



## CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	29 September 2022
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Temporary Changes to Critical and High Dependency Care Provision across Carmarthenshire
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Andrew Carruthers, Director of Operations
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Keith Jones, Secondary Care Director

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

### ADRODDIAD SCAA SBAR REPORT

#### Sefyllfa / Situation

This paper appraises the Board of the latest position with regard to Critical Care service provision at Prince Philip Hospital following the adjustment to admission protocols to the Critical Care Unit at the hospital implemented with effect from Monday 25<sup>th</sup> July 2022.

The Board is requested to note the current position and take assurance from the mitigating actions in place to limit service disruption and maintain patient safety.

#### Cefndir / Background

On 25<sup>th</sup> July 2022, an operational decision was implemented to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital as a consequence of a further deterioration in the availability of Critical Care consultant staff to provide appropriate and sustainable levels of on-site support to the unit. This decision was affirmed on 28<sup>th</sup> July 2022 by the Operational Planning & Delivery Group, chaired by the Director of Operations, following discussion at the In-Committee Board session earlier that day.

From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted/transferred to neighbouring Critical Care units, appropriate to their clinical needs. This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

Historically, Critical Care consultant support for the two Critical Care Units at hospitals in Carmarthenshire has been provided by a team of Critical Care consultants operating between Glangwili Hospital and Prince Philip Hospital. Each unit is also supported by 24/7 medical cover at middle grade and a team of experienced Critical Care nurses at each site. The Critical Care Unit at Prince Philip Hospital is funded for 5 beds with a designated configuration of 1 x Level 3 bed and 4 x Level 2 beds. Until 25<sup>th</sup> July 2022, consultant cover was rostered on a daily basis Monday – Friday with overnight emergency cover provided by the consultant based at Glangwili Hospital. Weekend daytime consultant cover has historically been shared between both units.

Of the 9 funded Critical Care consultant posts in Carmarthenshire, 4 of these are currently vacant with weekly availability fluctuating due the impact of annual leave and incidental sickness/absence. Current consultant workforce availability does not meet the requirements of the Royal College to support cover across both units, with the existing team of consultants working significantly increased and unsustainable levels of additional hours in recent months to support both units. The Faculty of Intensive Care has issued national guidance - Guidelines for the Provision of Intensive Care Services (GPICS) - which recommends the following:

- A consultant in Intensive Care Medicine must undertake ward rounds twice a day, seven days a week
- The consultant rota should seek to avoid excessive periods (>24 hours) of direct patient consultant responsibility
- A consultant rota with fewer than 8 participants is likely, with the frequency of nights and weekends to be too burdensome over a career

Repeated attempts to recruit to substantive and/or locum positions over the past 18 months have, to date, proved unsuccessful. Whilst recruitment efforts continue, feedback from potential candidates has highlighted on-call frequency, duration and dual site cover during weekends on-call as significant barriers to recruitment. Remaining members of the Critical Care consultant team have signalled their consideration of opportunities to move to the non-Critical Care general anaesthetic rota due to the intense nature of workload faced by the Critical Care team.

There is significant pressure on the Intensive Care consultant group to backfill gaps in the current rota via provision of additional hours / shifts. The table below offers an illustrative forecast of additional/locum duties required over a 6-month period, based on current vacancies within the team:

	<b>Week Daytime</b>	<b>Weekend Daytime</b>	<b>Week Oncall</b>	<b>Weekend Oncall</b>	<b>Total</b>
<b>Single Site Cover</b>	5	10	19	10	44
<b>Two Site Cover</b>	55	10	24	10	99

Repeated requests to agency for consultant backfill on longer term contracts have not been fulfilled. Requests for assistance have also been made to other hospitals across the Health Board and the wider Critical Care network across Wales with available levels of support insufficient to sustain the level of cover required within the Carmarthenshire Critical Care rota.

The Critical Care consultant recruitment challenges experienced within Carmarthenshire are reflective of the national picture, with latest available data from the Faculty of Intensive Care Medicine (FICM) suggesting approximately one third of units across the UK reporting 3 or more vacancies within their Critical Care consultant resource.

In view of the continuing significant workload faced by the Critical Care consultant team in Carmarthenshire, the admission protocols to the Critical Care Unit at Prince Philip Hospital were temporarily amended on 25<sup>th</sup> July 2020 to enable the consultant rota to be reconfigured

whilst maintaining the safety of patient care. With effect from this date, the following arrangements have been applied:

- PPH Critical Care admission acuity has been amended to provide support of Level 1 & 2 patients, with 24/7 on-site support from ICU nursing staff and resident Anaesthetic middle grade doctors. Patients requiring escalated / Level 3 care to be considered for transfer to neighbouring Critical Care units as appropriate for their needs.
- PPH Critical Care Unit has 24/7 ability to support, and hold, escalated Level 2 and Level 3 patients for stabilisation and assure readiness for transfer to neighbouring units.
- Consultant Critical Care roster has been reconfigured to provide 24/7 cover based at the larger 14 bedded GGH Critical Care unit, assuring the ability to support escalated Level 2 / Level 3 transfers from PPH
- GGH Critical Care consultant available to provide remote 24/7 advice to support referrals for ICU management from PPH. They will be responsible for accepting patients for stabilisation and transfer.
- PPH Consultant Physician is available 24/7 for advice / support. Any decisions regarding the transfer of patients are to be jointly discussed between the Critical Care and medical teams, taking account of patient condition and intended management plan.
- Wherever possible, transfers are to be enacted during daylight hours. The Adult Critical Care Transfer Services (ACCTS) have facilitated additional availability of capacity to support transfers

To support effective implementation of the above arrangements, several meetings have taken place with multi-disciplinary staff, advising the rationale for current arrangements, provide assurance regarding ongoing care and support for the deteriorating patient in PPH and to support decision making regarding potential transfers.

Communication has also taken place with the Welsh Government, the All Wales Critical Care Network and the Community Health Council. A Freedom of Information request has also been responded to.

### Asesiad / Assessment

#### Patient activity and flow:

During the 6 week period 25<sup>th</sup> July to 4<sup>th</sup> September 2022, 4 patients have been transferred from PPH to the GGH Critical Care Unit as a consequence of the current amended admission protocol to the unit at PPH. A further 2 patients have been transferred to Morriston Hospital for tertiary level care. Of the 4 patients transferred to GGH, 2 remained on the Critical Care unit in receipt of Level 3 care as at 4<sup>th</sup> September 2022.

Prince Philip Hospital (PPH) - admissions and transfer activity										
	Level 2 - elective	Level 2	Level 3		L2 transfers to GGH		L3 transfers to GGH		Other transfers out	Comments
Admissions PPH				TOTALS	WAST	ACCTS	WAST	ACCTS	WAST / ACCTS	
w/c 25Jul	3	0	0	3					X1 - Morriston (ACCTS)	
w/c 1Aug	3	1	1	5						
w/c 8Aug	2	2	0	4					X1 -Morriston (WAST)	
w/c 15Aug	4	0	0	4		L2 x 1 Urology				Elective patient - developed post op sepsis
w/c 22Aug	4	0	2	6			L3 x 1 - Medical	L3 x 2 - Medical		3rd Level 3 managed in AMAU prior to transfer
w/c 29Aug	2	1	0	3						
TOTALS	18	4	3	25						

The patients transferred during the 6-week period have been transferred safely with multi-disciplinary staff at PPH ably managing and supporting the patient stabilisation and readiness for transfer. The Welsh Ambulance Service NHS Trust (WAST) and ACCTS have supported timely access for transfer. There have been no incidents where patient safety was compromised.

This level of transfer activity is significantly below the anticipated level of 2-3 transfers per week when the admission protocols were amended. Arrangements are in place to continuously monitor and review patients transferred to ensure continuing appropriateness and consistency with the current admission protocols. Following initial joint reflection and review between the Critical Care and acute medical teams, it has been agreed that a weekly Multi-Disciplinary Team (MDT) meeting be established to review each case and further inform clinical thresholds for transfer, with a particular focus on patients requiring escalating Level 2 care, taking account of the expertise of the medical team at PPH in managing patients with acute respiratory disease.

#### Latest Medical Recruitment Update

The amendment of the admission protocols to the PPH Critical Care Unit were applied for an initial period of 10 weeks until 3<sup>rd</sup> October 2022, pending review of, and improvement to, Critical Care staffing levels within Carmarthenshire. Unfortunately, the latest recruitment round which closed on 28<sup>th</sup> August 2022 generated no applicants with suitable experience and therefore 4 of the 9 funded posts remain vacant.

In the event that no suitable additional locum or substantive appointments are secured by 3<sup>rd</sup> October 2022, the current amendment to the admission protocols will need to be extended for a further indefinite period until recruitment levels improve to enable restoration of consultant cover at PPH sufficient to support management of Level 3 patients beyond the initial pre-transfer stabilisation period.

In parallel with continuing recruitment efforts, the Deputy Medical Director will support the Critical Care and acute medical teams in further assessing opportunities to enhance levels of clinical support for patients requiring Critical Care at PPH, with the aim of further minimising the impact on patient flows and the number of patients who may otherwise require transfer for escalated care.

If an improvement in Critical Care consultant staffing levels is not achieved in the intervening period, it is proposed that a further assessment and updated be provided to the Board in January 2023.

#### Nursing Workforce

The Scheduled Care leadership team, supported by the Assistant Director of Nursing, continue to engage and communicate with the Critical Care nursing team to provide reassurance with regard to their roles and responsibilities during the period in which the admission protocols to the unit have been amended. No changes to current rosters have been applied as the unit continues to care for Level 1 & 2 patients on a 24/7 basis. Three recently appointed novice registered nurses have been provided with the opportunity to continue their orientation and competency programme at GGH to ensure their progression is not limited.

In keeping with normal practice, nursing staff are being utilised to support nursing deficits across both sites, where opportunities allow.

Daily support is provided to nursing staff at PPH by the Senior Sister at the PPH unit with regular support meetings scheduled with Band 7 staff.

### Conclusion:

To date, the volume of patients transferred from PPH requiring enhanced Critical Care support has been low and has remained within expected limits.

As reflected above, it is anticipated that the amendment of the admission protocols to the Critical Care unit at PPH will need to extend beyond 3<sup>rd</sup> October 2022, in the absence of improved recruitment levels within the consultant Critical Care team across Carmarthenshire.

Whilst these protocols and supporting transfer arrangements have proven to be effective and safe, the joint Critical Care and acute medical teams will continue to monitor and assess all transfers to identify any opportunities for learning and to further inform appropriate thresholds for transfer.

Further engagement is planned with the ACCTS and WAST services to ensure continuing availability of enhanced transfer support for the anticipated period beyond 3<sup>rd</sup> October 2022.

### Argymhelliad / Recommendation

The Board is asked to:

- **CONSIDER** the latest position in relation to the Critical Care service at Prince Philip Hospital, and **TAKE ASSURANCE** that the current arrangements in place to support transfer of patients requiring enhanced levels of care are both safe and effective;
- **AGREE** to receive a further assessment and update in January 2023, in the event that Critical Care consultant staffing levels do not improve to a sufficient level in the intervening period to enable restoration of the admission protocols in place prior to 25<sup>th</sup> July 2022.

### **Amcanion: (rhaid cwblhau)**

#### **Objectives: (must be completed)**

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1363 – April 2022, relating to risk of PPH service collapse due to ongoing gaps in Consultant Intensivist rotas.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	6K_22 workforce, clinical service and financial sustainability
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019</a>	9. All HDdUHB Well-being Objectives apply

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	Reflected in paper.
Rhestr Termiau: Glossary of Terms:	Reflected in paper.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Operational Planning & Delivery Board

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	No additional financial implications.
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Reflected in paper.
<b>Gweithlu: Workforce:</b>	Reflected in paper.
<b>Risg: Risk:</b>	As reflected in RR 1363.
<b>Cyfreithiol: Legal:</b>	N/A
<b>Enw Da: Reputational:</b>	Potential for political or media interest or public opposition mitigated by impact of protocols in place.
<b>Gyfrinachedd: Privacy:</b>	N/A
<b>Cydraddoldeb: Equality:</b>	N/A

## An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



### Introduction

In June 2019, the Intensive Care Society (ICS) and Faculty of Intensive Care Medicine (FICM) released the second edition of Guidelines for the Provision of Intensive Care Services (GPICS). The first edition of GPICS (2015) built on the earlier Core Standards for Intensive Care Units (2013) and has become the definitive reference source for the planning, commissioning and delivery of Adult Critical Care Services in the UK. Many units have found the GPICS standards and recommendations to be invaluable in developing successful business cases to enhance their local services and improve patient care. GPICS has also been used as the benchmark by which local services are peer reviewed and assessed by healthcare regulators, such as the Care Quality Commission (CQC). The ICS and FICM have worked in collaboration to develop this tool kit to help individual units to compare their services to the latest version of GPICS. The standards and recommendations are presented in Excel format with a drop down option of 'met', 'partially met', 'unmet' or 'not applicable to this service' next to each guideline. The tool kit also allows units to produce a PDF summary page which provides a useful overview of their responses.

This tool kit is not stand-alone and should be used alongside the full GPICS document which is available via the link below. We recommend that the toolkit is completed in collaboration with members of the multi-disciplinary team, so that each section is completed by individuals who are best placed to make an accurate assessment. We are aware that defining compliance with standards and recommendations is difficult and have deliberately left this to the judgment of local clinicians and managers.

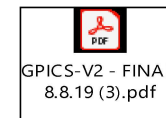
We see the further development of this tool kit as an iterative process, working with individuals and networks to improve and refine its functionality. If you have any suggestions or comments please contact us at [info@ics.ac.uk](mailto:info@ics.ac.uk).

We hope you find this tool kit useful.

[Click here to go to the full GPICS document online](#)

or double-click on the embedded PDF ( you may need to switch to Windows to view after opening)>>

[Click here to view the Instructions sheet](#)



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# An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



## Instructions

### 1. To add your unit name to the summary page please enter it here:

Critical care unit name:  
Operational Delivery Network (ODN) /Region  
Date (dd/mm/yyyy)

Bronglais General Hospital  
Wales  
30/06/2023

### 2. Filling in the sheet

Do not fill anything in on summary of scores sheet. On every other sheet, every box that is blue requires a number to be inputted as follows:

0 = Not met 1 = Partially met 2 = Fully met

3 = Not Applicable to your ICU

### 3. Navigating the sheets

To get to a sheet either click on the sheet name tab at the bottom of the screen, or from the Summary of scores, click on the text that you want to go to.

### 4. Creating a PDF

To create a PDF summary of the gap analysis of your ICU click on the button below (macros must be enabled for it to work).



Summary of the gap analysis of your ICU compared to the GPICS v2 Report date:

Section	Description	STANDARDS			RECOMMENDATIONS		
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Fully Met
1	CRITICAL CARE SERVICES: STRUCTURE						
1.1	Levels of Critical Care	0%	0%	100%	0%	0%	0%
1.2	Outcomes	0%	75%	25%	0%	67%	33%
1.3	Level 2 and 3 Physical Facilities	0%	0%	50%	0%	13%	50%
1.4	Clinical Information Systems	0%	0%	100%	90%	10%	0%
1.5	Clinical Equipment	6%	13%	81%	0%	0%	100%
1.6	Cardiothoracic Critical Care				0%	0%	0%
1.7	Neurocritical Care	0%	0%	0%	0%	0%	0%
2	CRITICAL CARE SERVICE: WORKFORCE						
2.1	Medical Staffing	0%	36%	64%	0%	0%	100%
2.2	Registered Nursing Staff	10%	10%	80%	25%	0%	75%
2.3	Workforce, Induction & Training of Medical and Nursing Staff	0%	14%	86%	10%	70%	20%
2.4	Advanced Critical Care Practitioners						
2.5	Pharmacists	50%	25%	13%	80%	0%	20%
2.6	Physiotherapists	13%	38%	50%	73%	18%	9%
2.7	Dieticians	0%	50%	50%	100%	0%	0%
2.8	Speech and Language Therapists	0%	50%	0%	63%	38%	0%
2.9	Occupational Therapists	100%	0%	0%	100%	0%	0%
2.10	Psychologists	0%	0%	100%	17%	50%	33%
2.11	Healthcare Scientists Specialising in Critical Care						
2.12	Support Staff	10%	20%	60%	20%	40%	40%
2.13	Smaller Remote and Rural Critical Care Units	0%	10%	90%	0%	0%	100%
3	CRITICAL CARE SERVICES: PROCESS						
3.1	Admissions, Discharge and Handover	27%	18%	55%	0%	0%	0%
3.2	Capacity Management	0%	30%	70%	25%	75%	0%
3.3	Critical Care Outreach and Rapid Response Systems	0%	0%	100%	20%	0%	60%
3.4	Infection Control	0%	33%	67%	0%	17%	83%
3.5	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology	0%	17%	83%	29%	0%	71%
3.6	Rehabilitation	29%	43%	29%	57%	29%	14%
3.7	Intensive Care Follow Up	50%	50%	0%	91%	9%	0%
3.8	The Patient and Relative Perspective	14%	14%	71%	60%	0%	40%
3.9	Staff Support	0%	0%	100%	0%	0%	100%
3.10	Inter and Intra Hospital Transfer of Critically Ill Patients	0%	13%	88%	8%	0%	92%
3.11	Care at the End of Life	0%	0%	100%	0%	11%	89%
3.12	Organ Donation	0%	0%	100%	0%	14%	86%
3.13	Legal Aspects of Capacity and Decision Making	100%	0%	0%	0%	100%	0%
4	CRITICAL CARE SERVICES: CLINICAL CARE						
4.1	Respiratory Support	10%	0%	90%	50%	0%	25%
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	100%	0%	14%	29%	57%
4.3	Renal Support	0%	0%	100%	0%	0%	100%
4.4	Gastrointestinal Support and Nutrition	0%	60%	40%	20%	10%	70%
4.5	Liver Support				22%	0%	78%
4.6	Cardiovascular Support	17%	17%	67%	33%	33%	33%
4.7	Echocardiography and Ultrasound	29%	14%	57%	0%	0%	100%
4.8	Neurological Support	14%	0%	86%	0%	0%	100%
4.9	Burns						
4.10	Care of the Critically Ill Pregnant (or Recently Pregnant) Woman	25%	0%	75%	17%	0%	83%
4.11	Care of the Critically Ill Child in an Adult Critical Care Unit						
4.12	Standardised Care of the Critically Ill Patient	0%	30%	70%	10%	20%	70%
5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS						
5.1	Research and Development	0%	0%	0%	0%	0%	100%
5.2	Audit and Quality Improvement	20%	40%	40%	33%	33%	33%
5.3	Clinical Governance	30%	0%	70%	33%	67%	0%
5.4	Critical Care Networks	0%	0%	100%	0%	0%	10%
5.5	Critical Care Commissioning	0%	0%	100%			
6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS						
6.1	Fire	10%	0%	80%	0%	67%	33%
6.2	Major Incidents	29%	0%	71%	56%	0%	22%
6.3	High Consequence Infectious Diseases: Initial Isolation and Management	0%	0%	100%	10%	10%	70%
6.4	Surge and Business Continuity Planning	0%	0%	100%	0%	20%	80%

