Admission to, and Discharge from Critical Care Guideline

Guideline information

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Clinical

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N/A

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Approval information

Approved by:
Scheduled Care Written Control Documentation Group
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Summary of document:
The guideline outlines best practice for the admission to and discharge from the Critical Care services in Hywel Dda UHB based on the Wales Critical Care and Trauma Network guidelines. This, includes adult Critical Care (Level 2 and Level 3) beds, and flexible, extended provision of Critical Care where these exist.

Scope:
This guideline applies to the four acute hospitals within Hywel Dda who are involved with making decisions about and managing patient flow in and out of Critical Care units.

To be read in conjunction with:
982 – Incident near miss and hazard reporting procedure - opens in a new tab

811 – MCA Practice guideline – opens in a new tab
166 – Organ Donation Policy - opens in a new tab
489- Emergency Pressure & Escalation Policy - opens in a new tab
371 – Prevention & Management of MRSA - opens in a new tab
354 – Standard Infection Prevention & Control Precautions (SICS) Policy - opens in a new tab

Patient information:
Include links to Patient Information Library

Owning group:
Hywel Dda University Health board Critical Care Delivery Group – GM Scheduled Care 22/05/2024

Executive Director job title:
Director of Operations

Reviews and updates:
Version 1 – New Guideline – Date Approved: 27/02/2018
Version 2 – fully reviewed 22.5.2024

Keywords
Critical Care, Admission, Discharge

Glossary of terms
NICE - National Institute for Health and Care Excellence
GPICS - Guidelines for the Provision of Intensive Care Services
EDs - Emergency Departments
BTS - British Transplantation Society
ICS - Intensive Care Society
ICU- Intensive Care Unit
DTOCs - Delayed Transfers of Care
DoH - Department of Health
WG - Welsh Government
SOP- Standard Operating Procedure
DCT - Data Collection Tool
CCMDS - Critical Care Minimum Data Set
Flexible Units - Units that can alter available number of beds dependent on acuity.
ICNARC - Intensive Care National Audit and Research Centre

Contents

Scope

Hywel Dda University Health Board incorporates four acute hospitals within West Wales. Each hospital has a Critical Care Unit, with Level 2 and Level 3 beds in various configurations (flexible units).

This guideline relates to Critical Care services in Hywel Dda University Health Board (HDUHB), specifically:

- **Glangwili General Hospital (GGH)** Critical Care Unit/High Dependency Unit
- **Prince Philip Hospital (PPH)** Critical Care Unit/High Dependency Unit
- **Withybush General Hospital (WGH)** Critical Care Unit/High Dependency Unit
- **Bronglais General Hospital (BGH)** Critical Care Unit/High Dependency Unit

It promotes communication to enhance effective patient flow between general wards and Critical Care, Critical Care Outreach (GGH & WGH) Theatres, ED and patient flow teams or anyone involved in managing decisions about capacity, staffing and patient flow in ICUs in HDUHB.

Any temporary amendment to Critical Care Services in relation to admission and discharge, will result in a change of process outside of this guideline. It will be supported by a local Standard Operating Procedure (SOP) for the duration of the period of adjustment.

Service Provision

The bed space capacity and **Funded Level 3** bed stock in each unit is as follows**:**

Hospital	Glangwili	Prince Philip	Withybush	Bronglais	HDUHB
Bed space capacity	18	6	9	5	38
Funded Level 3 beds	11	3	5	3	22

Whilst bed space capacity is 38, funding of Level 3 is 22, or Level 2 / Level 3 combination up to 38. Any admissions above the funded capacity, would require additional staffing, outside of current budgets. Should 1 site be at risk rather than another, consideration will be given to:

- Conducting risk assessment within current patient cohort and staff availability.
- Movement of staff to support another team.
- Transfer patient to available capacity with Adult Critical Care Transfer Service (ACCTS) or Welsh Ambulance Services NHS Trust (WAST).

