admission, reason for original admission, interventions, management and progress to date including any complications, and previous medical history.
    c. Direct clinician-to-clinician contact is not required at this point as the referral notification is a function to begin the transfer of care process and does not replace the clinician-to-clinician handover required to complete the transfer.
3. The receiving hospital is responsible for identifying the receiving clinical team, naming the responsible Consultant and confirming bed availability; these details must be communicated to the SPOC in the referring hospital. The specific process for determining the admitting Consultant and the bed in the receiving hospital will be established locally.
4. Patient handover will comprise clinician-to-clinician verbal handover along with written handover documentation. This will include the information required in steps 1 and 2b, in addition to an individualised patient management plan comprising the most recent Rehabilitation Prescription, medical report, imaging files and reports and medication prescription; this is not intended to be an exhaustive list of documents. This step should occur as early in the transfer of care process as is practical.
5. Confirmation of bed availability and timings of transfer must be communicated from the receiving hospital to the SPOC in the referring hospital. **Clock stops.**

6. The SPOC in the referring hospital will ensure that appropriate transport is booked in a timely manner and all appropriate documentation is completed, compiled and either sent to the receiving hospital in advance or accompany the patient.

Additional steps if required

7. If the patient's condition changes and an adjustment to the planned transfer is necessary, this must be communicated to the receiving hospital. Planning for transfer of care continues in line with ongoing determination of the patient's clinical readiness for transfer.
8. The referring hospital is responsible for ensuring that any required inpatient or outpatient follow-up investigations or appointments at the Model 3 or Model 4 hospital are made prior to discharge and that these plans accompany the patient throughout the remainder of their care process.

Figure 1 - Transfer of care process flowchart

3 Escalation

Patient transfer is to occur within 48 hours of the transfer notification being sent by the referring hospital. If the transfer is delayed beyond 48 hours, the escalation process will commence. To note, failure to transfer represents a failure to adhere to this policy and must be an exception. When cases are escalated, it must mean that all reasonable steps have already been taken to agree and facilitate the transfer.

Of note, the escalation pathway described in section 3.2 currently does not extend to units outside of the governance of HSE Acute Operations.

3.1 Reasonable steps to resolve the delay

It is expected and required that all reasonable steps will be taken to resolve the delay in transferring the patient and preventing the escalation process.

The reasonable steps comprise initial communication and discussions involving the following stakeholders:

- Clinical leadership of both the referring and receiving hospitals, such as the hospital Clinical Lead(s) for Trauma and/or Clinical Director(s)
- Senior management (including the Chief Executive Officers [CEOs]) in both the referring and receiving hospitals.
- Clinical leadership in the Hospital Group(s) with responsibility for the referring and receiving hospitals.
- Senior management (including the CEOs) in the Hospital Group(s) with responsibility for the referring and receiving hospitals.

3.2 Policy guidelines for escalation

Escalation is reserved for incidents where the patient is not transferred within the required standard timeframe, i.e. over 48 hours after the 'clock starts' (time of transfer notification being sent by the referring hospital), or any unreasonable delay after the 'clock stops' (confirmation of bed availability and timings of transfer by the receiving hospital). If the reasonable steps outlined above are unsuccessful at resolving the delayed transfer of care, the sequential steps to follow as part of the escalation process are:

1. The referring hospital, with the approval of the CEO of the Hospital Group with responsibility for the referring hospital, escalates to the National Office for Trauma Services via that hospital's Trauma Coordinator/ Bed Manager/ Patient Flow team or other designated contact person. The National Office for Trauma Services will record the incident and manage further steps in the escalation process. To note, without the approval of the CEO of the Hospital Group with responsibility for the referring hospital, the National Office for Trauma Services cannot progress the escalation process.
2. Informed by the National Office for Trauma Services, the National Clinical Lead for Trauma or other designated senior clinician nationally will review the incident and determine if all reasonable steps (outlined in step one above) have been taken. The designated senior clinician nationally will discuss the incident with the attending Clinical Lead for Trauma at

the referring hospital or the Consultant with responsibility for the patient's care. The designated senior clinician nationally may also contact the receiving hospital at this time.

3. If the escalation is appropriate, the designated senior clinician nationally will inform a senior leader in HSE Acute Operations who will raise the issue with the CEO of the Hospital Group with responsibility for the receiving hospital and/or the CEO of the receiving hospital as required. The objective will be to resolve any issue and mitigate further escalation.
4. Any escalation under this policy will be logged for inclusion in the Trauma Network Register and for discussion at the standing meetings of the governance fora of the Trauma System.