Section 1	CRITICAL CARE SERVICES: STRUCTURE		Level description	Choose level	Comments
1.1	Levels of Critical Care				
STANDARDS					
1	All patients admitted to a critical care unit must be included in a national clinical audit programme in which Levels of Care data are collected.		met / not met	2=Fully met	
2	Level of Care classification must not be used in isolation to decide upon a patient's requirements.		met/ not met	2=Fully met	
RECOMMENDATIONS					
	None.			3=Not applicable to Unit	
1.2	Outcomes				
STANDARDS					
1	Critical care units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.		met - comprehensive programme with multiprofessional involvement, partially - programme but limited multiprofessional involvement, not met - no review	1=Partially met	
2	The unit must participate in a National Audit Programme for Adult Critical Care.		See section 1.1	2=Fully met	
3	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care.		met / not met	1=Partially met	
4	Critical care units should participate in a programme of hospital-acquired infection surveillance to monitor and benchmark rates of catheter-related bloodstream infections, antimicrobial use and frequency of multi-resistant infections.eg Infection In Critical Care Quality Improvement Programme ICCQIP		Met / unmet	1=Partially met	
RECOMMENDATIONS					
1	The UK intensive care community should encourage and develop a validated methodology to review referrals to intensive care and evaluate decision making and subsequent outcomes relating to intensive care admission and refusal.		National measure		
2	Units should develop a consistent approach to patient-centred decision-making, evaluating burdens and benefits of admission to intensive care, and be able to demonstrate this through the audit of pre-admission consultation, agreed ceilings of therapy, and time-limited treatment trials.		met - all admissions audited and reviewed, partially met, some audit evidence of this process, not met - no audit information / no review of admissions	2=Fully met	
3	Longer-term mortality should be collected on all patients admitted to critical care.		met - collected on all patients, partially met - intermittent audit / review, not met - not reviewed	1=Partially met	
4	The UK intensive care community should encourage and develop validated measures of longer-term patient- and family-centred outcomes beyond mortality, including measures of functional ability, socioeconomic consequences, and carer burden.		National measure		
5	The UK intensive care community should encourage and develop validated measures of quality of care relating to end of life and bereavement.		National measure		
6	Critical care units should consider systematic assessment of patient and family experiences and demonstrate how these are used to guide improvement.		met - quarterly assessment, partially met - 1-2 yearly, not met - not done	1=Partially met	
1.3	Level 2 and 3 Physical Facilities				
STANDARDS					
1	Critical care facilities must comply with national standards.		met / not met	2=Fully met	
2	All new build units must comply with HBN 04-02.		met / not met / not applicable	3=Not applicable to Unit	
3	Medicines and fluid storage must comply with HBN 00-03.		met / not met		
RECOMMENDATIONS					
1	Existing units that do not comply should have a timeline to establish when national standards will be met.		met - time line and evidence to suggest progress, partially met - timeline but no evidence of progress, not met - no timeline / not applicable if standards met	2=Fully met	
2	Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.		met/not met	3=Not applicable to Unit	
3	The unit should have enough beds and resources to obviate the need to transfer patients to other critical care units for non-clinical reasons.		met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2=Fully met	
4	When planning or redeveloping a critical care area, Document HBN 04-02 should be considered.		met, partially met, not met, not applicable	3=Not applicable to Unit	
5	Critical care units should incorporate sufficient storage for medicines (including refrigerated and controlled drugs), IV fluids (including renal replacement) and enteral feeds. Storage areas/rooms should be secure and appropriately temperature controlled for all medicines. ICU designs also, need to account for how selected medicines, including patient's own drugs, will be securely stored and readily accessible near the patient's bedside.		met, partially met, not met, not applicable	2=Fully met	
6	It is recommended that critical care areas that have undergone recent new unit planning and building are contacted by those embarking on a new build to share experiences and learning.		met, partially met, not met, not applicable	3=Not applicable to Unit	
7	Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and dignity needs, and staff and visitor areas. Consideration should also be given to the patient's recovery and rehabilitation needs, including the potential for long-stay patients to spend periods outside.		met, partially met, not met, not applicable	1=Partially met	
8	Critical care units should be inspected as part of the peer-review process, including the review of the building and facilities. Feedback should include any concerns or highlight any slippage to timeframes.		met - peer reviewed, feedback included, partially met - peer review, no feedback, not met - no peer review	2=Fully met	
9	Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners.		National/regional measure		

1.4 Clinical Information Systems*				
*If no CIS then Not applicable				
STANDARDS				
1	The CIS must comply with the set of common specifications, frameworks and implementation guides that support interoperability as specified with the NHS Interoperability Toolkit. ( <a href="https://digital.nhs.uk/services/interoperability-toolkit">https://digital.nhs.uk/services/interoperability-toolkit</a> ).		3=Not applicable to Unit	
2	CIS procurements and customisation must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system. This must include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineering , the CClO (Chief Clinical Information Officer) and ICT specialists.	met, partially met, not met, not applicable	2=Fully met	
3	The CIS must have a rigorous business continuity access (BCA) plan and resilience system so that critical patient information remains available and system downtime must not compromise patient safety in any way. There must be a process to ensure that sufficient staff trained in BCA contingency measures are available 24/7.	Met = full BCP present and tested, partially = some aspects not expected to continue as usual or BCP untested, Not met = no documented BCP	3=Not applicable to Unit	
4	Where patient data management systems (PDMS) or electronic patient record (EPR) systems are used, there must be access to a dedicated workstation computer at each bed space. An appropriate number of both mobile and fixed workstations must be available to facilitate timely patient care by medical, nursing and allied staff on ward rounds and on an <i>ad hoc</i> basis.	Met = workstation for every bedspace plus additional workstations for mobile staff, partially met = insufficient mobile workstations, not met = absence of workstation at every bedspace (even if mobile stations available) or absence of any mobile workstations.	3=Not applicable to Unit	
5	The CIS must have robust implementation and ongoing training programmes to support all staff in its clinical and management use. These should be provided by the NHS organisation in partnership with the vendor company . Due consideration should be given to how this training will be provided to new starters and locum staff. There should be a mechanism by which any specialty involved in the patient's care while on the critical care unit has access to all pertinent information and is able to document in such a way as to facilitate care. This is particularly important when critical care and hospital documentation systems are distinct.	Met = training provided to all staff requiring it including new starters, >90% on first day of clinical duty or before, partially met >80% but <90% trained on first day of starting, not met = <80% trained on day 1	3=Not applicable to Unit	
RECOMMENDATIONS				
1	Critical care units should consider using a CIS.	met / not met	1=Partially met	WICIS Pending
2	CISs should be part of an electronic health record. The specification should include high-resolution data capture from patient monitoring, infusion devices, ventilators, cardiac output measurement, temperature management devices, intra-aortic balloon pumps, extra-corporeal life support (ECLS) devices, blood gas analysers and renal replacement therapy (RRT) devices. A CIS should be capable of customisable display of this information along with clinical notes.	Met = >90% of device types ever used linked to system, partially met = 80-90% of all devices linked, not met = <80% of devices linked (ie we wouldn't expect a unit using 2 IABPs a year to link them, but would expect a unit using them monthly to link them)	0=Not met	
3	The CIS should be connected to the hospital's patient information system for demographic and admission/discharge data, to laboratories for results, to radiology for reports and to other key software, e.g. National Critical Care Audit Systems and Hospital Electronic Prescribing and Medication Administration (HEPMA) for electronic data sharing. The CIS should be able to collect and share electronically Critical Care Minimum Data Sets (CCMDS) and national audit data to facilitate electronic generation of reports and audit. In the event of replacing existing CIS, it must be possible to access archived patient records in a user-friendly format.	Met = clinical staff do not need to routinely log in to another system to obtain results required to care for patients, partially met = clinical staff have to log into 1 additional system regularly, not met = staff have to access >1 additional system to obtain routine information required for patient assessment.	1=Partially met	
4	Investigation ordering should be fully integrated and recorded, and include electronic prescribing of drugs and fluids and ordering of laboratory and radiology services.	partially met = clinical staff have to log into 1 additional system regularly, not met = staff have to access >1 additional system to obtain routine information required for patient assessment.	0=Not met	
5	Daily summary plans should capture electronically activity data from the rest of the CIS, with the addition of free-hand text for healthcare professionals treating and visiting the patients.	Met = captures all required data, Unmet = unable to capture any information regarded as essential to review patient	0=Not met	
6	The CIS should be capable of forming worklists for individual members of the critical care team to allow patient- and staff-based lists of tasks to be completed. The CIS should include the ability to alert when tasks are near due, due and overdue, and record and audit performance.	Met = provides carer-specific worklists and alerts, partially met = either alerts or worklists not provided comprehensively, unmet = unable to provide worklists or does not provide alerts (could probably do with splitting)	0=Not met	
7	There should be a functionality within the database to alert, within a short timeframe, lack of compliance with care bundles and specifically for physiological abnormalities that are undesirable or life threatening. These alerts should be via dashboards displayed clearly within the unit and also via text or email to smartphones or notepad-type devices carried by healthcare staff.	Met = alerts provided in real time in format required by unit, partially met = some alerts but not all those required or can only be provided in a suboptimal medium, not met = no dashboard facility	0=Not met	
8	The CIS should include customisable transfer/discharge summary, pulling key information from diagnoses, intensive care management, clinical notes, labs and medication.	partially met = discharge summary can be created according to unit spec but requires re-entry of data already in system, not met = disch summary cannot be constructed to satisfactory standard	0=Not met	
9	Flexibility through assessing care records online or through mobile devices should be possible.	Met = can be accessed remotely from any device, partially met = can only be accessed from specific pre configured devices, not met = cannot be accessed or can be accessed but concerns over data security	0=Not met	
10	The CIS should handle authentication and authorisation through Single Sign On, including the use of RFID/smart cards/biometrics.	= single log in provided computer operating system already logged in, not met = user has to enter ID more than once to access	0=Not met	
11	The system should provide capacity to evolve sophisticated electronic decision support systems, to facilitate patient safety and quality. The CIS should be capable of feeding data to other tele-health solutions for remote monitoring and advice on patient management.	Met = versatile system where users have been able to create decision support algorithms as required, partially met = some pre specified decision support provided but limited additional configuration by end user, Not met = no decision support available	0=Not met	
1.5 Clinical Equipment				
STANDARDS				
1	All equipment must conform to the relevant safety standards and must be regularly serviced and maintained in accordance with the manufacturer's guidance.	met / not met	2=Fully met	
2	Uninterruptable power supply adequate to provide at least one hour of continuity of any critical equipment without battery back-up must be provided.	met / not met	2=Fully met	
3	There must be a programme in place for the routine replacement of capital equipment.	met / not met	1=Partially met	Capital Bid Programme.
4	All staff must be appropriately trained and competent and familiar with the use of equipment. Up-to-date training records must be maintained to demonstrate that all staff (medical, nursing, AHP and support staff) have complied with this provision.	met - >85% trained staff for all equipment, partially 75-85% trained staff all equipment, not met < 75% or no clear record.	2=Fully met	
5	There must be an individual designated equipment clinical lead for intensive care whose responsibilities will include the assessment, procurement, use and replacement of equipment on the critical care unit in collaboration with the electro-biomedical engineering (EBME) provider and the organisation's overarching	Met / not met	0=Not met	
6	EBME support must be available either in-house or on a contracted basis to ensure equipment is appropriately serviced. Regardless of the model of support, EBME personnel must have the appropriate skills and equipment to service the equipment used.	Met / not met	2=Fully met	
7	Equipment must be uniquely identified and listed on an appropriate asset register along with details of its life cycle and service history/requirements to facilitate planned maintenance and replacement.	met - >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record.	2=Fully met	
8	There must be documented procedures for decontamination (cleaning, disinfection and sterilisation as appropriate, depending on equipment risk category and sensitivity of devices). Appropriate sterile services must be provisioned so that national standards are followed for the re-sterilisation of endoscopes and reusable.	met - >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record.	2=Fully met	
9	Critical care units must be have appropriate systems in place to ensure an adequate supply of consumables.	Met = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents	2=Fully met	
10	There must be robust mechanism for reporting adverse incidents resulting from the use of clinical equipment. Serious incidents involving clinical equipment may also need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).	met - policy in place, partially met, no policy but can evidence, not met, no policy and / or no evidence	2=Fully met	
11	The MHRA may issue safety alerts pertaining to medical devices, as may device manufacturers from time to time. There must be designated role and robust mechanism for ensuring that such alerts are cascaded to staff and acted upon as appropriate.	met - 100 % alerts received and acted upon, partially met 85-100% received, not met - no robust mechanisms or not able to evidence	1=Partially met	No Consistency. No designated individual

12	Sufficient equipment must be available to meet the service demand to enable treatment provision (basic and specialist monitoring, ventilation, renal replacement therapy, information technology facilities etc.) in an appropriate timescale to meet patient need. Consideration must be given to the need to provide additional capacity in times of surge demand.	Met = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents	2=Fully met	
13	Magnetic resonance imaging (MRI) compatible equipment must be provided for use where mechanically ventilated patients are to undergo MRI investigation. These must be clearly labelled and staff must be adequately trained.	met / not met / not applicable	2=Fully met	
14	Where advanced monitoring techniques are used (e.g. diagnostic electroencephalography, cardiac output monitors, intracranial pressure/other invasive neuromonitoring), there must be provision of appropriately trained staff to adequately interpret the results in a timely manner and to deal with likely complications of their use where appropriate.	Met = all advanced techniques reported within 6 hours of event (inc verbal and provisional reports), Partially 6-24h, Not met = greater than 24h delay	2=Fully met	
15	Immediate access to point of care blood gas analysis and glucose/ketone analysis on a 24/7 basis must be provided.	Met / not met	2=Fully met	
16	Where equipment is to be trialled on a loan basis for evaluation purposes, it is essential that adequate indemnity and governance arrangements are in place in case of injury to either patients or staff from potentially unfamiliar equipment, and the supplier should provide adequate training to ensure correct use. The EBME provider should facilitate this process by testing the equipment for safety as well as evaluating servicing and maintenance implications.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Standardisation of equipment should be encouraged both within the critical care unit and in other areas where intensive care may need to be delivered.	Met = all L3 areas of the hospital use same monitoring / ventilators / portable ventilators / RRT / monitoring sets. Partially met = 1 item different, Not met = >1 item different (specialist equipment used in only 1 area not included)	2=Fully met	
2	The provision of diagnostic ultrasound equipment should be guided by the likely patient population and staff expertise. At very least, there must be immediate access to sufficient ultrasound equipment to ensure that intravascular catheters can be placed safely and in a timely manner, even in emergent circumstances.	met / not met	2=Fully met	
1.6 Cardiothoracic Critical Care				
*Not applicable to non Cardiothoracic Critical Care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of GPICS.	met / not met	3=Not applicable to Unit	
2	Each cardiothoracic critical care unit must have designated lead consultant with training in cardiothoracic intensive care. This should be recognised in their job plan and they should be involved in multidisciplinary service planning and governance within the unit	met / not met	3=Not applicable to Unit	
3	Each cardiothoracic critical care unit must have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service.	met / not met	3=Not applicable to Unit	
4	There must be a resident doctor or ACCP and a resident cardiac surgeon. There must be on-site 24/7 access to a doctor or ACCP with advanced airway skills. The resident team must be trained in Cardiac Surgery Advanced Life Support (CALS) and be capable of emergency chest re-opening 24/7.	met / not met	3=Not applicable to Unit	
5	Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complies with national standards. There should be a clear escalation pathway from post-operative care to intensive care.	met / not met	3=Not applicable to Unit	
6	The care of patients falling outside the protocolised care pathways must be reviewed by a multidisciplinary team led by a consultant trained in cardiac Intensive Care Medicine.	met / not met	3=Not applicable to Unit	
7	Ventilated patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	met / not met	3=Not applicable to Unit	
8	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care.		3=Not applicable to Unit	
9	There must be a critical care pharmacist for every cardiothoracic critical care unit, supported by sufficient pharmacy technical staff.	met / not met	3=Not applicable to Unit	
10	All cardiothoracic critical care units must participate in local and national audit. For example, for units in England, Wales and Northern Ireland, this is participation in the ICNARC ARCIC (Assessment of Risk in Cardiothoracic Intensive Care) programme - the national clinical audit for cardiothoracic critical care units.	met / not met	3=Not applicable to Unit	
11	Transthoracic and transoesophageal echocardiography must be immediately available.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	The patient monitoring and physical support requirements in a cardiothoracic critical care unit should be no less than the requirements of patients cared for in a general (Level 3) critical care unit.	met / not met	3=Not applicable to Unit	
2	Cardiac and thoracic surgery post-operative care is carried out in a dedicated environment with each component located in close proximity.		3=Not applicable to Unit	
3	The cardiothoracic critical care unit should have in place agreed clinical criteria for the appropriate case-mix and arrangements for escalation to a general critical care facility as required.	met = clear written protocol, partially met = occurs in practice but referer/accepter dependent, not met = escalation does not/cannot occur	3=Not applicable to Unit	
4	ACCPs, with adequate training and appropriate support, can provide a safe, sustainable alternative to medical staff in the cardiothoracic critical care unit.	Statement		
5	Each day, a consultant in charge of the cardiothoracic critical care unit should coordinate input from members of the various teams in the immediate post-operative period.	met / not met	3=Not applicable to Unit	
6	Perfusion services should be readily available.	met / not met	3=Not applicable to Unit	
7	Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an active part in shaping services and analysing quality. Patient mortality audit is currently in the public domain for each unit and each member of the MDT should have an understanding of how their own role contributes to patient outcomes.	met / not met	3=Not applicable to Unit	
1.7 Neurocritical Care*				
*NOT Applicable if non neurocritical care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in the relevant chapters of GPICS.	Met / not met	3=Not applicable to Unit	

2	Neurocritical care units should have access to investigation facilities and appropriate clinical expertise for the following: a) diagnostic radiology (24-hour access to CT; access to MRI for ventilated subjects, and diagnostic angiography), b) access to biochemistry and microbiology services to analyse cerebrospinal fluid (CSF), c) neurophysiology (including electroencephalography (EEG) and evoked-response diagnosis and monitoring). Access to continuous 24-hour EEG monitoring is highly desirable.	met - all available, partially - some available	3=Not applicable to Unit	
3	All cases requiring immediately lifesaving neurosurgery must be admitted to the local neurosurgical centre irrespective of the initial availability of neurocritical care beds.	fully met - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met	3=Not applicable to Unit	
4	Patients with a Glasgow Coma Scale (GCS) score of $\leq 8$ following a head injury at any time must have access to specialist treatment from neuroscience unit.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)	3=Not applicable to Unit	
5	As per NICE QST4, eligible patients must have assessment for in-patient rehabilitation if new cognitive, emotional, behavioural or physical difficulties persist for more than 72 hours.	met / not met	3=Not applicable to Unit	
6	In addition to general rehabilitation, neurologically impaired patients must have access to specialist neuro-rehabilitation services.	met = have access immediately once ready for discharge from acute centre, partially met = have access but discharge delays >48h for >20% patients, not met = no access or delays > 4 weeks to access neuro rehab	3=Not applicable to Unit	
7	Neurocritical care must have resources to support mechanical thrombectomy in line with NICE IPG 548.	met - 24/7, partially - 5/7 per week, not met - available less than less.	3=Not applicable to Unit	
8	Neurocritical care must have resources to support regional networks for the safe and timely management of patients with subarachnoid haemorrhage.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)	3=Not applicable to Unit	
9	Patients must be cared for by a multi-professional intensive care team with specialist expertise and experience in managing critically ill neurological patients using agreed protocols based on the best evidence available.		3=Not applicable to Unit	
10	Care of critically ill neurological patients must fully integrate involvement of admitting specialties (neurology, neurosurgery, spinal surgery), and diagnostic/interventional specialties (neuroradiology and neurophysiology).		3=Not applicable to Unit	
11	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.			
RECOMMENDATIONS				
1	Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care.	met / not met	3=Not applicable to Unit	
2	Both the patient and family of the patient on neurocritical care should be offered support and guidance in the disease process and longer-term outcomes using specialist nurses and psychologists.	met = readily available at any point in pathway, partially met = available but not necessarily during critical care stay, not met = no psychology provision	3=Not applicable to Unit	
3	Multimodal monitoring of patients with neurological injury should be consistent with international consensus recommendations.		3=Not applicable to Unit	
4	Early and formal involvement of the neurorehabilitation team as part of the multidisciplinary team should be sought to optimise outcomes and facilitate transitions of care.	met = neurorehab consult within first week after injury (may be specialist physio or practitioner or consultant), partially met = neurorehab review prior to transfer, not met = no review in acute setting	3=Not applicable to Unit	
5	Specialist equipment needs to be freely available to facilitate the acute rehabilitative needs of all brain and spinal injured patients while on neurocritical care.		3=Not applicable to Unit	
6	Neurocritical care units must be part of a regional network of care, with agreed rational transfer and repatriation protocols that ensure rapid acceptance of patients for specialist care, and transfer back to referring hospitals or onwards for further specialist long-term care when the need for specialist neuroscience care no longer exists.	met - meet full recommendation with audit data, partially - meet recommendation but no audit data, not met - no networks / poor network	3=Not applicable to Unit	
7	Follow up and audit of outcomes from neurocritical care should include a measure of functional recovery at a minimum of six months.	met / not met	3=Not applicable to Unit	
8	Regular neurocritical care morbidity and mortality meetings should be undertaken involving all members of the multidisciplinary team, including the admitting specialties, allowing structured judgement case review.	met = quarterly or more frequent MDT involvement, partially = less frequent or less MD, not met = no M&M	3=Not applicable to Unit	
9	Patients requiring intensive care for acute neurosurgical and neurological diseases in non-specialist centres should have direct communication to expertise in specialist neuroscience centres.	met/not met	3=Not applicable to Unit	