Aim

The aim of this document is to:

- This guideline outlines the best practice for the admission to, and discharge from, Critical Care services across Hywel Dda University Health Board. This relates to Adult Critical Care service provision at Level 2 and Level 3.

Objectives

The aim of this document will be achieved by the following objectives:

- Ensuring appropriate and timely admission of patients to Critical Care and to facilitate proper utilisation of limited capacity and staffing resource.
- Supporting well organised, safe, and timely discharge of patients from Critical Care.

Main body (Free typing add titles etc)

Levels of Care:

The levels of care referred to throughout this document align with the Guidelines for the Provision of Critical Care Services V2.1 (July 2022)

In 2021 the 'Levels of Adult Critical Care' classification was redefined to reflect the modern delivery of critical care and the changing demands upon it. It describes the care a patient requires, not where they are receiving it, nor does it measure the actual care being delivered.

Level 0 (Ward Care)	• Patients whose needs can be met through normal ward care in an acute hospital. • Patients who have recently been relocated from a higher level of care, but their needs can be met on an acute ward with additional advice and support from the Critical Care outreach team. • Patients who can be managed on a ward but remain at risk of clinical deterioration.
Level 1	• Patients requiring more detailed observations or interventions, including basic support. • For a single organ system and those 'stepping down' from higher levels of care. • Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward. • Patients who require ongoing interventions (other than routine follow-up) from Critical Care Outreach teams to intervene in deterioration or to support escalation of care. • Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged based on clinical circumstances and ward resources.

Level 2	• Patients requiring increased levels of observations or interventions (beyond Level 1), including basic support for two or more organ systems and those 'stepping down' from higher levels of care. • Patients requiring interventions to prevent further deterioration or to support ongoing rehabilitation needs, beyond that of Level 1. • Patients needing two or more basic organ systems monitoring and support. • Patients needing one organ system monitored and supported at an advanced level (other than advanced respiratory support). • Patients needing long-term advanced respiratory support. • Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, maintaining patient safety if severely agitated. • Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure and/or the patient's condition and comorbidities. • Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere. • Patients who require nursing and therapies input more frequently than available in Level 1 areas.
Level 3	• Patients who need advanced respiratory monitoring and support alone. • Patients who require monitoring and support for two or more organ systems at an advanced level. • Patients with chronic impairment of one or more organ systems sufficient to restrict daily activities (comorbidity), and who require support for an acute reversible failure of another organ system. • Patients who experience delirium and agitation in addition to requiring Level 2 care. • Complex patients requiring support for multiple organ failure; this may not necessarily include advanced respiratory support.

Admission Guideline:
The objective of the admission guideline is to ensure appropriate and timely admission of patients to Critical Care and to facilitate proper utilisation of limited capacity and staffing resource in Critical Care, Health Board wide.

General Principles:
Critical Care may be defined as a service for patients who can benefit from more detailed observation, monitoring and treatment than is available on a general ward. It is not within the scope of this guideline to be prescriptive about which patients should or should not be admitted; however, it is generally accepted that the clinical condition which has resulted in the patient requiring Critical Care should be identifiable, acute and potentially reversible.

Even when there is an acute reversible component, the patient's chronic health status and frailty may significantly affect their ability to survive and benefit from an Critical Care episode. This requires careful and explicit assessment but should not be prejudiced by age or disability. This is a clinical decision and can only be made for each individual patient at the time of referral.

Patient autonomy should be respected. As far as is reasonably ascertainable, the patient's past and present wishes, feelings, and beliefs, values, for or against intensive care, stated or written, should be considered. The patient must be involved, as much as possible, in the decision to admit, in accordance with the Hywel Dda UHB Policy 374 - Mental Capacity Act 2005.

The role of relatives in the case of an incapacitated patient is to represent their understanding of what the patient would wish for. Where a patient lacks capacity the admitting consultants must discuss this with other people (e.g., carers, close relatives, friends or anyone interested in the person's welfare or anyone named by the person as someone to be consulted), taking into account their views as to what would be in the best interests of the person lacking capacity (Mental Capacity Act 2005). The Mental Capacity Act (MCA) 2005 came into force in early 2007 and introduced the statutory role of the Independent Mental Capacity Advocate (IMCA) to support people who lack capacity to make certain decisions.