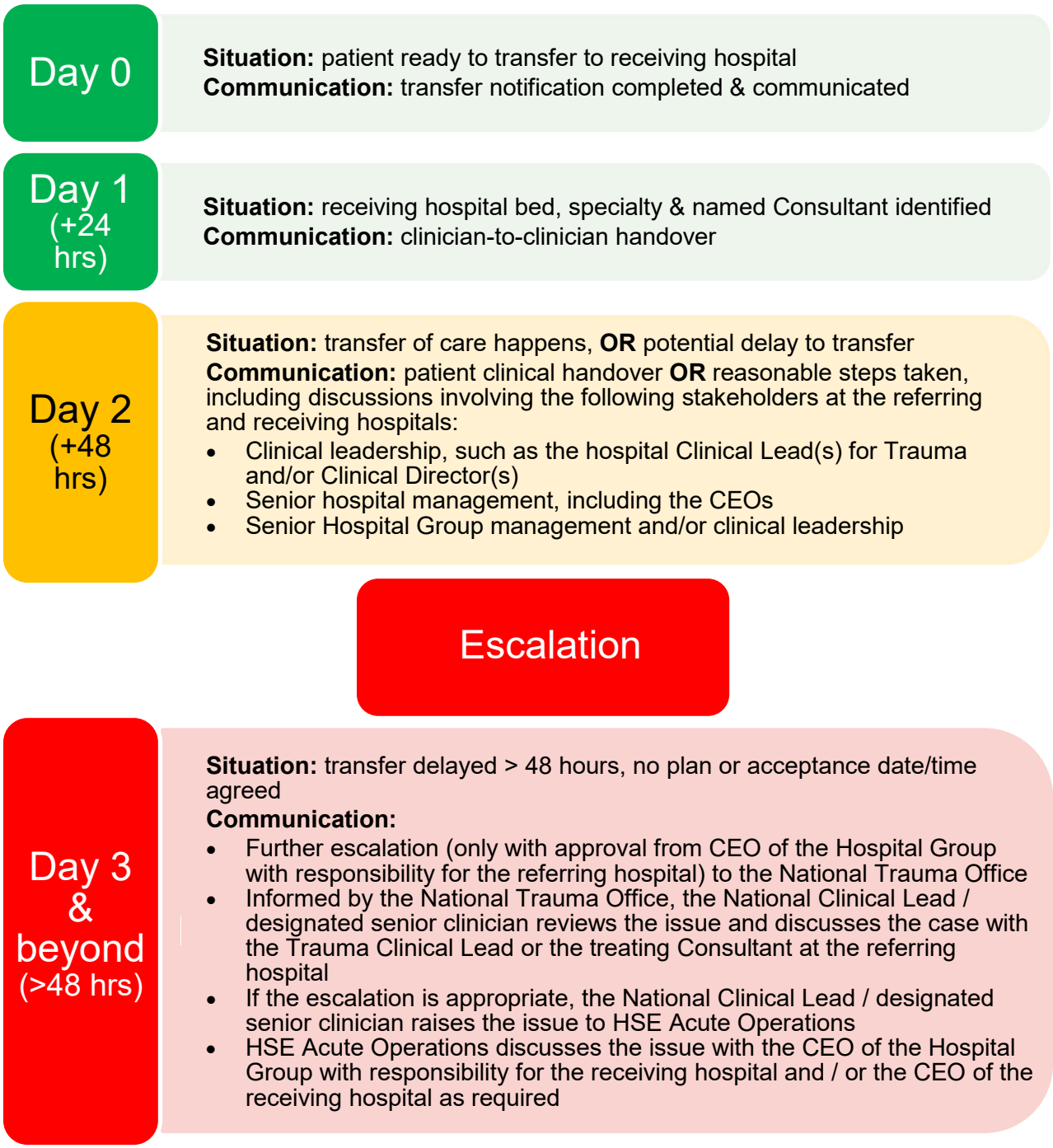

Figure 2 - Guidelines for escalation flowchart

4 Policy Revision - Timeframes and Scope

The policy as outlined in this document will apply in 2023 to all hospitals under the governance of HSE Acute Operations. The policy will be reviewed after 6-12 months from 28 March 2023 (the date of its approval by the Trauma Programme Steering Group) and after the establishment of the Regional Health Areas. As the Trauma System incrementally develops and the Sláintecare proposal of Regional Health Areas is progressed, the scope of the policy will be revised to include transfer to other units beyond acute hospitals alone, including facilities in the community setting and elsewhere.

5 References

Department of Health, 2018. Sláintecare Implementation Strategy. Dublin: Department of Health.

Griffin E. et al. Early repatriation post-thrombectomy: a model of care which maximises the capacity of a stroke network to treat patients with large vessel ischaemic stroke. 2020:12(12):1166-1171

Health Service Executive, Business Information Unit Acute February 2022. National Delayed Transfer of Care Data Collection System – Guidelines and Technical Information.

Health Service Executive, Royal College of Physicians of Ireland, March 2012. Acute Coronary Syndromes Programme – Model of Care.