Section 2	CRITICAL CARE SERVICES: WORKFORCE		Level description	Level	Comments
2.1	Medical Staffing				
STANDARDS					
1	Patients' care must be led by a consultant in Intensive Care Medicine, who is defined as "... a consultant who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine. A consultant in Intensive Care Medicine will have daytime Direct Clinical Care Programmed Activities in Intensive Care Medicine identified in their job plan. These programmed activities will be exclusively in ICM and the Consultant will not be responsible for a second speciality at the same time."	Met = 24/7 cover by consultant in ICM, partially met = all daytimes covered by ICM consultant but 1-2 nights per week covered by an anaesthetist with direct telephone access to a named "second on call" ICM consultant not met = anything else	1=Partially met	Consultant carries bleep and includes i	
2	Consultant work patterns must deliver continuity of care.	Met = daytime consultants work blocks of 3 or more days, with job planned handover time, partially met = blocks of <3 days or days themselves divided but with clear handover, not met = anything else	1=Partially met		
3	The daytime consultant to patient ratio must not normally exceed a range between 1:8 and 1:12.	Fully met = 7 days a week, partially met = 5 days per week	2=Fully met		
4	The daytime intensive care resident to patient ratio should not normally exceed 1:8.	Fully met = 7 days a week, partially met = 5 days per week	2=Fully met		
5	All staff that contribute to the resident rota must have basic airway skills. All critical care units must have immediate 24/7 on-site access to a doctor or ACCP with advanced airway skills.	Met / not met	2=Fully met		
6	There must be a designated Clinical Director and/or Lead Consultant for Intensive Care Medicine.	Met / not met	2=Fully met		
7	A consultant in Intensive Care Medicine must be immediately available 24/7. The consultant responsible for intensive care out of hours must be able to attend within 30 minutes.	Met / not met	2=Fully met	Anaesthetist with a special interest in i	
8	A senior number or units that remain started overnight by an anaesthetic consultant without daytime ICM sessions; by a necessity dictated by the unit's size and remoteness, must also have a consultant in Intensive Care Medicine available for advice 24/7, either by local presence or from within the Critical Care Network.	Met / not met	2=Fully met	On call Consultant in GGH	
9	A consultant in Intensive Care Medicine must undertake ward rounds twice a day, seven days a week.	Met = >95% of days 2 ward rounds occur, partially met = 90-95%, not met = <90%	2=Fully met		
10	The ward rounds must have daily input from nursing, microbiology, pharmacy and physiotherapy and regular input from dietetics, speech and language therapy, occupational therapy and clinical psychology to assist decision making. The nurse in charge should be present in person for the ward rounds.	Met - all met 7 days per week, partially met - ( define missing groups ) or only 5 days per week, not met - not achieved	1=Partially met	Microbiology	
11	Rotas for consultants and resident staff must be cognisant of fatigue and the risk of burnout.	Met = staff confirm rota is resilient, partially met = staff believe rota has features that are unsustainable in the long term, not met = failed rota requiring regular locum cover	1=Partially met	Vacancies	
RECOMMENDATIONS					
1	The consultant rota should seek to avoid excessive periods (> 24 hours) of direct patient consultant responsibility.	met / not met	2=Fully met		
2	The resident rota should be compliant with working time directives (i.e. Working Time Directive 2003)	met / not met	2=Fully met		
2.2	Registered Nursing Staff				
STANDARDS					
1	Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	met 98% of the time or not met	2=Fully met		
2	Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.	met 98% of the time or not met	2=Fully met		
3	Each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service e.g. a Band 8a Matron.	met / not met	2=Fully met	X2 SNM's across the HB.	
4	There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7 in critical care units. Units with fewer than six beds may consider having a supernumerary clinical coordinator to provide the supervisory role during peak activity periods, e.g. early shifts.	met = supernumerary nurse does not have their own patient >99% of time, partially met = supernumerary nurse is occasionally used in emergency to care for patient on <5% shifts, not met = supernumerary nurse is required to care for their own patient >5% shifts	1=Partially met	Not funded	
5	Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to enable the delivery of safe care (i.e. 11-20 beds +1, 21-30 beds +2, etc.). The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g. multiple pods/bays, single rooms). Consideration for the need of additional staff also needs to be given during events such as infection outbreak.	Met = unit >11 beds always has second supernumerary nurse available, Partially = available >60% shifts, not met = unit has >11 beds and no additional nurse	3=Not applicable to Unit	N/A to ICU Bronglais	
6	Each critical care unit must have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD framework for intensive care nursing staff and pre-registration student allocation. This should equate to a minimum of 1.0 WTE per 75 nursing staff.	met - 1.0 per 75, partially met 1.0 per 100, unmet - no educator or less than 1.0 per 100	2=Fully met	0.8 WTE for our unit	
7	All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to enable achievement of basic specialist competence.	Met = always provided until competence achieved, partially = provided but may have own patient before full competencies completed, Not met = anything else	2=Fully met		
8	A minimum of 50% of registered nursing staff must be in possession of a post-registration award in Critical Care Nursing.	met or not met	2=Fully met		
9	Units must not utilise greater than 20% of registered nurse from bank/agency on any one shift when they are NOT their own staff.	Met = >95% of shifts, partially =90-95% shifts, not <90%	0=Not met	33% (less than 90%)	
10	Where direct care is augmented using support staff (including unregistered nursing roles), appropriate training and competence assessment	met or not met	2=Fully met	HCSW training	
11	In addition to leadership competencies the lead nurse/matron (terms are synonymous for this purpose) for the critical care unit must meet, as a minimum, the same specialist critical care nurse educational standards as the staff caring for Level 3 patients.	met or not met	2=Fully met		
RECOMMENDATIONS					
1	Step 1 of National Competencies for Adult Critical Care Nurses should commence when a nurse with no previous experience of the specialty begins working in Intensive Care Medicine.	met / not met	2=Fully met		
2	Steps 2 and 3 of National Competencies for Adult Critical Care Nurses should be incorporated into academic intensive care programmes.	met / not met	2=Fully met		

3	Post-registration adult intensive care nursing courses should be awarded a minimum of 60 credits at Level 6. To meet the requisite standard, courses must adopt the core curriculum described in the National Standards for Critical Care Nurse Education (2016).	National measure		Fully met with 2 post reg courses
4	Additional Clinical Nurse Educators will be required for larger units, i.e. 1.0 WTE for approximately 75 staff. Clinical Nurse Educators should be senior intensive care nurses who have attained Step 3 competence, have completed a post-registration intensive care award and be in possession of a post-registration teaching qualification.	See above	3=Not applicable to Unit	
5	Registered nurses supplied through an agency to work in intensive care should provide evidence of appropriate experience and competence to care for critically ill patients.	met / not met	3=Not applicable to Unit	
6	The Best Practice Principles to Apply When Considering Moving Critical Care Nursing Staff to a Different and Unfamiliar Clinical Care Area should be followed at all times to enable staff to achieve and maintain competence in intensive care nursing. The potential adverse effects on staff morale, recruitment and retention should be considered, particularly when this is recurrent. Executive Directors of Nursing should take requisite steps to minimise this.	met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	
7	Supernumerary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive care nursing.	met / not met	0=Not met	Discuss with Sandra
2.3 Workforce, Induction & Training of Medical and Nursing Staff				
STANDARDS				
1	Each critical care unit must have a dedicated supernumerary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for coordinating the education and training and CPD framework for intensive care nursing staff and pre-registration students.	See above 2.2.6	2=Fully met	
2	All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to allow adequate time for registered nurses to develop basic skills and competencies assessed to ensure they can safely care for a critically ill patient.	See above 2.2.7	2=Fully met	
3	All registered nurses commencing in intensive care must be working towards Step 1 of the National Competency Framework for Adult Nurses in Critical Care.	See above 2.2.1- recommendation	2=Fully met	
4	A minimum of 50% of registered nursing staff must be in possession of a post-registration award in intensive care nursing.	See above 2.2.8	2=Fully met	
5	Where direct care is augmented using non-registered support staff, appropriate training and competence assessment must be provided.	See above 2.2.11	1=Partially met	
6	All non-consultant medical staff commencing a post in the critical care unit must have a consultant-led departmental induction to the unit with a formal published programme. This must take place prior to commencing any clinical duties, and must include, but is not limited to: a) Instructions on how to raise patient safety concerns, b) Instructions on how to raise issues of bullying and undermining, c) Introduction to key members of medical, nursing, allied professional and operational support staff, d) Highlighting key departmental guidelines and how to access all departmental guidelines, e) Explanation and distribution of the doctor's rostered work pattern, and their roles and responsibilities when rostered to work both during the daytime and out of hours, f) Arrangements for access to all IT systems, including passwords, provision of identification badges and tutorials on the use of any clinical IT systems on the day of induction, and g) Assigning each doctor an Educational Supervisor.	met - includes all elements, partially met - some elements, not met - no identifiable written programme.	3=Not applicable to Unit	
7	There must be a regular (e.g. weekly), consultant-led teaching programme relevant to all non-consultant grade doctors. Time to attend this must be protected, with attendance mandatory for all non-consultant grade doctors rostered to be on duty. These sessions should be open to all members of the MDT.	met - meets all elements, partially met - some elements met, not met - no regular teaching	3=Not applicable to Unit	
8	There must be regular clinical governance, morbidity and mortality, and literature review meetings open to all members of the MDT. These meetings must be attended by both consultants and non-consultant grade doctors and non-consultant grade doctors must have the opportunity to lead the presentations at these sessions.	met - meets all elements, partially met - some elements met, not met - no meetings as described	2=Fully met	
9	All consultants responsible for the educational supervision of trainees must be recognised by the GMC for this role and there must be a sufficient time allocated in the Educational Supervisor's job plan to allow 0.25 SPA per trainee.	met - 0.25 PA per trainee, partially met less than 0.25 per trainee, not met, no time allocated.	3=Not applicable to Unit	
10	All non-consultant grade doctors must have a bespoke personal development plan relevant to their developmental needs, and the doctor must be given the time and opportunity to achieve the objectives within the personal development plan as agreed with their Educational Supervisor.	met / not met	3=Not applicable to Unit	
11	All staff supplied through an agency to work in intensive care must provide evidence of appropriate experience and competence to care for critically ill patients.	met / not met / not applicable ( if never using agency)	2=Fully met	via agency screening
RECOMMENDATIONS				
1	Clinical Nurse Educators should be in possession of a post-registration award in intensive care and an appropriate postgraduate certificate in education or equivalent.	met / not met	1=Partially met	Partially, no post-graduate certificate in
2	Nurse education programmes should follow the National Standards for Critical Care Education (2016) and include both clinical competence and assessment.	met / not met	2=Fully met	
3	Study leave should be provided for all members of the MDT for intensive care-related courses and conferences.	Met = funded/partially funded (may be from charitable sources) study leave up to 10 days per year available to all staff, Partially = study leave available but unfunded or <4 days per year, Not met = anything else	1=Partially met	Does not do 4 days
4	A creative learning environment should be provided for all staff offering a range of learning experiences to meet the defined learning outcomes for their continuing professional development.	Met = montly forum for full MDT, partially met = some provision but not monthly or not formalised, Not met = no mechanism	1=Partially met	No designated training room
5	There should be a regular monthly forum chaired by a senior member of the department, where all members of the MDT can feed back any patient safety, educational or operational issues to the senior medical, nursing and management team.	Met = trust provides electronic access to appropriate ICM journals and resources, partially met = some access but clinicians believe notable omissions, Not met = no access	1=Partially met	Recently re-started
6	The hospital and/or departmental library should provide access to relevant and up-to-date Intensive Care Medicine journals and books relevant to nursing, medical and AHP staff.	Met = trust provides electronic access to appropriate ICM journals and resources, partially met = some access but clinicians believe notable omissions, Not met = no access	2=Fully met	Online version access available
7	The critical care unit should provide access to online clinical resources from within the clinical area for all clinical staff.	Met = trust provides electronic access to appropriate ICM journals and resources, partially met = some access but clinicians believe notable omissions, Not met = no access	1=Partially met	Access to on site library available
8	All consultants should provide regular teaching and feedback to non-consultant grade doctors, nursing staff and allied health professionals.	Met = fully evidence simulation and MDT education programme, Partial = some MDT teaching provided but not comprehensive	1=Partially met	Dr Ramesh, difficult intubation
9	There should be a regular multidisciplinary educational programme, including simulation involving medical, nursing and allied health professional staff.	Met = fully evidence simulation and MDT education programme, Partial = some MDT teaching provided but not comprehensive	1=Partially met	
10	Step 4 leadership competencies (or equivalent) (CC3N, 2018) should be completed by all senior nurses who undertake the role of shift leader (including those who lead partial teams in larger units) and those aspiring to such a role.	See above 2.2.5 recommendation	0=Not met	Ask Sandra
11	Specialist step competencies (CC3N, 2018) should be completed whenever relevant to the case-mix of the unit. For example, nurses working in critical care units in major trauma centres should complete the major trauma step competencies.	met = >50% staff complete, partially 25-50%, not <50%	3=Not applicable to Unit	
2.4 Advanced Critical Care Practitioners				

STANDARDS				
1	ACCPs must act within the formal code of conduct of their present statutory regulator. Trainee ACCPs are required to practice within the structure of the FICM curriculum, with the appropriate level of supervision.	Met/ not met	3=Not applicable to Unit	
2	All ACCPs / ACPs working on Critical Care should have completed non medical prescribing	Met = >95%, Partially = 75-95%, Not = <75%	3=Not applicable to Unit	
3	ACCPs must acknowledge any limitations in their knowledge and skills and should not perform clinical activities they do not feel skilled or competent to perform. As part of their training and ongoing professional development, they must develop (and continue to develop) a high level of clinical judgment and decision making.		3=Not applicable to Unit	
RECOMMENDATIONS				
1	A FICM-associated ACCP with supervision from an ICM consultant falls within the definition of an intensive care resident and may provide the onsite 24/7 immediate clinical/medical cover for patients.	Statement		
2	An ACCP who entered a training post after 5 November 2017 should successfully complete an ACCP specific two-year Postgraduate Diploma (PgDip) which meticulously follows the FICM ACCP curriculum, and register with FICM as a trainee ACCP. ACCPs who entered training pre the above date should ensure their training programme adheres to the requirements of the FICM ACCP Membership criteria.	Met / not met / not applicable (if no ACCP)	3=Not applicable to Unit	
3	After successful completion of clinical and academic PgDip ACCP requirements, including Non- Medical Prescribing, ACCPs should apply to the FICM for ACCP Membership.	Met = all ACCPs have FICM, partially met, = at least 50% have FICM not met = <50%	3=Not applicable to Unit	
4	It is recommended that employing units should only appoint FICM-associated ACCPs to ensure a standard knowledge base, minimum skillset and that FICM ACCP curriculum competencies have been met.	Met = all ACCPs have FICM competencies partially met > 50% have FICM competencies, not met = <50%	3=Not applicable to Unit	
5	While working autonomously, the ACCP will always work within a multi-professional team led by a consultant who is trained in ICM.		3=Not applicable to Unit	
6	It is recommended that critical care units employing ACCPs have transparent ACCP standard operating procedures and outcomes, and that any incidents are reviewed as part of the unit's governance arrangements.	Met = SOP in place, not met = no SOP	3=Not applicable to Unit	
7	It is recommended that line management of ACCPs forms a tripartite arrangement between an ICM consultant, ICU clinical supervisor and professional lead such as a senior nurse or AHP from the ACCP's base profession.	Met/not met	3=Not applicable to Unit	
8	Continuing professional development (CPD/appraisal) for ACCPs should be undertaken according to the FICM CPD/appraisal guidance on an annual basis.	met/not met	3=Not applicable to Unit	
2.5 Pharmacists				
STANDARDS				
1	There must be a designated intensive care pharmacist for every critical care unit.	met / not met	0=Not met	
2	There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and 2 for every Level 2 bed for a 5/7 a week service.	met = 0.1/bed, partially = 0.05-0.1 per bed, not <0.05	1=Partially met	
3	Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020.	met -7 days per week, partially met 5 days per week.	1=Partially met	
4	The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy.	met / not met	0=Not met	
5	Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so (Advanced Stage I) must have access to an Advanced Stage II (excellence-level) intensive care pharmacist for advice and referrals.	met / not met	0=Not met	
6	As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays). Attend = dips into ward round(s) as appropriate and discusses issues	met - 5 days per week, partially met - 3-5 days per week, not met - less than less or not on ward round.	0=Not met	
7	There must be sufficient patient-facing pharmacy technical staff to provide supporting roles.	met / un met	2=Fully met	
RECOMMENDATIONS				
1	To maintain the continuity of the service during annual leave, sick leave and training leave, additional appropriate resources will be required (20% minimum is recommended).	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no cover or on call type cover only	2=Fully met	
2	Intensive care pharmacists should undergo an independent, recognised process to verify competence level.	met / not met	0=Not met	
3	Senior specialist intensive care pharmacist support should, preferably, be provided within the organisation but may be provided from a critical care network or on a regional basis.	met / not met / not applicable	0=Not met	
4	A peer-to-peer practitioner visit should occur at least once a year to ensure training issues are identified and to help maintain the competence of small teams and sole workers. This supports General Pharmaceutical Council (GPhC) revalidation.	met -yearly, partially met 1-3 yearly, not met - not done or > 3 yearly	0=Not met	
5	Where a team of intensive care pharmacists is in place, there should be a structured range of expertise, from trainee to Fellow level.	met / not met	0=Not met	
6	Intensive care pharmacists are encouraged to become active independent prescribers.	Statement		
2.6 Physiotherapists				
STANDARDS				
1	Physiotherapists must participate in opportunities for integrated decision making and dissemination of clinical information. This may include handovers, consultant-led multidisciplinary ward rounds, MDT meetings, team briefings or operational and patient safety briefings.	met / not met	1=Partially met	MDT sessions are attended when capa