The final decision to admit or refuse admission of a patient to the Intensive Care Unit within the established capacity is the responsibility of the duty Critical Care Consultant. Any disputes should initially be discussed between the duty Critical Care Consultant and referring consultant. If further resolution is required, this should involve the respective lead clinicians or clinical directors.

All patients admitted to Critical Care will have their care directed by Critical Care staff. Whilst the referring team will regularly visit the Critical Care Unit and discuss the case with Critical Care staff the final decisions regarding changes to therapy will rest with the duty Critical Care Consultant. Or in some cases the final decision regarding changes to patient therapy will be a collaborative decision between the specialty/referring team and Critical Care Consultant when deemed appropriate.

We should strive to carry out an assessment of the rehabilitation needs of all patients within 24 hours of admission to Critical Care Unit and patients who need a rehabilitation plan in line with NICE CG83 on discharge from Critical Care will receive one from the Physiotherapist.

It is not an appropriate use of Critical Care resources to admit to the Critical Care Unit patients who can be managed on an appropriate general ward, due to purely organisational factors (e.g. ward staff shortages, admitting capacity). Such organisational factors should be brought to the attention of the referring consultant and if required the Hospital Management Team of the referring location.

Planned (Elective) Referrals/Admissions to Critical Care:

The referral for planned (elective) admissions should ideally be based on assessment of the patient's requirements rather than the procedure itself. In line with NICE CG50 'Acutely ill adults in hospital: recognising and responding to deterioration' (2007) if admission to Critical Care area is clinically indicated, then the decision to admit for elective admissions should normally involve both the referring consultant and the consultant in Critical Care.

When no other discharge, death or transfer is expected, the last Critical Care bed would not be offered to an elective patient except in specific circumstances and with the agreement of the Critical Care Consultant.

Bed Availability:
Surgeons and anaesthetists who have booked elective cases must check on bed availability prior to starting the case. If a case is started in the knowledge that there is no Critical Care bed, then the surgeon or anaesthetist must organise alternative suitable post-operative care, e.g. transfer to another unit, or in Recovery.

Cancelled Operations:
Elective admissions that are cancelled due to lack of Critical Care capacity or due to a shortage of staff, should be re-booked as soon as possible. The deferment/cancellation and the reasoning is captured by the waiting list team.

Audit Process:
The waiting list team monitors booked planned admissions against actual admissions and circulates this information via email weekly to Triumvirate and Directorate teams. It is a requirement of the Delivery Plan for the Critically Ill Adult that these be audited and reported to the Critical Care Delivery Group.

Unplanned Referrals/Admissions to Critical Care:
Referral of patients to Critical Care services should be undertaken at consultant level (NICE CG50 2007). All potential patients should be discussed with the duty Critical Care consultant by the admitting consultant. Direct referrals from the Emergency Department should come from either the admitting consultant or the Emergency Medicine consultant. The Clinical Site Manager must also be made aware of these admissions to ensure recording of accurate bed availability.

All patients referred for Critical Care should be reviewed by the Critical Care consultant prior to admission (NICE CG50 2007). In certain circumstances, this may not be practicable, in which case these patients should be reviewed by the Critical Care Consultant as soon as possible following admission to the Critical Care Unit.

It is the responsibility of the Critical Care service to assess a patient's suitability for Critical Care. No patient should be admitted without the explicit agreement of the Critical Care consultant.

The referring team shall maintain responsibility for the patient up to admission to Critical Care and shall remain responsible for ongoing management if admission is refused or deferred.

In circumstances of urgency, junior medical staff, nursing or allied health professional staff, or members of the Acute Intervention Team may need to alert Critical Care medical staff directly. In these cases, the referring consultant must always be alerted and agree to the referral.