HIQA, 2008 HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs) hse-national-framework-for-developing-policies-procedures-protocols-and-guidelines-pppgs-2016.pdf

HSE England. North East London and Essex Trauma Network Handbook, April 2021. Available at: 830212_9e6f25c78791402db1a7fe5ef020b5d3.pdf (neletn.nhs.uk)

NHS Commissioning Board, December 2012. Developing Operational Delivery Networks. The Way Forward. Available at: Developing Operational Delivery Networks (england.nhs.uk)

NHS England, April 2015. Operational Delivery Networks – Governance Framework. Available at: Operational Delivery Networks - Governance Framework (nornet.org.uk)

NHS England, June 2016. Peninsula Trauma Network Rehabilitation Standards. Available at: PTN-Rehabilitation-Standards-V8.pdf.

NHS England, June 2018. National Major Trauma Network to Network Repatriation Agreement. Available at: Microsoft Word - MT Network-Network Repatriation - final June 2018.docx (wymtn.com)

NHS England. July 2021. Midlands Critical Care and Trauma Networks – Repatriation/Reverse Transfer Principles and Escalation Policy. Available at: Guidelines and Protocols (mcctn.org.uk)

NHS England. September 2015. National Peer Review Programme. Trauma Quality Improvement Network System (TQuINS). http://www.tquins.nhs.uk

NHS England: East of England Trauma Network patient flow agreement, December 2014. Available at: trauma-east-manual-of-procedures-and-operations-edition-2-(2014)-complete_interactive (eoetraumanetwork.nhs.uk)

NHS Scotland. December 2020. North of Scotland Trauma Network Repatriation Policy. Available at: Major Trauma Repat Policy V2.1.pdf (nhsscotlandnorth.scot)

NHS Wales. South Wales Health Collaborative Service Model Review Major Trauma Network May 2015. Available at: Paper 1 (wales.nhs.uk)

NHS Wales. Swansea Bay University Health Board. Major Trauma Network Programme Business Case South & West Wales, South Powys. November 2019 Available at: https://sbuhb.nhs.wales/about-us/key-documents-folder/board-papers/november-2019-health-board/3-4-major-trauma-network-pdf/.

NHS Wales. University Health Board. February 2013. NHS Wales Policy for the Repatriation of Patients. Available at: QS13_034a All Wales Patient Repatriation Policy cover

NHS Wales. Welsh Health Specialised Services Committee, February 2018. Specialistised Services Commissioning Policy: CP140 Specialised Neurological Rehabilitation. Available at: https://whssc.nhs.wales/commissioning/whssc-policies/neurosciences/specialist-neurological-rehabilitation-commissioning-policy-cp140-march-2018/

Pre-Hospital Emergency Care Council (2014). Inter Facility Patient Transfer Standard. Available at: https://www.phecit.ie/Custom/BSIDocumentSelector/Pages/DocumentViewer.aspx?id=oGsVrspmiT0dOhDFFXZvIz0q5GYO7igwzB6buxHEgeD013qEh%252bBwnpgYGEV7P6lBaIHN9i3gtl91GoBfn2HXa8jFQskt1vlTHQAXZzRWrqfnU%252fs%252fg%252fPZHpree8grmUg3RC4N3AC5T6x%252bc2B%252bwT%252fwQY8l62aTIOZl6Vd%252fC6WUbYL9P5okOKJ%252bPQ%253d%253d.

Turner-Stokes L. June 2012 The Rehabilitation Complexity Scale – Trauma (RCSE-Trauma) Version 13. Available from: Microsoft Word - RCS-ET (Trauma RCS) (kcl.ac.uk)

Appendix: Hospitals within scope of this policy

Within the current framework of this policy document, the policy as outlined will apply to the following hospitals in 2023:

- Referring hospitals - any current Model 3 or Model 4 hospital providing acute care to trauma patients. A full list of all Model 3 and Model 4 hospitals currently providing acute care to trauma patients can be found below.
- Receiving hospitals - any hospital under the governance of HSE Acute Operations.

Hospital	Model
Beaumont Hospital	4
Cork University Hospital	4
Galway University Hospital	4
Mater Misericordiae University Hospital	4
St. James's Hospital	4
St. Vincent's University Hospital	4
Tallaght University Hospital	4
University Hospital Limerick	4
University Hospital Waterford	4
Cavan and Monaghan Hospital	3
Connolly Hospital Blanchardstown	3
Letterkenny University Hospital	3
Mayo University Hospital	3
Mercy University Hospital	3
Midlands Regional Hospital, Mullingar	3
Midlands Regional Hospital, Portlaoise	3
Midlands Regional Hospital, Tullamore	3
Naas General Hospital	3
Our Lady's Hospital, Navan	3
Our Lady of Lourdes Hospital, Drogheda	3
Portiuncula University Hospital	3

St. Luke's General Hospital, Kilkenny	3
Sligo University Hospital	3
Tipperary University Hospital	3
University Hospital Kerry	3
Wexford General Hospital	3