2	The critical care MDT must have an identifiable lead physiotherapist who will be accountable for clinical service delivery, provide training and mentorship to junior staff, and oversee clinical governance and quality assurance.	met / not met	2=Fully met	
3	All physiotherapy staff must receive appropriate competency-based training to ensure delivery of high-quality physiotherapy intervention within critical care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover.	met / not met	1=Partially met	rolling training programme to maintain
4	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care, ensuring compliance with both clinical and professional guidelines and standards.	met - fully meet standard 7 days per week , partially met - meet standard 5 day per week, not met	0=Not met	Staffing ratio should be 1:4, we are cur
5	Respiratory physiotherapy must be available to critical care patients 24 hours a day and seven days a week. This includes the provision of an out of hours/on-call service which may utilise specialist and non-specialist intensive care staff.	met / not met	2=Fully met	
6	Physiotherapists, as part of the multidisciplinary team, must ensure the completion of a comprehensive clinical assessment of those at risk of or with identified physical and non-physical morbidity within four days of admission to intensive care and before discharge from intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation goals.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	
7	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	met - 7 days per week, partially met 5 days per week,	1=Partially met	Physio attend on oncall basis (resp car
8	Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team(s) following discharge from intensive care. This should include the holistic individualised structured rehabilitation plan.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	
RECOMMENDATIONS				
1	The service provision should be based upon the overall patient case-mix taking into account acuity, dependency and complexity of the clinical case-mix. Staff resources and capability should be appropriately matched both in knowledge, skills, and number to deliver comprehensive respiratory care and holistic rehabilitation. However, further work is recommended of paramount importance exploring demand-capacity models to robustly determine physiotherapy staffing ratios in intensive care. The suggested ratio would be one WTE physiotherapist to four ICU Level 3 beds	met 1 WTE to four level 3 beds ( or equivalent level 2 ), partially met 0.5-1.0 WTE per four level 3 beds, not met < 0.5 per four level 3 beds	0=Not met	
2	Physiotherapy services should provide assessment and intervention for physical rehabilitation seven days per week.	met 7 days per week, partially met 5 days per week, not met < 5 days per week	1=Partially met	
3	The value and role of Therapy Support Workers or Rehabilitation Assistants should be considered as part of either the intensive care physiotherapy or multidisciplinary workforce.	Statement		not sure why this is purple? Scoping c
4	Competency/capability frameworks should be in place encompassing all Agenda for Change (AfC) bands applicable to the local service. This should reflect relevant national competency and professional development frameworks. A local training and development programme should exist to align with these frameworks.	met / not met	0=Not met	on-call training only
5	Clear role specifications should exist for intensive care physiotherapists who have reached the level of Advanced Practice according to the Health Education England Framework.	met / not met	0=Not met	N/A to ICU Bronglais
6	The intensive care physiotherapy service should have a clear local operational policy and core standards for service provision which reflects both national guidance and standards and local variations.	met / not met	0=Not met	
7	The intensive care physiotherapy service or, where appropriate, as part of the MDT, should have robust and evidence-based clinical guidelines/standard operating procedures surrounding airway clearance interventions and specialist rehabilitation interventions including early mobilisation of patients in intensive care.	met / not met	0=Not met	
8	The lead physiotherapist, or appropriate deputy, should participate in all relevant local (and where appropriate, regional) intensive care operational delivery, governance and quality improvement groups. This may include governance meetings, service improvement work-streams, morbidity and mortality review meetings, business continuity meetings, operational or clinical management meetings. This should also include active participation/collaboration with their regional Critical Care Operational Delivery Network.	met / not met	0=Not met	
9	The physiotherapy intervention(s), as part of the patient's individualised, structured rehabilitation plan, should be matched to the acuity, dependency and complexity of the patient, considering the patient's clinical needs and tolerance to intervention. This should align with the individualised, patient-centred rehabilitation goals and a holistic rehabilitation approach should be taken across a 24-hour period.	met / not met	1=Partially met	
10	Physiotherapists should play a key collaborative role in the coordination and delivery of ventilation and tracheostomy weaning plans, including post-extubation and post-decannulation care. Additionally, physiotherapists should be a core part of the multidisciplinary delivery of non-invasive ventilation in intensive care.	met / not met	0=Not met	capacity and demand across hospital c
11	Targeted airway clearance interventions should only be considered in selected patients when clinically indicated. Routine secretion clearance therapy for all invasively-ventilated patients is not recommended.	met / not met	2=Fully met	
12	Where a local intensive care follow-up clinic/services exists, a physiotherapist should contribute to this service.	met / not met	0=Not met	no capacity with current staffing
2.7 Dietetics				
STANDARDS				
1	Critical care units must have access to dietitian five days a week during working hours	met / not met	2=Fully met	
2	There must be a dietitian as part of the critical care multidisciplinary team. If the critical care dietitian is working alone, they must be at the level of advanced practice. Where more than one dietitian is required, there must be an identifiable lead dietitian of advanced clinical practice level 4 to ensure an appropriate range of expertise within the team and to have overall responsibility for the service provision.	met = dedicated named dietician(s) / not met	1=Partially met	
3	Intensive care dietitian(s) must have satisfied local or national competency requirements and be able to undertake a nutrition assessment and implement an appropriate nutrition support plan for critically ill patients. If working at advanced clinical practice level, dietitians must be able to demonstrate application of the documented capabilities outlined in the multi-professional framework for advanced clinical practice in England.	met / not met	2=Fully met	
4	Intensive care dietitian(s) must work collaboratively contributing to consultant-led ward rounds, MDT meetings, and have regular consultant communication where nutritional goals, risks and plans are discussed as per the NICE CG63.	met / not met	2=Fully met	
5	Intensive care dietitian(s) must lead on the development and implementation of any local nutrition support guideline(s).	met / not met	2=Fully met	
6	Intensive care dietitian(s) must contribute to appropriate strategic meetings and clinical governance activities, including leading regular nutrition-related audits and acting on the results, plus undertaking quality improvement projects that demonstrate the impact of dietetics on service delivery, quality and effectiveness.	met / not met	1=Partially met	
7	Intensive care dietitian(s) must provide ongoing education and training for other healthcare professionals.	Met = comprehensive nutrition teaching programme for other staff, Partially = evidence of ad hoc teaching by dietician, Not met = no dietician led teaching	1=Partially met	
8	Intensive care dietitian(s) must provide a structured handover to a ward dietitian when patients are discharged from the critical care unit, considering nutrition-related morbidity as per the NICE Quality Standard.	Met = >75% patients, Partially 50-75%, Not <50%	1=Partially met	

RECOMMENDATIONS				
1	There is a staffing level of at least 0.05-0.1 WTE per critical care bed to provide the dietetics service is recommended.	Met = >0.05, Partially = 0.025-0.05, Not <0.025	0=Not met	
2	Intensive care dietitian(s) provide extended scope practitioner roles such as inserting feeding tubes, using indirect calorimetry to determine energy expenditure and supplementary prescribing where appropriate.	Met = all listed, Partially = some, Not = none	0=Not met	
3	Intensive care dietitian(s) should consider undertaking and disseminating nutrition-related research to widen the evidence base.	Statement		
4	Intensive care dietitian(s) should consider joining national (Critical Care Specialist Group of the British Dietetic Association) and international intensive care and nutrition-specific societies (Intensive Care Society, European Society for Intensive Care Medicine, European Society for Parenteral and Enteral Nutrition, etc.).	met / not met	0=Not met	
5	Intensive care dietitian(s) should represent dietetics on national and international society committees and guideline development groups.	Statement		
6	Intensive care dietitian(s) working at an advanced level should have or be working towards a master's level award.	Statement		
2.8 Speech and Language Therapists				
STANDARDS				
1	Critical care units must have access to a speech and language therapist five days a week during working hours.	met = 5 days, partially =>3 days, not <3 days	1=Partially met	There is no dedicated SLT services in
2	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	Met = >98%, partially met > 80%		
3	All critically ill patients who have communication and/or swallowing difficulties (dysphagia) must have timely access to an SLT service.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours		
4	All Speech and Language Therapists working in intensive care must be appropriately trained, competent and familiar with the use of relevant equipment.	met / not met	1=Partially met	Limited amount of SLT's with appropri
RECOMMENDATIONS				
1	The critical care SLT service is provided by a minimum of 0.1 WTE (whole time equivalent) per bed	met = 0.1, partially 0.05-0.1, not <0.05	0=Not met	
2	Patients should have access to a communication aid according to individual need in order to facilitate patient interaction and rehabilitation.	met = always available inc advanced devices, partially = available but may not have same day access or simple devices only, not met = no access (apart from simple white boards/paper)	1=Partially met	
3	Speech and Language Therapists should contribute to a suitable tracheostomy or non-invasive ventilation weaning plan for complex or long-stay patients.	met / not met	0=Not met	
4	SLT are available seven days a week.	met 7 days per week, partially met 5 days per week, not met, less than 5 days or sporadic service	0=Not met	
5	FEES should be available for Speech and Language Therapists to use in assessment and management of dysphagia in intensive care patients.	met - FEES available 5 days/week, partially met - adhoc availability, not met - no service	0=Not met	
6	Speech and Language Therapists should work as an integral member of the multidisciplinary team on the critical care unit, contributing to all multidisciplinary ward rounds, tracheostomy teams, clinical governance groups, audit, research, education and policy development.	met - SLT attend daily ward rounds 5 days a week, partially met - available on request, not met = no service	1=Partially met	
7	Swallowing and communication recommendations and treatment plans should be included in any medical handover when the patient is transferred from intensive care to another unit or ward.	Met (included in standardised handover process) or not met	1=Partially met	
8	Patients who are being considered for 'risk feeding' should have access to an SLT assessment in order to clarify their level of aspiration risk and optimum oral feeding consistencies.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours	0=Not met	We have not had referrals asking for S
2.9 Occupational Therapists				
STANDARDS				
1	Critical care units must have access to occupational therapy services 5 days a week during working hours.	met = 5 day a week access, partially met = < 5 days/week, not met = no service or on call service from other depts only	0=Not met	No dedicated OT, but an OT that cover
2	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient; rehabilitation plans should be updated accordingly.	See 2.6.7	0=Not met	
3	All occupational therapy staff working in a critical care environment must adhere to the Royal College of Occupational Therapists' Code of Ethics and Professional Conduct (COT 2015) and the Professional Standards for Occupational Therapy Practice (COT 2017).	met / not met	0=Not met	
RECOMMENDATIONS				
1	There should be an identifiable lead occupational therapist with appropriate experience, who will be accountable for service provision and development.	met / not met	0=Not met	
2	The occupational therapy clinical lead should be responsible for supporting learning opportunities, training and clinical supervision for junior staff providing occupational therapy services in intensive care.	met / not met	0=Not met	
3	The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation programmes that address the complex functional, cognitive and psychosocial needs of the patient cohort.	met / not met	0=Not met	

4	Occupational therapy staff on the critical care unit should be able to assess and provide non-pharmacological treatment for those patients who present with delirium.	met (OT involved in management of delirium in ICU) partially = involved but no routine review of patients with delirium or not met	0=Not met	
5	Occupational therapists should be involved in intensive care follow-up clinics to assess and facilitate appropriate referrals rehabilitation or specialist services and to address any long-term physical and non-physical impairment affecting occupational performance.	met / not met	0=Not met	Ots followups complex patients within :
2.10 Psychologists				
STANDARDS				
1	All patients must be screened daily for delirium using a validated instrument.	met = > 95% screened, partially met > 80%, not met - < 80% or no audit data	2=Fully met	
2	Non-pharmacological strategies must be in place to prevent and reduce delirium.	met - there is a local delirium guideline detailing non pharmacological strategies. Not met	2=Fully met	
RECOMMENDATIONS				
1	Psychologists should ensure that delirium is accurately assessed by nurses using a validated instrument, and that when delirium is detected, risk factors are reviewed and corrected by the MDT. They should advise on non-pharmacological strategies to prevent and reduce delirium at the ward level (by improving the environment) and patient level (to facilitate orientation and engagement).	met / not met	2=Fully met	
2	Psychologists should ensure that patients and relatives receive psychological education to explain the psychological impact of intensive care drugs, procedures and environment. This can be delivered in person or via information leaflets.	met / not met	1=Partially met	
3	NICE CG83 and QS158 stipulate that patients should receive assessments and interventions for psychological as well as physical problems throughout the intensive care pathway. These should be delivered or supervised by qualified psychologists.	met = triggered or routine assessment available for all patients, partially = only available at certain points in pathway (ICU/ward/follow up), Not met = not available at all	2=Fully met	
4	Psychologists should organise short psychological assessments for all awake, alert patients in intensive care using a validated measure such as the Intensive Care Psychological Assessment Tool.	met = >75% suitable patients assessed, partially 50-75%, not <50% (or no audit data)	0=Not met	
5	If a patient is screened as being at risk of future psychological morbidity, psychological support should be offered by psychologists or other appropriately trained staff (e.g. nurses or psychology trainees) to give patients the opportunity to express their needs and feelings, and to have those feelings validated and normalised.	met/not met	1=Partially met	
6	All patients found to be at risk of psychological morbidity (following the short assessment) should receive a comprehensive assessment before discharge from critical care. Psychologists should ensure that psychological needs, support and goals are included in the individualised structured rehabilitation programme that is formally documented and handed over at the time of transfer to general wards.	met = 75% assessed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met = not assessed	1=Partially met	
7	The psychologist should advocate (in conjunction with hospital outreach and mental health teams) for a system to be in place for at-risk intensive care patients to receive psychological support on general wards.	met/not met	0=Not met	
8	Psychologists should contribute to the information (verbal and written) patients and relatives receive to help them continue their personal rehabilitation plans and to know who to contact if they need support after leaving hospital.	met/not met	1=Partially met	
9	Psychologists should participate in the follow-up reviews that intensive care patients receive in the community or at outpatient clinics.	met = always available at FU clinic, partially = available by referral, not met = not available	3=Not applicable to Unit	
10	As part of the critical care unit MDT, the psychologist should provide: a) Training for staff to increase knowledge and understanding of psychological reactions, delirium, environmental stressors and psychological outcomes of critical illness, b) Consultation with the multidisciplinary team on communication, sleep, effects of sedation, anxiety, stress, mood, delirium, family issues and holistic care plans, c) Psychological support for families. Relatives may need support to cope with the shock of a family member becoming critically ill and being admitted to the critical care unit, as well as stress and exhaustion from caring for a patient during a long-term admission. They may also need bereavement support if their family member dies in the critical care unit.	Met = all elements, partially = some, not = none (could be split)	2=Fully met	
11	During patients' rehabilitation and recovery period, the psychologist should provide: a) Consultation with outreach and general ward staff regarding psychological support for intensive care patients, b) Tailored evidence-based interventions for persisting morbidity such as anxiety, depression or PTSD; these should be offered by psychologists in a well-resourced follow-up service and should include trauma-focused cognitive behavioural therapy, c) Where funding for this is not available, referrals of patients directly to psychological therapy services, or recommendations for GPs to make referrals to these services, or advice to patients on how to access local psychosocial services, and d) Drop-in support groups for intensive care patients and their families after discharge from hospital, held in the hospital or community.	Met = all elements, partially = some, not = none (could be split)	1=Partially met	
12	Employers have a duty of care to support staff working in a stressful environment such as intensive care, where burnout is highly prevalent. Workplace stress should be addressed at organisational, team and individual levels. Psychologists should consult with intensive care leadership on systemic issues influencing staff well-being. Additionally, psychologists should run or oversee staff support programmes including one-to-one sessions, drop-in groups or reflective rounds according to staff wishes and availability, as well as coaching sessions for senior managers.	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1=Partially met	
13	To develop this coordinated service for patients, families, and staff, critical care units should employ a senior HCPC-registered practitioner psychologist. Large critical care units should have access to a WTE, and smaller units should have access to a psychologist with dedicated time for intensive care to deliver the points above.	met/not met	2=Fully met	
2.11 Healthcare Scientists Specialising in Critical Care				
STANDARDS				
1	Critical Care Scientists must comply with the professional standards of behaviour and practice set out in Good Scientific Practice (GSP).	met/not met	3=Not applicable to Unit	
2	Critical Care Scientists responsible for management of medical devices and point of care diagnostic services must comply with the standards set by the Medicines and Healthcare Products Regulatory Agency (MHRA) and the International Organisation for Standardisation (ISO) standard (22870:2016).	met/not met	3=Not applicable to Unit	
3	Critical Care Scientists voluntarily registered with the Health and Care Professions Council (HCPC) must meet the Standard of Proficiency and comply with the Standards of Conduct, Performance and Ethics.	met = are registered and comply / not met	3=Not applicable to Unit	
4	Critical care units receiving trainee healthcare scientists for training in intensive care must comply with the requirements for training set for them by the National School of Healthcare Scientist (NSHCS).	met / not met	3=Not applicable to Unit	

RECOMMENDATIONS				
1	The Critical Care Scientists should successfully complete an approved training programme, either via accredited specialist training or as part of the Scientist Training Program (STP) commissioned by the National School of Healthcare Science (NSHCS) and should be registered with the HCPC.	met/not met	3=Not applicable to Unit	
2	The Critical Care Scientists should work collaboratively to be a dynamic member of the multidisciplinary team, assisting in the provision of high quality, patient-centred care within the critical care environment.	met = embedded in dept, partially = available but not embedded, not	3=Not applicable to Unit	
3	The Critical Care Scientists should draw on specialist knowledge to provide advice to medical, nursing and wider multidisciplinary team working in a critical care setting about the safe and effective use of medical devices used within the critical care environment, including monitoring, diagnostic and therapeutic technologies supporting critically ill patients.	met / not met	3=Not applicable to Unit	
4	The Critical Care Scientists should develop and support research activities, including facilitating evidence based practice and implementation of the latest technologies and software to the critical care environment.	met / not met	3=Not applicable to Unit	
5	The Critical Care Scientists should provide effective management and support for medical devices, including advising on optimal clinical settings and troubleshooting, resulting in focused, efficient and high-quality care.	met = evidence eg logs or equipment testing available / partially = happens but no evidence, not met	3=Not applicable to Unit	
6	The Critical Care Scientists should contribute to the educational needs of the multidisciplinary team, including delivering training, mentorship and educational support.	met = evidence of involvement in teaching and training / not met	3=Not applicable to Unit	
7	The Critical Care Scientists should demonstrate flexibility and adaptability to work across diverse pathways of patient care and clinical services that are both routine and highly specialised.	Statement		
8	The Critical Care Scientists should work safely and effectively within their scope of practice and ensure they do not practise in areas where they are not proficient.	met/not met	3=Not applicable to Unit	
9	As part of the multidisciplinary team, the Critical Care Scientists should contribute to the strategic direction, planning and delivery of critical care services.	met (ideally evidence eg attend dept meetings)/ not met	3=Not applicable to Unit	
10	The Critical Care Scientists should engage with the Society of Critical Care Technologies (SCCT) as their professional body in order to work in collaboration with the Academy for Healthcare Science and the NSHCS.	met/not met	3=Not applicable to Unit	
2.12 Support Staff				
STANDARDS				
1	All support staff must have clearly identifiable roles with specific competencies.	met / not met	1=Partially met	Band 4- Ongoing work re National Con
2	All support staff must have a period of induction and supernumerary status.	met / not met	2=Fully met	
3	All support staff must be appropriately trained, competent and familiar with the use of equipment.	met / not met	2=Fully met	
4	All support staff must be included within the intensive care team and be updated on key unit issues and developments.	met / not met	2=Fully met	
5	Support staff roles must be clearly identifiable to colleagues, patients and visitors to the department, either by uniform and/or name badges.	met / not met	2=Fully met	
6	Intensive care areas must develop healthcare support worker roles to assist registered nurses in delivering direct patient care and in maintaining patient safety.	met / not met	2=Fully met	
7	Healthcare support workers must complete the Care Certificate and adhere to the Code of Conduct for healthcare support workers.	met / not met		
8	Administrative roles must be developed to ensure all clinical staff are free to give direct patient care, and supported with essential data collection.	met / not met	1=Partially met	
9	Each intensive care area must have sufficient staff responsible for the cleanliness of the environment.	met / not met	2=Fully met	
10	Where direct care is augmented using support staff (including unregistered nurses), appropriate training and competence assessment of those staff are required.	met / not met	0=Not met	
RECOMMENDATIONS				
1	All staff should be encouraged to attend further training and/or education to support their development.	met / not met	2=Fully met	
2	Each critical care area should have healthcare support workers 24/7 to assist nursing staff in delivery of direct patient care.	met = all shifts covered, partially = 75% covered, not <75%	1=Partially met	
3	Each critical care area should have ward clerk/receptionist cover seven days per week.	met = 7/7, partially 5/7, not = no receptionist	0=Not met	
4	Each critical care area should have a dedicated housekeeper/cleaner seven days per week.	met = 7/7, partially 5/7, not = no dedicated staff	2=Fully met	
5	Each critical care area should have a data clerk or dedicated time allocated to a suitable member of staff for data entry to a nationally recognised audit programme (such as ICNARC or SICSAG) and responsibility for the validation of these data. The Intensive Care National Audit & Research Programme (ICNARP) is recommended.	met = full cover with leave cover, partially = less than recommended cover or no leave cover, not met = no dedicated cover	1=Partially met	No Cover on AL
2.13 Smaller Remote and Rural Critical Care Units				
		Only relevant for small number of units. An autopopulate feature of not applicable would be useful		
STANDARDS				
1	Network support must be in place to ensure smaller, remote and rural critical units meet these standards and recommendations.	met = active participation in network / not met	2=Fully met	
2	The critical care service must be led by consultants trained in Intensive Care Medicine (ICM).	met / not met	2=Fully met	
3	There must be access to appropriate advice from a consultant in ICM at all times.	met = 24/7 access to advice / not met	2=Fully met	

4	Dedicated daytime critical care must be provided by a consultant trained in ICM with no other commitments.	met = 7/7, partially = 5/7 (or involves covering other areas at same time)	1=Partially met	
5	There must be a doctor or ACCP with advanced airway skills resident within the hospital 24/7.	met / not met	2=Fully met	
6	There must be a 24/7 dedicated resident on the critical care unit.	met / not met	2=Fully met	
7	There must be structured handover between day-time and night-time staff supported by standardised policies for practice.	met / not met	2=Fully met	? Policy
8	Appropriate CPD must be supported by the employer and undertaken by all professionals who deliver intensive care.	met / not met	2=Fully met	
9	Regional transport arrangements (road and air) must be put in place to allow timely, safe transfer of patients with an appropriate level of monitoring, staffing and skills.	met / not met	2=Fully met	
10	All critical care units, including Level 2 units, must enter data into national databases such as ICNARC or SICSAG.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Network support should be explicit, resourced and supported by all the Healthcare Organisations, Boards, networks and regions involved, and recognised in job planning.	met / not met	2=Fully met	
2	Units should consider the development of telemedicine techniques for clinical decision making and educational support, in conjunction with their regional network.	Statement		
3	Remote critical care units should implement appropriate joint clinical governance procedures with both networked units and transfer services to include case-based review, critical incident analysis, and joint educational sessions.	met = formal arrangements with SLA in place / not met	2=Fully met	
4	Where an intensive care pharmacist or healthcare professional, such as a physiotherapist or dietician, cannot be effectively delivered locally in a small unit, advice should be accessible from specialist colleagues through network support. Appropriate training bodies should devise and support remote and rural training posts in critical care.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit	