Priority for admission is:

- Emergency in house
- Emergency in HDUHB
- Repatriation from outside HDUHB
- Repatriation from within HDUHB
- Urgent cases in house
- Elective cases in house

This prioritisation list is only for guidance and can be superseded by clinical judgement/risk assessment after discussion with all parties involved.

A side room should be considered until infection screening is complete. This is to include screening for Carbapenemase-Producing Enterobacterales (CPE) and MRSA In line with Hywel Dda UHB procedures. Where possible, infection prevention and control team's discussions should be made prior to admission.

If a patient arrives without a named consultant, the on-take team in the relevant specialty at the time of arrival will be responsible for the care of the patient; they will be notified as such by the Bed Manager.

No Critical Care Health Board Wide shall accept a patient for transfer from another hospital both within and outside the Health Board unless that patient has been referred to the Critical Care team and assessed as suitable for Critical Care by the Consultant.

Repatriation from Tertiary and Other Centres:
Patients should be repatriated, preferably to within the patient's locality as soon as a bed becomes available (see section 2.3 for priority of admissions). Refer to existing guidance Designed for Life: Welsh Guidelines for the transfer of the critically ill adult' (2016)

A side room should be considered until infection screening is complete. This is to include screening for Carbapenemase-Producing Enterobacterales (CPE) and MRSA In line with Hywel Dda UHB procedures. Where possible, infection prevention and control teams' discussion should take place prior to repatriating.

If a patient arrives without a named consultant, the on-take team in the relevant specialty at the time of arrival will be responsible for the care of the patient; they will be notified as such by the Bed Manager.

Admission for Organ Donation:
Patients initially assessed in EDs in whom organ donation is a possibility should be admitted wherever possible to Critical Care in order that their clinical and broader interests (including the potential for donation) can be fully assessed, in line with the Hywel Dda UHB Policy 166 - Organ Donation. It is recognised that this course of action is dependent on the availability of resources. Where capacity issues may prevent admission to Critical Care for organ donation, this must be escalated to the Consultant Anaesthetist and / or Clinical Lead for the unit.

Admission to Critical Care for neuro-prognostication:
If an acute, severely brain injured patient has been declined for referral by a neurosurgical unit, it is often difficult to prognosticate in the acute setting. These patients should normally be admitted to the Critical Care Unit for assessment unless other co-morbidities or advanced directives preclude this (*FICM, 2022).*

Admission when Critical Care is full:
Whenever a resource is limited, it is possible that demand may outstrip supply. The Critical Care clinical team is responsible for allocating available Critical Care resources in the most effective way.

When the Critical Care Unit is full, and another patient requires admission it will be necessary for the consultant and senior nurse responsible for the unit to consider the relative needs of all the patients. This will include many issues such as the dependencies of all the patients, any speciality requirements and suitability for transfer.

The Critical Care team will undertake a balanced clinical risk assessment of the short-term strategies available to deal with further referrals for care, pending a definitive Critical Care beds; these may vary in each of the four localities but include flexing above capacity either within the unit, or by use of theatres/recovery. These decisions will be influenced by medical and nursing staff issues, and the availability of physical resources. A clinician cannot make an isolated decision to surge capacity without considering the nurse staffing availability and implications.

Patients accepted for Critical Care will become the clinical responsibility of the Critical Care Consultant, in collaboration with the referring team. Other resources e.g. additional staffing, equipment and placement will need to be arranged in collaboration with the Senior Nurse Manager (in hours) and the Nurse in Charge of the Unit and Clinical Site Manager (out of hours).

Transfer for Non-Clinical Reasons i.e., when Critical Care is full:
The decision of which patient to transfer has significant ethical and medico legal implications. HDUHB has a duty of care to all its patients inside and outside Critical Care and must triage resources accordingly.

Non-clinical transfers *should not* take place where there are Delayed Transfers of Care (DTOCs) on the Critical Care Unit.

Refer to existing guidance ‘Designed for Life: Welsh Guidelines for the transfer of the critically ill adult’ (2009) which essentially states that an ethical decision needs to be made whether to transfer a stable patient already on the critical care unit, or the new patient requiring critical care. The guidance advocates moving the new patient to a place of safety i.e. transferring, however it also recognises that there will be instances when moving the stable patient is the best option.