Section 3		CRITICAL CARE SERVICES: PROCESS	Level description	Level	Comments
3.1 Admission, Discharge and Handover					
STANDARDS					
1	The decision to admit to the critical care unit and the management plan must be discussed with the duty consultant in Intensive Care Medicine.	Met = >95%, partial = >90%, not <90% or not data	2=Fully met		
2	There must be documentation in the patient record of the time and decision to admit to critical care.	< 85% met, 75-85 partially met, < 75% or no data not met	1=Partially met		
3	Unplanned admissions to the critical care unit must occur within four hours of making the decision to admit.	Met = >95%, partial = >90%, not <90% or no data	2=Fully met		
4	Patients must have a clear and documented treatment escalation plan.	Met >95%, partial 80-95%, not <80 or no audit evidence	2=Fully met		
5	Patients must be reviewed, in person, by a consultant in Intensive Care Medicine as urgently as the clinical state dictates and always within 12 hours of admission to critical care.	95% of the time - Met, <95% or no data - not met	2=Fully met		
6	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2=Fully met		
7a	Consultant in Intensive Care Medicine-led ward rounds must occur twice a day (including weekends and national holidays).	< 85% met, 75-85 partially met, < 75% or no data not met	1=Partially met		
7b	The nurse in charge should be present in person for the ward round.	< 85% met, 75-85 partially met, < 75% or no data not met	2=Fully met		
8	Patients discharged from critical care must have access to an intensive care follow-up programme.	met / not met	0=Not met		
9	Discharge from critical care to a general ward must occur within four hours of the decision and must occur between 07.00hrs and 21.59hrs.	met = >80%, partially = 60-80%, not <60%	0=Not met		
10	There must be a standardised handover procedure for medical, nursing and AHP staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation prescription.	met / not met	0=Not met		No Rehabilitation Prescription.
11	Patients undergoing specialist care must be repatriated to a healthcare organisation closer to their home when clinically appropriate to continue their rehabilitation, and this must occur within 48 hours of the decision to repatriate.	< 85% met, 75-85 partially met, < 75% or no data not met	2=Fully met		
RECOMMENDATIONS					
	None				
3.2 Capacity Management					
STANDARDS					
1	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care patients must be prioritised, such that patients requiring critical care support are admitted without delay (within four hours after decision to admit and completion of essential resuscitation/imaging) and patients no longer requiring critical care are discharged within four hours.	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not data	2=Fully met		DTOC not met for discharge
2	The final decision on utilisation of critical care beds and staff (which includes moving staff to help in other areas of the hospital at times of need) rests jointly with the duty consultant and the duty nurse in charge of the critical care unit. Under no circumstances should clinical decisions be over-ridden by non-clinical operational management teams.	met / not met	1=Partially met		Consultant is not always involved in the decision - Site Manager
3	Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans.	met / not met	2=Fully met		
4	Hospital boards must demonstrate regular oversight of the use of critical care escalation and the provision of intensive care outside of the critical care unit.	met / not met	2=Fully met		
5	Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit.	met / not met	2=Fully met		consultant to consultant discussion
6	Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios.	met / not met	2=Fully met		
7	Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duty intensive care consultants and duty nurses in charge to coordinate the usage of intensive care beds across the network.	met / not met / not applicable	1=Partially met		Mutual aid document
8	Regional pandemic escalation plans must include trigger levels for agreed critical care admission criteria and thresholds for restriction of planned activity to assist neighbouring critical care units	met / not met / not applicable	3=Not applicable to Unit		HB escalation plan
9	Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units to include escalation and, if required, prioritisation of transfers over local elective activity.	met / not met / not applicable	1=Partially met		
10	Regional Intensive Care Networks must ensure that a system to record capacity across the network is in use, and that this is updated regularly.	met / not met / not applicable	2=Fully met		
11	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	Met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2=Fully met		
RECOMMENDATIONS					
1	Critical care units should determine the emergency capacity they require to meet Standard 1 locally, based on their admission and occupancy data. The capacity to cope with the predicted emergency workload can then be managed by ensuring an appropriate number of beds available for emergency admissions before accepting elective admissions.	met / not met	0=Not met		
2	Acute hospitals will require at least one critical care bed per 35 acute hospital beds; hospitals undertaking a large amount of complex major surgical procedures are likely to need significantly more than this.	met = 1:35 or greater, partially 1:45-1:35	1=Partially met		medical patients only
3	Training should be provided to nursing staff in areas used for critical care escalation.	met = comprehensive documented training plan in place, partially = some training but not comprehensive	1=Partially met		
4	When using alternative areas of the hospital to provide critical care capacity, there should be adequate senior nursing and medical input such that the standards of care provided to those patients meet the standards provided to the patients within the critical care unit.	met = immediate access to ICU resident / registrar /nurse in charge for advice + twice daily consultant ward round	3=Not applicable to Unit		
5	Decisions to proceed with major elective surgery should take into account current occupancy, provision of emergency capacity over the next 24 hours and, at times of regional network escalation, the emergency capacity in neighbouring units.	met / not met	1=Partially met		

6	Critical care units may find it useful to develop a statistical model locally that provides predictable data on the number of emergency admissions they should plan to accommodate in each 24-hour period, and use this model to assist decision making on when it is safe to proceed with planned elective work.	Statement		
3.3 Critical Care Outreach and Rapid Response Systems				
STANDARDS				
1	There must be a hospital wide, standardised approach to the detection of the deteriorating patient and a clearly documented escalation process.	met / not met	2=Fully met	HB policy
2	All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical deterioration in all non-pregnant adult patients over 16 years. The National Early Warning Score (NEWS-2) is the recommended for call systems as the more efficient and effective. Using a common score ensures that staff operate the same language across the patient pathway and enhances the benefits of an early warning system. As part of a multi-trigger system, other triggers such as urine output/ acute kidney injury alerts, cause for concern and patient/carer <i>Call for Concern</i> , should be considered as they will enhance the recognition of the deteriorating patient.	met / not met	2=Fully met	HB policy
RECOMMENDATIONS				
1	Each hospital should have a graded clinical response strategy consisting of three levels: low, medium and high. Each level of response should detail what is required from staff in terms of observational frequency, skills and competence, interventional therapies and senior clinical involvement. It should define the speed and urgency of response, including a clear escalation policy to ensure that an appropriate response always occurs and is available 24/7.	met / not met	2=Fully met	Hb policy
2	Each organisation should ensure patients receive care from appropriately trained critical care outreach, rapid response or equivalent teams. The critical care outreach (CCO)/Rapid Response staff should have annual competency-based assessment of core and additional specific competencies from a local or regional programme. This should relate to first line clinical assessment and intervention, be clearly outlined and closely reflect the Department of Health (DH) competencies for the recognition and response to the acutely ill patients in hospital.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	2=Fully met	HB policy
3	There should be accessible educational support for registered and non-registered ward staff in caring for the acutely ill ward patient in line with recorder and first responder level as outlined in the DH competencies for the recognition and response to the acutely ill patients in hospital <sup>5</sup> . Staff looking after Level 1 and enhanced care area patients should be trained following the National Competency Framework for Level 1 and Enhanced Care Areas.	met / not met		xxx
4	Organisations should aim to deliver Comprehensive Critical Care Outreach as outlined by the seven core elements and have an operational policy that defines the remit of the CCO/Rapid Response or equivalent team within the organisation, in regard to these seven core elements.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	0=Not met	CCO/Hospital at night hybrid in discussion
5	All patients should be reviewed by the CCO team (or equivalent) following discharge from the critical care unit to the ward.	Met - < 85%, partially met 85-75%, unmet > 75% or no data	3=Not applicable to Unit	
6a	All CCO teams should participate in the National Critical Care Outreach Activity Outcome Dataset.	met / not met	3=Not applicable to Unit	
6b	Each organisation should develop audit tools to assess utilisation of their track and trigger and graded response system with clear governance procedures for action of poor compliance healthcare organisation-wide. This should be undertaken in combination with an audit of compliance against the standards within NICE CG502 and must be fed back to healthcare organisation Boards and Critical Care Networks where relevant.	met / not met	1=Partially met	xxx
7a	Each hospital should be able to provide a CCO/rapid response team, or equivalent, that is available 24 hours per day, seven days a week.	met / not met	2=Fully met	
7b	There should be regular review of service provision to facilitate proactive approaches in order to match service configuration against local demands and activity. These should be reflected in the operational policy. There should be a nominated lead of service at healthcare organisation Board level with appropriate communication cascade.	met / not met	0=Not met	CCO/Hospital at night hybrid in discussion
3.4 Infection Control				
STANDARDS				
1	Staff must follow safe insertion and maintenance procedures for intravascular and urinary catheters, and remove them when not required to minimise the risk of infection.	met = policy and training in place with daily care bundle checklist and audit data, partially = no formal daily checklist or no audit, not met = no policy	2=Fully met	
2	Infection control procedures must be documented and agreed by the multi-professional team.	met - policy in place not met - no policy	2=Fully met	
3	The WHO <i>Five Moments of Hand Hygiene</i> must be observed. Hand contamination is often due to contact with the environment rather than directly with the patient.	Handwashing audit - Met - < 95%, partially met 95-85%, unmet > 85%	2=Fully met	
4	Cleaning of the environment must be undertaken by trained staff and subject to audit and quality control, with particular attention to high-contact surfaces. Duties of cleaning and nursing staff, in cleaning specific surfaces, should be clearly defined.	met = policy in place with regular audit data and systematic reports, partially = policies in place but only ad hoc audits, not met = anything else	2=Fully met	credits for cleaning, Symbiotix
5	There must be surveillance systems in place for audit and feedback of nosocomial infection, reporting to the national scheme where applicable, for example, reporting central venous catheter-related bloodstream infection to the Public Health England Infection in Critical Care Quality Improvement Programme (ICQIP).	met - supply data to ICQIP ( or equivalent) , partially met - locally monitored, not met - not regularly monitored	1=Partially met	No Submitted VAP data
6	The principles of antibiotic stewardship must be adhered to in consultation with the microbiology team.	met = documented daily consultant microbiologist input at least on 70% of audit data against trust stewardship programme >85% compliance, partially = <85% (some units exempt from audits because of 24-hour consultant input)	1=Partially met	
RECOMMENDATIONS				
1	Patients should be screened for carriage of MRSA and/or carbapenemase-producing organisms according to locally determined prioritisation. Sensitivity of risk factor algorithms is generally low and universal screening is preferable in highly endemic regions.	met - done > 95% of the time , partially met 85-95% of the time, unmet - <85% or no data or not done	2=Fully met	
2	Patients with MRSA carriage or infection should receive topical suppression to reduce shedding and, if possible, single-room isolation.	met / unmet	2=Fully met	In accordance with hb policy
3	Patients with diarrhoea and airborne infections should take precedence over others in allocation of single-room isolation. Patients with suspected or confirmed influenza should be placed in single rooms appropriate for respiratory isolation.	met / not met	2=Fully met	
4	Design of new units should include infection control specialists as part of the planning team. In particular, the bed spacing, proportion of single rooms and provision of sinks should be considered according to patient case-mix, national guidelines and prevalence of multi-resistant infections.	met / not met / not applicable	3=Not applicable to Unit	

5	The intensive care team should have access to an infection control and prevention team led by a microbiologist who can offer timely review and advice. Ideally, this should be part of timetabled microbiology rounds during the week. The microbiologist will advise on the choice and duration of antimicrobial chemotherapy in accordance with local formularies as a part of antibiotic stewardship.	met / not met	2=Fully met	
6	Infection control nursing staff or intensive care nurses with infection control training should be available to provide day-to-day advice on prevention of spread of infection, isolation priority and procedures and decontamination. Allocation of patients to single-room isolation for known or suspected infection should be reviewed on admission and frequently thereafter.	met / not met	1=Partially met	not available at weekends
7	There should be a means of continuous improvement in infection prevention and control, for example using surveillance and feedback.	met = formal audit and review process in place / unmet	2=Fully met	
3.5	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology.			
STANDARDS				
1	There must be daily input from microbiology.	Met = 7/7 , partially, 5/7 plus on call, unmet if less	1=Partially met	1-2 Ward Round weekly
2	There must be local antimicrobial prescribing guidelines in accordance with the principles of antimicrobial stewardship.	met / not met	2=Fully met	hb policy
3	Clear protocols must be in place for management of massive haemorrhage including the role of laboratory services.	met / not met	2=Fully met	hb protocol
4	Acutely ill patients must have access to diagnostic radiology services at all times including timely access to a radiologist.	met / not met	2=Fully met	
5	All imaging investigations must be reported within an agreed timeframe relevant to the investigation by someone appropriately trained. All imaging investigations need to be accompanied by a formal, permanently recorded report covering the entirety of the investigation.	met / not met	2=Fully met	
6	There must be seven-day availability of radiology services, appropriate to the specialties being cared for, to allow timely investigation of critically ill patients. This would include, for example, ultrasound and CT-scanning to aid sepsis diagnosis and source control; and in neurocritical care units, access to interventional neuroradiology.	met = full service 7/7, partially = 7/7 service but some elements not always available (eg 7/7 reporting but interventional service only daytimes), unmet = <7/7 service	2=Fully met	
RECOMMENDATIONS				
1	Microbiology advice should be from an adequately senior clinician, and onsite, face-to-face interaction is encouraged.	Met / not met	2=Fully met	xxx
2	Critical or unexpected results of clinical pathology, microbiology or radiological investigations should be actively communicated to a responsible clinician according to local fail-safe policies.	policy in place = met, no policy = not met	2=Fully met	HB policy
3	Urgent clinical chemistry and haematology advice should be available within 60 minutes from an appropriate specialist and a radiologist should be immediately contactable to support the management of acutely ill patients at all times.	met / not met	2=Fully met	
4	All point of care laboratory devices used to assist clinical decision making should be subject to appropriate quality assurance mechanisms, agreed by laboratory and end users.	met = fully centralised lab standard QA process in place with audit evidence, partially = some QA process with intermittent audit, unmet = no laboratory standard QA process	2=Fully met	
5	Clear protocols for access to radiology services that are not available on site (e.g. interventional radiology, MRI in ventilated patients) should be available.	met / not met	3=Not applicable to Unit	
6	Liaison psychiatry services should be available in all acute hospitals with a single point of referral. Emergency mental health referrals should be seen within one hour of referral and urgent mental healthcare referrals within 24 hours of referral (within the liaison team's usual operating hours).	met = available and meets time criteria, partially = available but not <1h <24h, not met = not available	0=Not met	
7	Patients who have self-harmed, irrespective of the apparent motivation, should have a comprehensive psychosocial assessment. This should generally be the responsibility of the liaison psychiatry service and should not be delayed until after medical treatment is complete unless life-saving treatment is necessary, or the patient is unconscious or otherwise incapable of being assessed.	met / not met	0=Not met	patients must be medically fit for crisis team assessment
8	Liaison professionals should be available to advise on issues around mental capacity and there should be working arrangements detailing who is responsible for assessing patients who may need to be detained under mental health legislation.	met / not met	2=Fully met	
3.6	Rehabilitation			
STANDARDS				
1	The rehabilitation needs of all patients must be assessed within four days of admission to intensive care (or on discharge if sooner) and a rehabilitation plan outlined by all relevant therapy professions as clinically indicated.	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	1=Partially met	
2	Patients receiving rehabilitation must be offered therapy by the multi-professional team across a seven-day week and of a quantity and frequency appropriate to each therapy, in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	all rehab needs met 7 days a week = met, all rehab needs met 5 days per week = partially met, rehab needs not met consistently = unmet	1=Partially met	
3	All patients must be screened for delirium at least daily, and when changes or fluctuations in behaviour occur; in the event of a positive delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors completed.	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2=Fully met	
4	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	0=Not met	
5	Patients who stay in critical care for more than four days and are at risk of morbidity must have their ongoing rehabilitation needs addressed at post discharge follow-up, or in the community setting, at two to three months after discharge from critical care. At this point, additional referrals to any necessary services can be made.	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	0=Not met	
6	Adults at risk of poor quality recovery must have an individualised rehabilitation plan documented in their formal handover of care when transferred from critical care to a general ward. All members of the care team must be aware of this. Patient involvement in setting this rehabilitation plan should occur as soon as feasible and appropriate.	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	1=Partially met	
7	Adults who were in critical care and at risk of poor quality recovery must be given information to explain what they can do to help their recovery. This information should be provided, at the latest, before discharge from hospital.	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2=Fully met	
RECOMMENDATIONS				
1	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per week; provision should be made for other therapy services to be provided as needed at weekends.	met 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet	1=Partially met	respiratory care only due to capacity
2	Specialist rehabilitation co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to ensure that assessments, referrals and documentation are completed and transferred to ongoing services and teams.	met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doesn't exist	0=Not met	



3	The role of therapy support workers or rehabilitation assistants should be considered as part of the rehabilitation team; these roles may be un-professional or multi-professional in nature and recruited from nursing or allied health backgrounds. These may enable enhanced delivery and increased efficiency of rehabilitation service delivery, as well as ongoing rehabilitation to be delivered following discharge from critical care. Further work is required to determine the appropriate grading of these roles.	Statement		no funding for physio support staff in ICU
4	Rehabilitation outcomes should be monitored and progression made using outcome measures appropriate for the stage of recovery, individual therapy, and dependent on local resources (including personnel, equipment, and finance).	met = rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially = on icu only, unmet = no progression monitoring	0=Not met	
5	The rehabilitation plan that forms part of the handover of care on discharge from critical care should address all relevant domains for individual patients including, but not restricted to, physical, functional, communication, social, spiritual, nutritional and psychological.	met / not met	0=Not met	
6	To facilitate the rehabilitation component of the formal handover of care on discharge from critical care to a general ward, weekly multidisciplinary rehabilitation ward rounds should be led by a senior member of the critical care multi-professional team and result in an update to the rehabilitation goals. These should be set in conjunction with the patient and/or carer where appropriate.	met / not met	0=Not met	
7	Expectations of both patients and families should be identified regularly and addressed in a consistent manner by the most appropriate senior member of the team; all patient and family communication should be centrally documented to ensure that it can be accessed easily by all team members.	met / not met	2=Fully met	
8	For high-risk/complex patients, capturing the experience for the patient and family in a manner that they can reflect upon and engage with during the time spent in hospital should be considered. This may take the form of diaries, either paper or electronic, and may include photos, videos and written information. This material may be collected prospectively or retrospectively depending on the desire of patient and family.	met / not met	1=Partially met	Physios will fill out diaries
3.7 Intensive Care Follow Up				
STANDARDS				
1	Patients with higher risk of morbidity related to critical illness must be given information about ongoing rehabilitation goals in the community.	met = all patients provided with rehab goals, partially = selected patients, unmet = none	1=Partially met	
2	Patients discharged from the critical care unit must have access to an intensive care follow-up programme, which can include review of clinical notes, patient questionnaires to assess recovery and an outpatient clinic appointment two to three months' post hospital discharge if required for specific patients.	met / not met	0=Not met	
RECOMMENDATIONS				
1	The follow-up programme should be formally and clearly communicated to the patient and their relatives on discharge from critical care, and again on discharge from hospital. Primary care should also be informed through the discharge summary.	met = all patients, partially = selected patients, unmet = none	0=Not met	
2	The follow-up programme should ensure the delivery of structured and supported self-directed rehabilitation to all patients at critical care discharge and at hospital discharge.	met = all patients, partially = selected patients, unmet = none	0=Not met	
3	A minimum 20-30 minute follow-up appointment should be offered two to three months after hospital discharge if appropriate. The follow-up team should include an intensive care consultant, intensive care nurse, clinical psychologist, physiotherapist, dietician and occupational therapist according to the individual patient's needs.	met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none	0=Not met	
4	Selection of patients for follow up should be based on length of stay (more than three days) or at increased risk (e.g. following anaphylaxis, or post-partum intensive care). Self-selection of patients should also be facilitated.	met / not met	0=Not met	
5	Follow up should involve actively seeking common physical sequelae, such as weakness, weight loss and sexual dysfunction, and the consequences of critical care unit-related procedures (e.g. tracheostomy).	met / not met	0=Not met	
6	Review of current medication should be performed and rationalised with input from pharmacy if required.	met / not met	0=Not met	
7	Psychological sequelae (such as anxiety, depression, nightmares and post-traumatic stress disorder) should be sought via screening tools e.g. Hospital Anxiety Depression Scale (HADS), and UK Post Traumatic Stress Syndrome score (UK PTSS-14). This could be facilitated by review of clinical notes with patients and family or patient diary, use of screening questionnaires and review by a clinical psychologist.	Met = screening process in place for psychological seq for all patients, partially = for selected patients, unmet = no screening	0=Not met	
8	Following structured review, appropriate referrals to other services may be required and should be arranged where required.	met- referral from clinic / not met - referral via GP	0=Not met	
9	A bereavement follow-up service should be offered where explanations of diagnoses, treatments and support can be provided.	met / not met	0=Not met	
10	The establishment of a critical care patient and relatives support group should be encouraged.	met / not met	1=Partially met	Established pre covid but not sustained during
11	Patients and relatives should be surveyed regularly and this information should be utilised to assess rehabilitation and follow-up services.	see other standards	0=Not met	
3.8 The Patient and Relative Perspective				
STANDARDS				
1	All patients must be regularly assessed for the presence of pain which should be managed with a protocolised multimodal analgesic regimen.		2=Fully met	
2	The effects of delirium must be explained to patients and their families and this should be emphasised in follow-up visits post critical care. Written information about delirium must be provided.	met - all elements done, relatives provided with written info, Partially met - some elements done or not all families, not met - not done	1=Partially met	
3	When patients are sedated or unconscious or have delirium and require any intervention or nursing care, staff must explain to them in simple terms what they are doing.	met = Unit has guideline/protocol for delirium prevention/management that includes these measures and is included in induction training for staff / not met	2=Fully met	
4	Critical care staff must offer patients ways to help improve the quality of their sleep, for example eye masks and ear plugs. Staff must try to minimise light and noise during the night.	met - guideline in place and done, partially met - some elements but not comprehensive or systematically applied, not met - not done	2=Fully met	
5	Patients and families must be given high quality verbal and written information while the patient is in critical care (such as information about the patient's treatment, what the patient might experience and how they might feel) and when they leave the unit (to help explain what has happened to the patient and what might help them in their recovery). Each unit must have such documents readily available and ready for patients and relatives. Young visitors and their parents will need specific support.	met = written and >75% families having a formal documented communication, partially 50-75%, unmet = no written info and/or <50% having formal communication	0=Not met	
6	Patients must be given help to communicate (e.g. speaking valves (for patients with a tracheostomy, wipe boards or flash cards).	met = SLT involved and have full range of communication aids available / partially met = limited access to speech and language / not met		fully met
7	Critical care units must have policies about how to safeguard vulnerable adult patients.	met / not met	2=Fully met	
8	Units must obtain regular feedback about the care that patients and relatives received during their critical care admission in order to learn from and act on the feedback received.		2=Fully met	

RECOMMENDATIONS				
1	Intensive care patients should have a patient diary.	met = >90% patients >48h stay, partial = only longer stay or <90%, unmet no diary	2=Fully met	
2	Understanding the individual who has become critically ill is important to help their treatment and recovery. A 'This is Me' board or document for each patient is very beneficial and should be used if possible.	met / not met	0=Not met	
3	Intensive care and ward staff should have training in what intensive care is like for patients and relatives and what challenges patients face while in intensive care and during their rehabilitation. Asking former patients and relatives to help with this training is beneficial.	met / not met	0=Not met	
4	Intensive care staff should let relatives know how they can help the patient, for example by talking to or reading to the patient (even if the patient is unconscious or sedated), as a familiar voice can be reassuring. Relatives should also be allowed to help with simple aspects of caring for the patients, if they would like to, such as applying hand cream or brushing hair. Written information should be provided for relatives.	met / not met	2=Fully met	
5	Intensive care staff should spend time talking to the patient and relatives, seeing how they feel, asking about any worries they have and checking their understanding of any information that has been given. Clear information should be given to relatives regarding when they can visit.	met / not met	2=Fully met	
6	A room should be provided for relatives to wait in or have time away from the unit. This room should be comfortable and its facilities regularly reviewed. Feedback should be sought from families whether additional facilities and support are required.	met - relatives room, partially met, relatives room but poor facilities, not met - no dedicated relatives room	2=Fully met	
7	On discharge from the critical care unit, patients should be given the contact details of the healthcare professionals who are co-ordinating the patient's rehabilitation pathway.	met / unmet	0=Not met	
8	All patients should be visited by a critical care outreach team, who can help with the transition from Critical Care to ward this transition.	met / not met	0=Not met	
9	Intensive care patients should have access to formal support provided by the critical care service after they leave. ie critical care followup / outreach services	met / not met	0=Not met	
10	Critical care units should provide relatives of patients who died in intensive care the opportunity of a follow-up meeting with an ICU staff member to discuss any questions they may have about their relative's time on the unit. Families may be given a leaflet after their relative dies in order that they can arrange a meeting at a later date if they wish to. It can also include other sources of support. Some units hold memorial services for relatives.	met / not met	0=Not met	Work underway to develop bereavement pathway supported by clinical psycho
3.9 Staff Support				
STANDARDS				
1	All units must have policies in place to support staff engagement and retention.	met / not met	2=Fully met	
2	Induction and escalation policies must be clearly identified for all staff groups.	met / not met	2=Fully met	
3	100% of new staff must receive a job-specific induction to the unit.	met / not met	2=Fully met	
4	Workplace equity within staff groups must be transparent (e.g. rostering, annual leave policies, job plans). Staff must be aware of the policies.	met / not met	2=Fully met	
5	Staff well-being is an organisational priority. Units must monitor and regularly review metrics of staff well-being as quality indicators (e.g. sickness rates).	met - quarterly , partially met 1-2 yrs, unmet - not monitored or more than 2 yearly intervals	2=Fully met	
6	All staff must have opportunities for personal development reviews including annual appraisals.	met - > 85% of staff appraised / PDP done, Partially met 75-85% not met < 75% of staff	2=Fully met	
7	All staff working in critical care must be able to access the Freedom to Speak Up Guardian.	met / not met	3=Not applicable to Unit	
8	Staff must be provided with adequate resources consistent with other GPICS standards to deliver their job role, e.g. adequate staffing ratios, access to facilities for nutrition and hydration, adequate equipment.	Statement		
9	Staff rostering must comply with Health and Safety Executive recommendations for sleep and rest.	met / not met	2=Fully met	
10	Units must provide adequate workplace facilities for staff breaks, which are separated from areas for relatives.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	All staff engaged in a managerial or leadership role should have access to appropriate mentoring and/or coaching services to support them in their role.	met / not met	2=Fully met	
2	All units should promote healthy rest and sleep policies for staff required to work overnight.	met / not met	2=Fully met	
3	All staff members should have access to an independent, professional psychological support service, which provides counselling services.	met / not met	2=Fully met	
4	All staff members should have self-referral access to an occupational health service and rapid access physiotherapy services.	met / not met	2=Fully met	
5	All units should provide frequent opportunities for shared learning, clinical communication, and reflection, to reduce professional isolation. This includes routine clinical practice (e.g. multidisciplinary rounds, mortality and morbidity meetings), as well as specific reflective events (e.g. Schwartz Centre Rounds, debriefing following medical emergencies).	met / not met	2=Fully met	
6	All staff should have ergonomic clinical work areas with appropriate access to light and control of noise.	met / not met	2=Fully met	
7	All staff should be supported to maintain a healthy lifestyle, e.g. provision of advice on diet and exercise.	met / not met	2=Fully met	
8	All units should conduct regular (at least annual) reviews of organisational policy on staff health and well-being.	met / not met	2=Fully met	HB wide policy
3.10 Inter and Intra and Hospital Transfer of Critically Ill Patients				
STANDARDS				
1	Transfer to other critical care units for non-clinical reasons must be avoided where possible.		2=Fully met	

2	Appropriate equipment must be available to undertake a safe transfer and to manage complications/adverse events which may occur during a transfer. All equipment used for patient transfers must conform to the relevant safety standards, be regularly serviced, and checked immediately before use.	met / not met	2=Fully met	
3	All staff involved in a patient transfer must be trained, competent and familiar with the use of equipment.	met / not met	2=Fully met	
4	Where patient transfers result in a change of team managing the patient during or following a transfer, an appropriate and documented handover must be undertaken between the teams to ensure good continuity of care. This should include providing copies of the clinical record.	met / not met	2=Fully met	
5	A named intensive care consultant must take overall responsibility for the decision to transfer a patient and the level of support required, but does not necessarily have to undertake the transfer.	met / not met	2=Fully met	
6	Inter-hospital transfers must be undertaken in a timely fashion according to the patient's clinical condition.	met / not met	2=Fully met	
7	For inter-hospital transfers, there must always be a named consultant who will take responsibility for the patient on arrival at the receiving hospital. This must be agreed prior to the transfer being undertaken.	met / not met	2=Fully met	
8	Where patients have completed specialist care and ongoing intensive care needs can be provided in the patient's home, hospital transfer must take place within 48 hours of referral to the receiving hospital.	Percentage occurring within 48 hours of decision. Met > 85%, partially met 75-85%, not met < 75% of the time or no data collected.	1=Partially met	
RECOMMENDATIONS				
1	Transfers should follow the advice and protocols presented in the latest ICS transfer guidance.	met - meet standard, partially met, dont meet standard but risk assessment in place , not met.. dont meet standard and no risk assessment	2=Fully met	
2	The reason for any transfer should be documented in the patient's notes. This should include an assessment of potential benefits against risks. Transfer decisions should only be made by consultant intensive care team members, and this information should also be documented.	met = documented 95%, partially met 80-95%, unmet <80% or no data or not a consultnat decision	2=Fully met	
3	An adequately stocked and regularly checked, dedicated transfer bag should be available for use during all patient transfers. This bag should contain appropriate drugs and equipment for interventions that might be required in transit. The transfer bag contents should be checked routinely (ideally daily and a log of checks maintained) or, if sealed with a tag, then a daily check that the seal is unbroken. The transfer bag must be restocked between uses to avoid delays when it is needed. Staff carrying out patient transfers should be familiar with bag layout and content.	met = checked with log and tagged, partially = daily check but not tagged or logged, unmet = no checking or significant deficiencies in kit available	2=Fully met	Supported by operating theatre
4	The patient's vital signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy any physiological deterioration during the transfer.	met = audit evidence of obs or transfer forms, unmet = no evidence	2=Fully met	
5	Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be scrutinised within a robust audit system, allowing eventful or substandard transfers to be investigated and lessons learnt to be shared widely, as well as numbers and reasons for transfers.	met = use of a network wide agreed form or electronic recording system, unmet = no standard system	2=Fully met	
6	Where an adverse event occurs during a transfer, this should be reported and investigated using the healthcare organisation incident reporting system at the transferring unit. All learning should be widely shared.	met / not met	2=Fully met	
7	Every acute healthcare organisation should have a designated consultant and nurse who are responsible for maintaining standards of transfer of critical care patients, guideline production, training, governance, audit and reporting.	met - both, partially met - one, not met - none	0=Not met	
8	Training in transfer medicine should be an integral part of Intensive Care Medicine training for doctors and nurses.	Statement		
9	Where multiple teams are involved in a patient's care, appropriate handover should be undertaken between the teams prior to transfer. This should not delay the transfer.	met / not met	2=Fully met	
10	The patient, where possible, and their next-of-kin should be informed of the decision to transfer and an explanation given to them of the need for transfer. This discussion should be documented.	met = 95%, partially = 80-95%, unmet <80% documented	2=Fully met	
11	There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area. The definition of 'delay' will vary according to the reason for the transfer. For patients being transferred from a specialist critical care unit to a general critical care unit at the completion of specialist care, a delayed transfer is one that has not been undertaken 48 hours after the time of referral to the general critical care unit.	met / not met	2=Fully met	
12	Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who are at a high risk of harbouring such infections both during transfer and in the receiving hospital; their availability should be such that this does not delay a patient transfer. Similarly, isolation facilities must be available for immunocompromised patients who require them.	met / not	2=Fully met	
13	Critical care units should have an agreement with their local ambulance providers in relation to the contracted transport provision for intensive care services, and to ensure these standards are met throughout the entire patient pathway.	met / not met	2=Fully met	
14	There should be a system for monitoring the quality of inter hospital transfers and governance arrangements which includes capture of numbers, indication for transfer, incidents, delayed transfers and outcomes. Audit measures and learning should be widely shared.	met - well established processes, data avaiable, partially met - reviewed, limited data available, not met. rarely undertaken or not at all	2=Fully met	
15	There should be standardised network wide transfer documentation and training programmes.	met = both / partially met = one or the other / not met = neither		
16	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and prevent the adverse impact of transfers on the transferring unit due to loss of key staff.	Statement		
3.11 Care at the End of Life				
STANDARDS				
1	Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and communicated to patients and their loved ones. The latter being of particular relevance if patients lack capacity (below).	met = 98% with clear documentation, partially = 95-98% documented but gaps found in documentation on audit, unmet = <95% or major failings in what is documented	2=Fully met	
2	Decision making surrounding end of life care (EoLC) must be performed in accordance with relevant statutory requirements and professional guidance: a) Mental Capacity Act 2005 (MCA 2005), England and Wales, b) Adults with Incapacity Act (2000), Scotland, c) Mental Capacity Act (Northern Ireland) 2016, d) Human Tissue Act, England, e) General Medical Council's Good Medical Practice; specifically Treatment and Care Towards the End of Life: Good Practice in Decision Making.	met / not met	2=Fully met	
3	Declaration of death by cardiorespiratory or neurological criteria must be done in accordance with professional guidance.	met / not met	2=Fully met	
4	Consideration must be made as to whether organ and tissue donation can be offered to every dying patient, and where appropriate the specialist nurse-organ donation (SNOD) should be contacted.	met = considered with audit data on referral rates reviewed quarterly, partially = considered but no audit data or <70% referral rate, unmet = not done	2=Fully met	
5	In order to identify dying patients and respond to changes in their condition, those at high risk of dying must have their condition regularly reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.	Statement		
RECOMMENDATIONS				
1	Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying. Best practice dictates that those close to the patient should also be informed.	met / not met	2=Fully met	

2	Decision making related to care at the end of life should, wherever possible, involve patients and people close to them, as well as medical professionals. If the patient lacks capacity and there is no individual with Lasting Power of Attorney, responsibility for determining treatments rests with treating clinicians. Previous decisions should also be taken into account e.g. treatment escalation plans (TEP), ReSPECT (Recommended Summary Care Plan for Emergency Care and Treatment).	met / not met	2=Fully met	
3	At least two consultants, supported by senior ICU nursing agreement, should contribute to the process of recommending withdrawal or withholding treatments. Such processes are decided on a case-by-case basis and clarity of communication can be improved by outlining likely burdens and benefits of acts or omissions.	met - 7 days per week, partially met 5 days per week,	1=Partially met	
4	Once patients are recognised as being in their final days/hours of life, therapeutic goals should be reviewed and accordingly altered to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn. The discussion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is intrinsic to palliative care in critically ill patients. This should be discussed with patients and families within that context. If instituted in emergent situations for incapacitated patients, DNACPR decisions should be discussed with patients' surrogates (as defined by the MCA or equivalent) at the earliest opportunity. The British Medical Association, Resuscitation Council-UK and Royal College of Nursing issue regularly updated guidance on DNACPR.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	2=Fully met	
5	Dying patients should be managed by multi-professional teams that include senior medical and nursing staff from intensive care and referring teams. It may also include specialist palliative care teams.	met / not met	2=Fully met	
6	Therapeutic plans should be made and anticipatory medications prescribed for all patients in their final hours/days of life, enabling prompt symptom control. This includes therapeutic options for analgesia, dyspnoea, anxiety and agitation. Doses should be titrated for symptom relief based on explicit assessments. Where appropriate, the double effect of drugs used should be transparent to patients, staff and family.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	2=Fully met	
7	Care should address dying patients' need for spiritual and emotional support, and include that of their families and others close to them. The needs of loved ones to be with, care for and otherwise attend to dying patients should be met as far as is possible. If appropriate, religious or secular expertise should be sought (e.g. referral to chaplaincy, psychological services or patients' GPs). Staff should also have access to these support services.	met / not met	2=Fully met	
8	If death is considered to be very close, patients should not normally be transferred out of the critical care unit unless it is to facilitate (via discussion with patients and loved ones) significant improvements in care. If practical to do so, patients should be given the opportunity to die at home or in a hospice. All transfers should involve a handover of plans and goals of care.	met / not met	2=Fully met	
9	Intensive care clinicians often have a responsibility for decision making and care of acutely unwell and deteriorating patients outside of the critical care unit. When reviewing such patients for potential treatment escalation, they should work with patients' clinical teams to ensure that decisions and communication regarding care at the end of life are made to the same standards as on the critical care unit.	met / not met	2=Fully met	
3.12 Organ Donation				
STANDARDS				
1	If a patient is close to death, doctors must explore with those close to them whether they had expressed any views about organ or tissue donation. Doctors must follow any national procedures for identifying potential organ donors and, in appropriate cases, for notifying the Specialist Nurse-Organ Donation (SNOD).	met = routinely done with collaborative requesting when possible, partially met = routinely done but not with collaborative requesting, unmet = poor results on referral rates	2=Fully met	
2	The National Institute for Health and Clinical Excellence guidance requires that the intensive care team caring for the patient should initiate discussions about potential organ donation with the SNOD whenever a patient meets the criteria for undertaking the tests, to confirm death using neurological criteria or when there is an intention to withdraw life-sustaining treatment in patients with a life-threatening or life-limiting condition which will, or is expected to, result in circulatory death.	met >85% of the time, partially met 75-85% of the time, un met < 75% of the time or no data collected.	2=Fully met	
3	Critical care units must comply with the criteria for diagnosing death using neurological or circulatory criteria as set by the Academy of Medical Royal Colleges.	met / not met	2=Fully met	
4	All units must contribute data to the national potential donor audit.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Each acute hospital should have an Organ Donation Committee to oversee all aspects of deceased organ donation as recommended by the Department of Health's Organ Donation Taskforce. Funding for the committee's activities is provided by NHS Blood and Transplant (NHSBT).	met / not met	2=Fully met	
2	Each acute hospital should have a clinical lead for organ donation (CLOD) funded by NHSBT, with responsibility to implement organ donation policies, promote the adoption of best practice guidelines and to address any local barriers to donation.	met / not met	2=Fully met	
3	Each critical care unit should have an embedded or assigned SNOD employed by NHSBT to provide advice on all issues relating to donation, organise donor coordination, support the intensive care staff in donor management, complete the potential donor audit, engage in teaching and training and support donor families.	met / not met	1=Partially met	SSNOD x 2 hared across fourhospitals
4	Guidelines on end of life care and withdrawal of life-sustaining treatments (WLST) should be compliant with the Mental Capacity Act 2005, and based on the guidance provided by the General Medical Council, and should be followed irrespective of any potential for organ donation. Determining best interests at the end of life should include an assessment of a patient's preferences and wishes regarding organ donation. Guidance on decisions regarding WLST in patients with devastating brain injury (DBI) should be based on the recommendations of FICM/ICS and other professional bodies.	met / not met	2=Fully met	
5	A planned and collaborative approach to the family for organ donation between the intensive care team and the SNOD team should be routine practice as recommended by NICE in 2016.	met / not met	2=Fully met	
6	Consultants in Intensive Care Medicine should actively manage brain stem dead consented donors to optimise organ quality and increase the number of organs successfully retrieved and transplanted. Donor optimisation care bundles or protocols should be available and used.	met / not met	2=Fully met	
7	The intensive care team should manage resources flexibly to facilitate organ donation and/or end of life care for patients outside the critical care unit whenever appropriate.	met / not met	2=Fully met	
3.13 Legal Aspects of Capacity and Decision Making				
STANDARDS				
1	Units must have regular, minuted, multidisciplinary team meetings to review cases where dispute have or may have arisen.	met / not met	0=Not met	
2	All patients must be presumed to have capacity to consent or withhold consent.	Statement		
3	If the patient has made a valid and applicable Advance Decision Refusing Treatment (ADRT), it must be respected (although an ARDT does not have formal legal standing in Scotland, they are likely to be highly persuasive to the court).	Statement		