Escalation of Critical Care Services
There is a Welsh Government expectation that all Critical Care Units in Wales have plans in place to escalate 100% Level 3 capacity should the need arise i.e. mass casualty event, pandemic flu. The Health Board escalation plan is as follows.

Critcon 0 ***Normal business as usual***	Normal, able to meet all critical care needs, without impact on other services. Normal winter levels of non-clinical transfer and other overflow activity.
Critcon 1 ***Low surge***	Usual funded critical care capacity full. Some non-clinical transfers
Critcon 2 ***Medium surge***	Usual funded critical care capacity full Overflow into quasi-critical care areas (theatre recovery, other acute care areas). Phased reduction of routine elective work and review urgent/cancer. High level of non-clinical transfers Health Boards beginning mutual aid
Critcon 3 ***High surge***	Maximum mutual aid between Health Boards, with network and regional co-ordination. The prime imperative in Critcon 3 is to prevent any single trust entering Critcon 4.
Critcon 4 ***Triage/Emergency***	Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation). This must only be implemented on national directive and in accordance with national guidance.

Admission of Children (18 years and under):

Our Critical Care Units are not the preferred places to provide Critical Care for children under the age of 18 and should only be considered in exceptional circumstances as a short-term facility when there are capacity issues at tertiary centres. Children below 12 can only be accepted in exceptional circumstances after careful assessment and discussion between Critical Care Consultant, Paediatric Consultant and Paediatric Intensive Care Unit (PICU) and the Welsh And West Acute Transport Children Service (WATCH).

Standards of care for children admitted to adult Intensive Care Units are set out by the Paediatric Intensive Care Society (2015) *(opens in a new tab)*. An All Wales Risk Assessment Tool and action plan for use in wards/areas that admit children/young people 0-18 years will require completion.

All paediatric admissions should be always cared for in a side room with a paediatric nurse present. Throughout the admission a paediatric nurse should be available, and the child should be reviewed twice daily by paediatric senior medical team. Clinical management will be the joint responsibility of the paediatricians (or referring specialist) and the Critical Care Consultant, supported by paediatric intensivists at the tertiary centre as required.

General Principles/Discharge Guidelines:
The objective of the Discharge Guideline general principles is to support well organised, safe and timely discharge of patients from Critical Care.

Once a patient's dependency is assessed as having changed to that consistent with ward care, the patient should be discharged.

Finding the most appropriate ward bed may take a short time; this is the responsibility of the acute hospital patient flow team, but it is important that patient discharge should not be delayed longer than four hours from the time a bed is requested. Discharges after four hours will be classed as a 'Delayed Transfer of Care" (DTOC). This is recorded by the Critical Care ICNARC Clerk, the collated information is then shared internally and with Welsh Government.

After the decision to transfer a patient from a Critical Care area to the general ward has been made, the patient should be transferred as early as possible during the day. Transfer from Critical Care areas to the general ward between 22.00 and 07.00hrs should be avoided whenever possible and should be documented as an adverse incident on DATIX if it occurs in line with Hywel Dda UHB Policy 514 – Management and Investigation of Incidents.

Complex Critical Care Patients:
Discharge of any patient from the Critical Care requires planning. However, it is especially important to plan the discharge of long term or complex patients. Defining this group is difficult but should include all patients who have required Critical Care for more than four weeks.

Patients, their relatives and ward staff all need time to prepare for the discharge. Specific needs must be identified as soon as practically possible and will require multidisciplinary liaison. Specialist services will need time to coordinate all aspects required for continuing care. This may take several days but the process should start before the predicted discharge date i.e. discharge planning should not be a reason for patients staying beyond their need for Critical Care and involve the admitting physician/surgeon.

Discharge Process:
1. The Critical Care team decide that the patient is ready for discharge.
2. The admitting/on-call physician/surgical team are informed.
3. Critical Care staff to inform the patient flow team of the need for a patient discharge as soon as patient is ready. Time of call should be noted. Any additional/special requirements should be stated at this time.
4. This time should be recorded onto the Data Collection Tool (DCT) by the ICNARC data clerks.
5. Clinical Site Manager will facilitate discharge to an appropriate ward in partnership with the ward staff.
6. Any Delayed Transfers of Care should be highlighted and discussed with Critical Care Consultant and Senior Nurse Manager.
7. Any delayed transfers of care that remain in Critical Care should be reviewed daily by the surgical/medical teams for ongoing management of care and therapy.

8. The Physiotherapy team will commence the rehabilitation plan to ward and document in the patient's healthcare records.
9. The Critical Care team and the receiving ward team should jointly ensure that there is continuity of care through a formal documented handover of care from Critical Care staff to ward staff (including both medical and nursing staff); this should be supported by a written plan recorded in the patient's healthcare records, in accordance with NICE CG50 (2007).
10. Critical Care Outreach should be informed of patients being discharged in both Glangwili and Withybush Hospital as soon as the decision has been made to allow appropriate follow up.

Patient Information on Discharge from Critical Care:
When patients are transferred to the general ward from the Critical Care area, they should be offered information about their condition and encouraged to actively participate in decisions that relate to their recovery. The information should be tailored to individual circumstances and give details of the patient's rehabilitation goals. If they agree, their family and carers should be involved.

References

Department of Health (2005) Quality Critical Care: Beyond 'Comprehensive Critical Care'. A report by the Critical Care Stakeholder Forum.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121050.pdf *(opens in a new tab)*

Designed for Life: Quality Requirements for Adult Critical Care in Wales' (2006).
http://wales.gov.uk/topics/health/publications/health/guidance/qualityrequirementsadultcritical?lang=en *(opens in a new tab)*

Designed for Life: Welsh Guidelines for the transfer of the critically ill adult' (2016)
http://www.wales.nhs.uk/sites3/Documents/753/Guidelines%20for%20the%20transfer%20of%20the%20critically%20ill%20adult_Approved.pdf *(opens in a new tab)*

Welsh Government (2017) Delivery plan for the critically ill to 2020
https://gov.wales/topics/health/nhswales/plans/delivery-plan/?lang=en *(opens in a new tab)*

Guidelines for the Provision of Intensive Care Services (GPICS) (2015). http://www.ics.ac.uk/ics-homepage/latest-news/guidelines-for-the-provision-of-intensivecare-services/ *(opens in a new tab)*

Mental Capacity Act (2005). London, Stationary Office
http://www.legislation.gov.uk/ukpga/2005/9/contents *(opens in a new tab)*

NICE CG50 (2007) Acutely Ill Patients in Hospital
http://guidance.nice.org.uk/CG50/Guidance/pdf/English *(opens in a new tab)*

NICE CG83 (2009) Rehabilitation after critical illness
http://guidance.nice.org.uk/CG83/Guidance/pdf/English *(opens in a new tab)*

NICE (2017) QS158, Rehabilitation after Critical Illness in Adults
https://www.nice.org.uk/guidance/qs158 *(opens in a new tab)*

North Wales (and All Wales) Critical Care Levels of Care
www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=753&id=147816 *(opens in a new tab)*

Paediatric Intensive Care Society: Quality Standards for the Care of Critically Ill Children
http://picsociety.uk/wp-content/uploads/2016/05/PICS_standards_2015.pdf *(opens in a new tab)*

Wales Critical Care and Trauma Network,
www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=753&id=147816 *(opens in a new tab)*

NICE (2016) CG135 Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation

https://www.nice.org.uk/guidance/cg135 *(opens in a new tab)*

Management of perceived devastating brain injury after hospital admission.
https://ficm.ac.uk/sites/ficm/files/documents/2021-10/Management%20of%20Perceived%20Devastating%20Brain%20Injury%20After%20Hospital%20Admission.pdf *(opens in a new tab)*

Appendix

Blank risk assessment tool 16-18 year olds (opens in a new tab)