4	Final determination of capacity for a specific treatment must be made by the treating clinician and documented.	Statement		
5	If a patient has capacity, their decision must be respected, even if the treating clinician considers the decision to be unwise.	Statement		
6	Patients who lack capacity must only be treated in their best interests (England & Wales) or if it is of benefit to the patient (Scotland).	Statement		
7	Determination of best interests/benefit must involve consultation between the treating consultant and individuals close to the patient (family and friends).	Statement		
8	The aim is to achieve consensus between team and family/friends as to what is in the best interests/benefit to the patient. When there is continued disagreement about best interests/benefit, the treating clinician must not act unilaterally.	Statement		
9	If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application must be made.	Statement		
RECOMMENDATIONS				
1	A written departmental protocol for resolution of disagreements should be in place. Disagreements may be within the team, between different clinical teams or between team and family/friends.	met / not met	1-Partially met	Hospital concerns policy (from family)
2	An ADRT that does not meet the criteria to be formally legally binding should nevertheless be taken into account as part of the best interests assessment as a strong indication of the patient's wishes and opinions.	Statement		
3	In situations of intractable disagreement, mediation should be considered prior to approaching the Court of Protection (England & Wales)/Court of Session (Scotland). NHS Resolution or the Civil Mediation Council provide access to individual mediators or recognised groups.	Statement		
4	Independent Mental Capacity Advocates (IMCA) should be consulted (in England and Wales) when a patient is 'unbefriended'. This only applies when there is no one who can be consulted about best interests, i.e. no family or friends. IMCAs should not be consulted because there is dispute about best interests between the medical team and family.	Statement		

Section 4	CRITICAL CARE SERVICES: CLINICAL CARE		Level description	Level	Comments
4.1	Respiratory Support				
STANDARDS					
1	Units must have access to sufficient modern invasive and non-invasive ventilators which will support pressure/volume controlled ventilation, titration of inspired oxygen concentration, support spontaneous ventilation and allow application of PEEP.	met / not met	2=Fully met		
2	Pulse oximetry, capnography, ECG, blood pressure monitoring and ventilator alarms must be used for all ventilated patients whose trachea is intubated.	met / not met	2=Fully met		
3	An accurate height must be measured on admission for every patient requiring invasive mechanical ventilation to calculate predicted body weight (PBW) and corresponding target tidal volume to allow protective ventilation (6ml/kg PBW in those with ARDS or at risk of ARDS).	met / not met	2=Fully met		
4	Units must have evidence-based, written guidelines covering the use of non-invasive ventilation, the management of ARDS, prevention of ventilator-associated pneumonia and weaning from ventilation (including the use of sedation).	met - guidelines for all and review date within last 3 years , partially met - one or more gudelines missing or not reviewed within the last 3 years, not met - limited guidlines and / or older than 3 years	0=Not met		Follow National Guidelines
5	Referral pathways for patients with severe but potentially reversible acute hypoxaemic respiratory failure must be in place with Regional Extra-corporeal Membrane Oxygenation-capable (ECMO) Centres.	met / not met	2=Fully met		
6	Units must have written guidelines on the indication, risks and practice of prone positioning in hypoxaemic respiratory failure.	met / not met	2=Fully met		
7	Units must have immediate access to point-of-care testing to enable arterial blood gas analysis.	met ABG machine on unit or within easy use, with a backup within 5 mins of unit or >1 machine, partially = single ABG machine with backup machine 5-30 minutes away or 24/7 on call repairs within 30 mins, unmet	2=Fully met		
8	Standard operating procedures, including checklists, should be developed for intubation, extubation, bronchoscopy, prone positioning, tracheostomy and any high risk/invasive procedures.	met - guidelines for all and review date within last 3 years , partially met - one or more gudelines missing or not reviewed within the last 3 years, not met - limited guidlines and / or older than 3 years	2=Fully met		
9	Non-invasive ventilation must be considered and available for patients with acute hypercapnic respiratory failure.	met / not met	2=Fully met		
10	High flow nasal oxygen must be available for the management of patients with acute hypoxaemic respiratory failure.	met / not met	2=Fully met		
RECOMMENDATIONS					
1	Tidal volume (ml/kg PBW) , plateau airway pressures and cumulative fluid balance should be monitored and recorded daily in all patients requiring invasive ventilation.	met - all recorded daily , partially met - one / two not recorded daily, not met - more than two not recorded	2=Fully met		
2	Audit of compliance with ARDS, ventilator associated pneumonia and weaning guidelines should be undertaken quarterly.	met / not met	0=Not met		
3	Units should have standardised systems to monitor VAP rates and antibiotic resistance patterns.	met / not met	0=Not met		
4	There is insufficient evidence at present to inform clinicians about the role of Extracorporeal Carbon Dioxide Removal (ECCO2R) in acute hypoxaemic respiratory failure and ARDS. Patients should only receive ECCO2R within the governance framework set out in NICE Guidance.	met / not met			
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services				
STANDARDS					
1	Level 3 units must have access to a regional home ventilation and weaning unit. Arrangements must be in place to collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex weaning problems to the Regional Centre.	met / not met	1=Partially met		
2	Units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.	met / not met	1=Partially met		No M&M Meeting
RECOMMENDATIONS					
1	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or neurological co-morbidities. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure.	met / not met	1=Partially met		Verbal discussion-no written documentation.
2	Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietitian members.	met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved	1=Partially met		
3	These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols.	met protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols in place/not reviewed in last 2 years	0=Not met		
4	Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and resources to provide these services as described in the section of this document on rehabilitation (Chapter 3.6).	met / not met	2=Fully met		
5	The use of non-invasive ventilation (NIV) as a bridge to spontaneous breathing should be considered in selective groups. Resources and skill in NIV should be available in all units managing patients with prolonged ventilatory needs.	met / not met	2=Fully met		
6	Early discussion with regional domiciliary ventilation services should occur in any patient with chronic neuromuscular impairment, and in those requiring more than 21 days of ventilation. Regional weaning centres should offer advice to referring units to assist with weaning .	met / not met / NA if no regional weaning service	2=Fully met		
7	The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation centres and protocols should be in place to aid these decisions.	met / not met / NA if no regional weaning service	2=Fully met		
4.3	Renal Support				

STANDARDS				
1	Critical care units must have the necessary facilities and expertise to provide acute RRT for patients with AKI on a 24/7 basis.	met / not met	2=Fully met	
2	Patients receiving acute RRT, where the cause of AKI is unclear or where RRT will be needed on intensive care discharge, must be discussed with the local renal team as per the NICE guideline.	met / not met	2=Fully met	
3	Patients receiving acute RRT must be cared for by a multi-professional team that is trained and experienced in delivering and monitoring RRT.	met / not met	2=Fully met	
4	Acute RRT for patients with progressive or severe AKI must be started before the onset of life-threatening complications associated with renal dysfunction.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	The decision to initiate RRT should be based on the condition and prognosis of the patient as a whole, and not on isolated urea or creatinine values as per Kidney Diseases Improving Global Outcomes (KDIGO) recommendations and the NICE guideline.	met / not met	2=Fully met	
2	Where life-threatening complications of AKI occur, such as intractable hyperkalaemia, RRT should be started emergently unless a decision has been made not to escalate therapy.	met / not met	2=Fully met	
3	Patients with end-stage renal failure who are not in a renal unit/dialysis centre and require urgent RRT may require critical care admission. In such cases, there should be close liaison with the regional renal service regarding transfer and vascular access.	met / not met	2=Fully met	
4	Continuous and intermittent RRT should be considered as complementary therapies for AKI. The choice of therapy should be based on patient status, expertise of the clinical staff and availability of machines.	met / not met	2=Fully met	
5	The dose of RRT should be prescribed at the beginning of the RRT session. It should be reviewed daily and tailored to the needs of the patient.	met = clear standardised RRT prescription with evidence of daily review and audit, partial = done but not clearly evidenced, no audit, unmet = no standardised RRT prescription	2=Fully met	
6	The decision to use anticoagulation to maintain circuit patency and the choice of anticoagulant should be based on the potential risks and benefits in an individual patient, the expertise of the clinical team and the options available. KDIGO guidelines suggest using regional citrate anticoagulation for CRRT rather than heparin in patients who do not have contraindications for citrate.	citrate anticoagulation should be available Met/unmet	2=Fully met	
7	Bicarbonate, rather than lactate should be used as a buffer in dialysate and replacement fluid for acute RRT.	met / Partially met = daily prescription chart but compliance not audited / not met	2=Fully met	
8	Drug dosing may need adjusting whenever RRT is started or the RRT prescription is altered. Close collaboration with an intensive care pharmacist with suitable experience in AKI and the effects of RRT is essential.	met / not met	2=Fully met	
9	Patients treated with acute RRT should receive standard enteral nutrition as long as there are no significant electrolyte abnormalities or fluid overload refractory to RRT.	met / not met	2=Fully met	
10	When discharged from critical care, the accepting team and GP should be informed that the patient had received RRT for AKI while in intensive care so that appropriate follow-up arrangements can be made.	met / not met	2=Fully met	
4.4 Gastrointestinal Support and Nutrition				
STANDARDS				
1	The type and position of nasogastric feeding tubes (NGTs) used for enteral feeding, hydration and/or drug administration, must comply with NHS Improvement guidelines.	met / not met	2=Fully met	
2	Intensive care services must have a nutrition support guideline with institutional strategies to promote nutrition delivery and to overcome EN intolerance. It is suggested that it should include: a) Measures to minimise the risk of EN aspiration, b) Criteria for the use of prokinetic medications, c) Criteria for naso-jejunal feeding, d) Criteria for use of parenteral nutrition, e) Consistent times for stopping and restarting EN around anaesthetic, surgical or bedside procedures and f) A protocol for initiation of nutrition without waiting for a dietitian's plan.	met = clear guideline in place meeting these criteria, partial = guideline in place with some omissions or >3y since review, unmet = no guideline or fails many of these criteria	1=Partially met	New guideline is underway as part of all Wales ICU systems
3	Intensive care services must have guidance in place relating to the identification of, and nutrition support for, those at risk of re-feeding syndrome.	met = clear guideline in place meeting these criteria and audit evidence, partial = guideline in place with some omissions or >3y since review or no audit evidence, unmet = no guideline or fails many of these criteria	1=Partially met	Guidance needs updating
4	Intensive care services must ensure that there is access to a range of parenteral nutrition bags which include vitamins, trace elements and minerals. A 'standard' bag of parenteral nutrition must be available within 24 hours.	met = all elements listed, partial = TPN available but limited range, unmet = not available or a single standard bag only available	1=Partially met	Limited range
5	Intensive care services must have access to a range of enteral nutrition products to include: a) Low electrolyte, b) High protein, c) Fluid restricted and d) 'Tolerance' (semi-elemental)	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Nutritional status and risk should be assessed on admission, and energy, protein and micronutrient needs determined by a critical care dietitian or clinician with appropriate specialist training or experience.	met / not met	2=Fully met	
2	It is recommended that nutrition support (PN if EN is not possible) should be instigated within 48 hours in patients expected not to be on a full oral diet within three days.	met / not met	2=Fully met	
3	Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them.	met / not met	2=Fully met	
4	Efforts need not be made to cover full energy targets with EN or PN until clinical stability has been achieved. Delivering a calorie load which exceeds energy expenditure appears harmful and should be avoided, whereas hypocaloric nutrition may be safe initially.	met / not met	2=Fully met	
5	The energy content from certain drugs (e.g. Propofol, IV glucose and citrate anti-coagulation renal replacement therapy) should be accounted for to avoid overfeeding.	met / not met	2=Fully met	
6	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines.	met / not met	2=Fully met	
7	Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly infusion rate of EN to optimise delivery after interruptions.	met / not met	0=Not met	Will be part of WICIS
8	There should be access to nasal bridges to secure NGTs in agitated patients and guidelines for their use and aftercare.	met / not met	0=Not met	No bridges across the HB
9	Nutrition support targets should be included in the rehabilitation of critically ill patients.	met / not met	2=Fully met	
10	There should be bowel management guidelines which include: a) Regular monitoring and documentation of bowel habits (frequency & type), b) Minimising the use of drugs that can cause constipation or diarrhoea, c) The need for rectal examinations and treating faecal loading/impaction, d) When to use laxatives, enemas and suppositories, e) Management of ileus.	met = bowel management guideline and audited, partially met = protocol but not audited, unmet - no guideline	1=Partially met	Ongoing Work

4.5 Liver Support				
STANDARDS				
1	Contact with regional liver and or liver transplant centre must be made early following admission to a critical care unit of a patient with ACUTE liver failure. Advice about management, prognosis and possible transfer can be discussed.	Statement		
2	Patients with ALF must be managed in a liver transplant centre if liver transplantation is clinically indicated.	Statement		
RECOMMENDATIONS				
1	Patients with liver failure plus any other organ dysfunction should be managed in a critical care environment. Attention should be made to cardiovascular support, rapid correction of actual or relative hypovolaemia, early renal and metabolic support.	met / not met	2=Fully met	
2	Sepsis is very common in patients with liver failure and intravenous antibiotics should be prescribed in any patient with a suggestion of sepsis on admission to critical care. The choice of antibiotic will be driven by knowledge of local microbiological flora and resistance patterns.	met / not met	2=Fully met	
3	The use of prophylactic blood products and other procoagulants products prior to interventions should be avoided. In general, patients with liver failure develop a balanced coagulation disorder. Both pro- and anti-coagulant protein production is reduced. Viscoelastic tests, such as thrombo-elastography or ROTEM, may help in management.	met: thromboelastography available, partially; principles followed but no TE available, unmet	2=Fully met	
4	Patients with ALF should have access to plasma exchange therapies.	met / not met / not applicable	0=Not met	
5	Patients with ALF should have access to techniques used to assess intracranial pressure and/or cerebral perfusion, with intracranial hypertension being a recognised complication in patients with ALF. Strategies to monitor and manage ICH should be available.	met / not met / not applicable	0=Not met	
6	Advice should be sought from a specialist hepatologist for help with diagnosis, specific therapies and prognosis.	met / not met	2=Fully met	
7	Centres managing liver failure and liver trauma should have access to interventional radiologists.	met / not met / not applicable	3=Not applicable to Unit	
8	Links should be made with regional centre providing transjugular intrahepatic portosystemic shunt (TIPSS) for patients with bleeding varices.	met / not met	2=Fully met	
9	Units that manage patients with liver failure should have 24-hour access to both diagnostic and therapeutic upper GI endoscopy service.	met = both, unmet if not available or no intervention available	2=Fully met	
10	Drug dosing may need adjusting in patients with liver failure. Close collaboration with an intensive care pharmacist with suitable experience in liver failure is essential.	met / not met	2=Fully met	
4.6 Cardiovascular Support				
STANDARDS				
1	Electrocardiography, chest X-Ray and transthoracic echocardiography (includes focused echo) although expertise may not be in unit and could be provided by other specialty such as cardiology, must be available at all times at the patient's bedside.	met = all available, partial = echo availability in hospital 24/7 but not always on unit, unmet = no echo available	1=Partially met	
2	A consultant cardiologist must be available at all times either locally or through a formal network.	met / not met	2=Fully met	
3	Adults with acute heart failure must be reviewed within 24 hours of admission by a dedicated specialist heart failure team (or equivalent), and their management should follow the guidelines detailed in the NICE Quality Standards.	met / not met	0=Not met	
4	Protocols for immediate transfer to a facility able to provide percutaneous revascularisation of patients presenting a myocardial infarction must be in place.	met / not met	2=Fully met	
5	The intensive care team must facilitate the implementation of national standards, guidelines and pathways pertaining to the patients with a cardiac disease, to be delivered in addition to the other organ support being provided.	met / not met	2=Fully met	
6	The advanced management of patients with acute valvular insufficiency or acute heart failure secondary to valve disease must be guided in consultation with a local cardiologist and the specialist cardiothoracic surgical unit.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	A validated method for advanced haemodynamic assessment with a skilled operator in both the practical use of the device and interpreting the data it provides should be available at all times.	met / not met	1=Partially met	PICCO Implementation pending
2	An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.	met / not met	0=Not met	
3	Local protocols in the use of vasoactive drugs should be in place, although there is little evidence to support the use of any single agent in practice.	met / not met	2=Fully met	
4.7 Echocardiography and Ultrasound				
STANDARDS				
1	The gold standard investigation is a comprehensive study, performed and reported by a fully trained clinical specialist.	Statement		
2	A more limited study, focusing on a specific clinical question, is appropriate in many instances. This must be performed by a trained and competent practitioner.	met / not met	1=Partially met	FICE course completed by some
3	Individuals who scan and report independently must be trained to a level that is appropriate for their clinical practice.	met / not met	0=Not met	
4	The service must have a nominated lead consultant with dedicated time in their job plan that is sufficient to reflect the demands of the service and associated governance processes.	met / not met	2=Fully met	



5	Ultrasound equipment must be readily available, serviced regularly and up to date. There must be sufficient equipment to ensure immediate access for ultrasound guided vascular access at all times. Linear, curvilinear and phased array probes are required to provide a comprehensive ultrasound service.	met= immediate availability (ie on unit) of ultrasound machine for vascular access and rapid access of machine for focused echo/lung ultrasound / partially = not all elements eg only 1 machine on a large unit / not all probe types/ not met	2=Fully met	
6	Infection control measures must be adhered to at all times.	met / not met	2=Fully met	
7	The disinfection and storage of transoesophageal echocardiography probes must follow national guidelines. A record must be retained in order to identify and track patients after device usage in the event of future complication/infection.	met / not met / not applicable ( no TOE)	3=Not applicable to Unit	
8	All images must be securely stored for quality assurance purposes with appropriate data governance. Reliance on the ultrasound machine storage capacity is not a secure method.	met = all images are stored, reviewed by trained echo specialist and uploaded to PACS, partial = uploaded but not reviewed or reviewed but non centralised storage, unmet = images not safely archived in PACS	3=Not applicable to Unit	
9	Whenever scans are performed to inform clinical decision making, a structured report must be generated and stored in the patient record.	met = structured report and audited, with > 90% compliance, partially met reported but not structured, not audited or < 90% compliance , not met = < 50% reported/documentd in notes	2=Fully met	
10	Training scan reports must not be stored in the patient record unless someone suitably trained verifies the document first.	met / not met	3=Not applicable to Unit	
11	Quality improvement, audit, and peer review activity must occur regularly.	Fully met = peer review process at least monthly, partially met = peer review less frequently, not met = no regular system of peer review (excludes ad hoc peer review)	0=Not met	
12	Transoesophageal echocardiography (TOE) must be immediately available in all cardiothoracic critical care units and those units providing extra-corporeal circulatory support.	met / not met / not applicable ( no TOE)	3=Not applicable to Unit	
RECOMMENDATIONS				
1	All critical care units should be able to ensure the provision of point-of-care ultrasound.	met / not met	2=Fully met	Radiology and Cardiology providing service
2	The service should be supported by a fully trained link-person within the cardiology and radiology departments, as appropriate.	met / not met	2=Fully met	
3	Individuals who participate should regularly attend their institutional ultrasound meetings.	met / not met	2=Fully met	
4	Individuals who scan and report independently should keep a personal logbook of their images and reports.	met / not met	2=Fully met	
5	Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to more advanced accreditation.	met / not met	2=Fully met	
6	Images and reports should be uploaded together to the same archive used by the host institution's cardiology or radiology department, as appropriate. Reports should identify the focused nature of the investigation and the clinical context. Scans undertaken as part of training should not be archived before they have been verified by a trainer.	met / not met	2=Fully met	
7	Regional networks and electronic image transfer systems should be created to allow for prompt access to review scans by a specialist with Level 2 accreditation, or equivalent, when this is required.	met / unmet	2=Fully met	
8	Consideration should be given to the development of fully qualified physiologists with dedicated intensive care commitment and experience under joint supervision to deliver echocardiography services within intensive care.	met / not met / not applicable	3=Not applicable to Unit	
9	Regular replacement of ultrasound equipment is required to ensure it remains up to date. Normal guidance states that electrical equipment is replaced every seven years, however ultrasound equipment may need to be updated more frequently to keep up with technological advances.	met / not met	2=Fully met	
4.8 Neurological Support				
STANDARDS				
1	Adult patients with refractory convulsive status epilepticus must be admitted to critical care and have EEG monitoring established; the primary endpoint of treatment being the suppression of epileptic activity on EEG.	met - continuous EEG or processed EEG available on unit, not met, no EEG / Processed EEG available	0=Not met	
2	Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infarction must be considered for coronary angiography with follow-on primary percutaneous coronary intervention if indicated.	met / not met	2=Fully met	
3	Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the linked spinal cord injury centre consultant within four hours of diagnosis to establish a partnership of care.	met / not met	2=Fully met	
4	Previously fit adults, admitted to critical care following a primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation.	met / not met	2=Fully met	
5	Adults under the age of 60 with middle cerebral artery infarction admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre.	met / not met	2=Fully met	Cardiff
6	Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice.	met / not met	2=Fully met	
7	Prognostication in hypoxic-ischaemic brain injury after resuscitation from cardiac arrest should follow the European Advisory Statement on Neurological Prognostication in comatose survivors of cardiac arrest.	met - able to fully follow partially met - able to undertake some additional testing beyond CT, unmet - unable to meet any additional investigations	2=Fully met	
RECOMMENDATIONS				
1	Protocols should be available to deliver post-resuscitation care to comatose survivors following cardiac arrest as per the Resuscitation Council (UK) guidelines.	met / not met	2=Fully met	
2	The management of traumatic brain injury should follow national and international best practice guidance.	met / not met	2=Fully met	
3	Management of patients with prolonged disorders of consciousness should follow national guidance.	met / not met	2=Fully met	
4	Patients with perceived devastating brain injury should be admitted to the critical care unit to aid prognostication as per national guidance.	met / not met	2=Fully met	
5	Intracerebral haemorrhage should be managed in accordance with international guidance with particular attention to the reversal of anticoagulation and acute control of blood pressure.	met / not met	2=Fully met	
6	The management of suspected viral encephalitis or acute meningitis in adults should follow national guidance.	met / not met	2=Fully met	
7	The management of patients with ventilatory insufficiency due to neuromuscular disease should follow BTS/ICS guidelines.	met / not met	2=Fully met	
8	The management of decompensated acute inflammatory neuropathy should follow best practice guidance.	met / not met	2=Fully met	
9	Autoimmune encephalitis should be suspected and investigated in all adults presenting with the internationally described criteria proposed to identify this disease.	met / not met	2=Fully met	

10	Adults admitted with an acute neurological problem should have access to daily consultation or advice from neurology specialists, if necessary by telemedicine.	met - as per recommendation, partially met - less frequently than daily consultation, no telemedicine, unmet - difficult to access neurology advice	2=Fully met	
11	Critical care units caring for patients with neurological pathology should have agreed venous thromboembolism (VTE) policies that balance the risk of recurrent haemorrhage with the need to provide prophylaxis against VTE.	met / not met	2=Fully met	
12	Fever control to normothermia following traumatic brain injury, aneurysmal subarachnoid haemorrhage, ischaemic stroke, or haemorrhagic stroke may improve outcome.	a temperature controlling device with a closed feedback loop must be available met / not met	2=Fully met	
13	Appropriate patients with acute ischaemic stroke should be referred for mechanical thrombectomy in accordance with national commissioning policy.	met - referral pathway in place 24/7 partially met - referral pathway less than 24/7, unmet - no referral pathway	2=Fully met	
4.9 Burns				
Burns units only				
STANDARDS				
1	Staffing models must promote joint care between burn and critical care teams as this may improve safety and confer a significant survival benefit.	met / not met	3=Not applicable to Unit	
2	A burns theatre must be located in immediate proximity (preferably within 50 metres) to any service providing critical care for burn injured patients.	met / not met	3=Not applicable to Unit	
3	Burn injured patients who require critical care must be managed by consultants in Intensive Care Medicine who have an appropriate level of training in this field and have acquired the relevant knowledge and skills needed to care for these patients.	met / not met	3=Not applicable to Unit	
4	Burn injured patients must be cared for in an appropriate service as determined by the National Burn Care Referral Guidance.	met / not met	3=Not applicable to Unit	
5	Transfer of critically ill burn patients between services must comply with Intensive Care Society guidelines.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	All burns over 20% total body surface area (TBSA) should have access to thermally controlled single-bedded cubicles.	met / not met	3=Not applicable to Unit	
2	Fibre-optic bronchoscopy should be used to assess inhalation injury.	met / not met	3=Not applicable to Unit	
3	Services providing centre level care should be co-located with a major trauma centre. Where this is not the case, mechanisms for ensuring appropriate integration with trauma centre care should be in place.	met / not met	3=Not applicable to Unit	
4	In specialist centres, clinical guidelines should include: a) Fluid resuscitation and management of associated complications, b) Assessment and management of burns to the face and airway, c) Management of smoke inhalation injury and its sequelae, including carbon monoxide and cyanide poisoning, d) Recognition and management of the acutely unwell and deteriorating burn injured patient, including burn specific criteria for the diagnosis of sepsis, e) Management of hypothermia and hyperpyrexia, f) Management of burn wound infections including antimicrobial stewardship, g) Nutritional assessment, h) Rehabilitation. These guidelines should be subject to periodic review and update.	met - all guidelines and reviewed within 3 years, partially met - one / two missing guidelines or not reviewed within 3 years, not met - more than two missing or not reviewed within 3 years	3=Not applicable to Unit	
5	The implementation of end of life care as a result of burn injury should only be made following assessment by at least two consultants, one of whom should be a specialised burn care surgeon.	met / not met	3=Not applicable to Unit	
6	There should be a nominated lead consultant for burns, who participates in network and national morbidity and mortality audit meetings.	met / not met	3=Not applicable to Unit	
4.10 Care of the Critically Ill Pregnant (or Recently Pregnant) Woman				
STANDARDS				
1	Any critical care unit that admits antenatal women over 20 weeks' gestation must have rapid access to obstetric and paediatric services able to attend in an emergency. There must be a clear plan and equipment immediately available for performing a perimortem caesarean section in the event of maternal cardiac arrest, with appropriate neonatal resuscitation equipment.	met / not met	2=Fully met	
2	An obstetric team (normally a consultant obstetrician, a consultant obstetric anaesthetist and a midwife) must review all pregnant women admitted to critical care at least once in every twenty-four hour period.	met - as per standard, partially met - less frequent, unmet - difficult to achieve	2=Fully met	
3	In antenatal ICU admissions, when fetal viability is a possibility, a health care professional trained in neonatal resuscitation must be available within 10 minutes and a senior neonatologist or paediatrician must be able to attend within 30 minutes.	met / not met	2=Fully met	
4	All critical care units that admit pregnant or recently pregnant women must have a named lead clinician for maternal critical care (MCC). The main function of this role is to be the point of liaison between critical care and obstetric services (including obstetric anaesthesia).	met / not met	0=Not met	
5	Breast feeding (including the use of breast pumps) must be encouraged and supported in all post-natal women admitted to critical care.	met / not met	2=Fully met	
6	Women who require care that falls outside Enhanced Maternal Care (EMC) must be referred as soon as possible to the general critical care service. The route of escalation to critical care services must be clearly defined.	met / not met	2=Fully met	
7	Critical care outreach or equivalent must be available and provide clinical support and education into EMC.	met / not met	0=Not met	No CCOT
8	Critically ill pregnant or recently pregnant women who undergo intra- or inter-facility transfer must be transferred in accordance with standards equivalent to the Intensive Care Society's Guidelines for the transport of the critically ill adult	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Level 3 antenatal ICU admissions and post-natal admissions that are anticipated to last more than 48 hours should be considered for transfer to a regional or supra-regional critical care unit with experience in MCC.	met / not met	2=Fully met	
2	Physical contact between a mother and her baby should be maintained during post-natal critical illness, even if the mother is unconscious. This contact and other events of the admission should be recorded in a critical care diary which can be used in psychological rehabilitation after critical care or in bereavement counseling.	met / not met	2=Fully met	
3	All women admitted to critical care should be offered an appointment in a critical care follow-up clinic or a post-natal review, which includes input from a clinician with experience in critical care follow-up.	met / not met	0=Not met	

4	Recognition of EMC should be incorporated into midwifery pre & post registration curricula and feature in obstetric, anaesthetic and critical care training programmes.	Statement		
5	Healthcare professionals looking after critically ill women should undergo regular, cross-specialty, multidisciplinary team training, to encourage sharing of knowledge and skills and to promote teamwork and effective communication.	met / not met	2=Fully met	PROMPT
6	Simulation-based learning should be considered to assist healthcare professionals to develop the technical and non-technical skills for EMC.	met / not met	2=Fully met	PROMPT
7	Critical care networks should consider nominating specific units as the nominated regional or supra-regional unit for MCC.	met / not met	3=Not applicable to Unit	
8	Obstetric units delivering EMC or level 2 critical care should be members of a regional MCC network which itself should have a formal relationship with the local Critical Care Operational Delivery Network and Strategic Clinical Networks.	met / not met	2=Fully met	
9	MCC quality indicators should be monitored, using data reported through the ICNARC Case Mix Programme and the Scottish Intensive Care Society Audit Group and used to improve local performance.	met / not met	3=Not applicable to Unit	
4.11	Care of the Critically Ill Child in an Adult Critical Care Unit			
STANDARDS				
1	Critically ill children under 16 years old must only be admitted to and stay on an adult critical care unit if a PICU bed is unavailable, or when there is an expected short duration of critical care e.g. an older child with overdose or alcohol excess.	met / not met	3=Not applicable to Unit	
2	Admission must be discussed and agreed by the local consultant in Intensive Care Medicine, local consultant paediatrician and the consultant in paediatric Intensive Care Medicine (this may be the regional paediatric transport team consultant).	met / not met	3=Not applicable to Unit	
3	A nominated lead intensive care consultant and lead nurse in the adult critical care unit must be responsible for intensive care policies, procedures and training related to the care of children.	met / not met	3=Not applicable to Unit	
4	An adult critical care unit that may provide care for critically ill children must have an appropriately equipped area for providing paediatric critical care.	met / not met	3=Not applicable to Unit	
5	Medical staff with responsibility for the resuscitation and airway management of the critically ill child on an adult unit must have up-to-date competencies in advanced paediatric life support and advanced airway management. This medical cover may be provided by anaesthetists or consultants in Intensive Care Medicine according to local arrangements.	met / not met	3=Not applicable to Unit	
6	Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer of critically ill children and the provision of paediatric critical care must be available.	met / not met	3=Not applicable to Unit	
7	Escalation, end of life and organ donation decisions must be discussed in collaboration with the regional consultant in paediatric intensive care (this may be the regional paediatric transport team consultant), under a shared care and shared responsibility model.	met / not met	3=Not applicable to Unit	
8	There must be collaborative working between the adult critical care unit and the regional PICU to ensure that staff are supported to work outside their normal core competencies. There must be 24/7 access to paediatric medical and paediatric nursing advice.	met - as per standard, partially met - no formal arrangement, unmet - not anticipated to happen	3=Not applicable to Unit	
9	A local consultant paediatrician and consultant in paediatric Intensive Care Medicine must be available for advice at all times.	met / not met	3=Not applicable to Unit	
10	There must be 24-hour access for parents/carers to visit their child.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	A registered paediatric nurse should be available at all times to support the care of the child.	met / not met	3=Not applicable to Unit	
2	The child should be reviewed by a consultant paediatrician twice a day during their stay on the adult unit.	met - as per standard, partially met - visited as requested / required , unmet unlikely to achieve standard	3=Not applicable to Unit	
3	There should be access to specialist paediatric healthcare professional and pharmacy advice at all times.	met - as per standard, partially met - visited as requested / required , unmet unlikely to achieve standard	3=Not applicable to Unit	
4.12	Standardised Care of the Critically Ill Patient			
STANDARDS				
1	Patients must be assessed daily for risk of thromboembolic disease and receive appropriate prophylaxis.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
2	Patients undergoing controlled mechanical ventilation must receive tidal volumes based on predicted body weight (PBW). Patients with ARDS must receive a tidal volume of less than or equal to 6 ml/kg PBW.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	1=Partially met	
3	Ventilated patients must have respiratory function evaluated daily and undergo spontaneous breathing trials where appropriate.	met / not met - no SBTs	2=Fully met	
4	Sedation must be individualised to patient needs and the appropriateness of a sedation hold considered daily.	met / not met	2=Fully met	
5	All patients must be assessed regularly for evidence of pain, with analgesia optimised to minimise sedation requirements.	met / not met	2=Fully met	
6	All patients must be screened daily for evidence of delirium using a validated method such as the Confusion Assessment Method for the ICU (CAM-ICU) or the Intensive Care Delirium Screening Checklist (ICDSC).	met / not met	2=Fully met	
7	Indwelling intravascular catheters must be inspected daily for evidence of infection using a suitable scoring system e.g. Visual Infusion Phlebitis Score (Jackson 1998) to guide necessity for removal.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	1=Partially met	
8	The continued need for indwelling catheters (intravascular or urinary) must be considered daily.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	1=Partially met	
9	Monitoring of invasively ventilated patients must include continuous waveform capnography.	met / not met	2=Fully met	
10	Care bundles must be in place for Intubation Associated Pneumonia (IAP) prevention, Central Venous Catheter (CVC) insertion and maintenance, and Peripheral Venous Cannula (PVC) insertion and maintenance.	met / not met	2=Fully met	
RECOMMENDATIONS				

1	For patients without ARDS, a tidal volume of 4-8 ml/kg PBW and a peak/plateau pressure (depending on mode) of below 30 cmH2O should be targeted.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	1=Partially met	
2	A ventilated patient care bundle should be in place with appropriate mechanisms for ensuring adherence.	met / not met	2=Fully met	
3	Ventilated patients should receive H2 receptor blockade (e.g. ranitidine) or a proton pump inhibitor for gastric protection until established on full enteral nutrition.	met / not met	2=Fully met	
4	Unless clinically contra-indicated, ventilated patients should be nursed in a semi-recumbent position at 30 to 45 degrees.	met / not met	2=Fully met	
5	Where there is no contraindication, enteral nutrition (EN) should be initiated within 48 hours after admission to the ICU.	met / not met	2=Fully met	
6	When EN is not feasible or insufficient, parenteral nutrition should be started as soon as possible in patients with (or at high risk of) malnutrition, (which may be a combination of cachexia (disease related) and malnutrition (inadequate consumption of nutrients)).	met / not met	2=Fully met	
7	All sedated patients should have sedation levels monitored hourly using a scoring system such as the Riker Sedation-Agitation Scale or the Richmond Agitation-Sedation Scale to ensure sedation is minimised.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	1=Partially met	
8	Noise levels and patient interventions should be minimised overnight to facilitate natural sleep.	met / not met	2=Fully met	
9	A transfusion threshold of 70g/L should be used in general intensive care patients. A higher target Hb may be beneficial in patients with sepsis (in the first six hours), ischaemic stroke, traumatic brain injury with cerebral ischaemia, or acute coronary syndromes.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	0=Not met	
10	Critical care units should consider standardisation of drug concentrations in line with FICM/ICS guidance.	met / not met	2=Fully met	



Section 6		CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS	Level description	Level	Comments
6.1		Fire			
STANDARDS					
1	All units must have well marked fire call points, fire extinguishers and oxygen shut-off valves.	Met or unmet	2=Fully met		
2	Each unit must have a specific fire evacuation policy in place, which takes account of: a) the layout of the building, including any need to negotiate stairs during an evacuation, b) the provision of ventilatory support, intravenous therapies and invasive monitoring for patients during such an evacuation, c) the fact that critical care staff may themselves be affected by a fire and therefore be unable to continue working. Action cards summarising the evacuation procedure should be displayed within the unit. Ideally next to fire call points, so that they can be referred to in an emergency.	Met or unmet	2=Fully met		
3	Recommendations for the safe use of oxygen cylinders must be adhered to at all times and include: the safe use of oxygen cylinder bed brackets, b) the safe storage of oxygen cylinders and c) following the recommended sequence of events when turning on an oxygen cylinder.	Met / unmet	2=Fully met		
4	Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring and curtains.	Met / unmet	2=Fully met		
5	New units must be designed using Department of Health guidance and in conjunction with the Trust fire safety officer, with consideration given to the provision of: a) multiple exit routes, b) ski pad, ski sheets or other evacuation aids for all bed spaces which are readily available, c) adopting small bays rather than open areas and d) splitting ICU departments into separate clinical and non-clinical areas.	met / not met / not applicable	3=Not applicable to Unit		
6	Units must have a major incident plan in place which allows for the transfer in of multiple critical care patients from a neighbouring hospital's critical care unit should it need to carry out an emergency evacuation.	Met / unmet	2=Fully met	Major incident plans in place, along with Business Continuity plans. Activity 18 relates to	
7	Any problem with oxygen cylinders and associated equipment must be reported immediately to both the medical gas supplier and the Medicines and Healthcare products Regulatory Authority (MHRA).	Met / unmet	2=Fully met		
8	All staff must undergo regular training in fire prevention and fire procedures, to include training in-situ in the specific clinical areas in which they work. All staff must know: a) the location of fire call points within their own unit and how to operate them, b) the location of fire extinguishers within their unit and which type to use in the event of a fire. Medical and senior nursing staff must also know the location of the medical gas isolation shut-off valves in their unit, how to operate them and the implications of doing so.	met = > 90% of staff compliant , partially met > 75%, , not met < 75%	2=Fully met		
9	All intensive care staff must be given basic training regarding the safe use of oxygen cylinders.	met = > 90% of staff compliant , partially met > 75%, , not met < 75%	2=Fully met		
10	Local unit evacuation policies must be drawn up, with consideration for: a) other locations within the hospital where critical care might be provided on a temporary basis; b) provision of equipment and drugs; c) evacuation case at each bed space; d) triage of patients (the least unwell patients being evacuated first and the most unwell patients last); e) possible co-existing power and/or equipment battery failure; f) use of transport ventilators and hand ventilation if needed; g) temporary discontinuation of renal replacement therapy; and h) transfer of hospital notes especially if electronic patient monitoring is in use. In a major fire, it is possible that serial evacuations will be required with a staged move to the outside, and that the whole hospital may need to be evacuated.	Met / unmet	0=Not met	Departmental fire plans currently being updated to include guidance from the Association	
RECOMMENDATIONS					
1	Evacuation policies should include liaison with the Bronze (Operational), Silver (Tactical) and Gold (Strategic) commanders in conjunction with the senior fire officer on scene. Timing of evacuation is crucial: if evacuation occurs too early, then patients may be harmed by a transfer; if evacuation occurs too late, then patients and staff may be harmed by fire and smoke.	Met - tested annually , partially met tested daytime only and / or less than annually, unmet, not tested in the last 2 years	1=Partially met	Fire evacuation plan discusses Liaison with hospital fire response team. Patients evacuat	
2	Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be practised.	Met - system available / unmet - no system in place to do this	=Partially met		
3	Units should have a system whereby staff involved in a traumatic incident, such as a fire in the critical care unit, receive debriefing and are followed up for signs of a trauma stress reaction or Post Traumatic Stress Disorder (PTSD). The Trauma Resilience Management (TRM) system is a screening tool used in the military and more recently used successfully in healthcare which could be considered.	met / not met / not applicable	2=Fully met	Included in Fire Plan	
4	Critical care networks should develop systems to support planning for, and management of, a major incident in one critical care unit within the network, so that other units can cooperate to accommodate all critically ill patients in this type of situation. A retrieval team approach, with staff from neighbouring units travelling to the affected unit to transfer patients, should be planned. Liaison with neighbouring units and local ambulance services at an early stage is advised.		3=Not applicable to Unit	Local BCP and Major Incident plans apply	
6.2		Major Incidents			
STANDARDS					
1	All hospitals designated receiving hospitals with Level 3 critical care capability must be prepared to double their normal Level 3 ventilated capacity and to maintain this for up to 96 hours.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard	0=Not met	Inadequate logistics to double capacity	
2	All nominated supporting hospitals with Level 3 critical care capability must be prepared to double their normal capacity for Level 3 beds for essential use and to support the demand of patients from other receiving hospitals.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard	0=Not met	Inadequate logistics to double capacity	
3	All hospitals with intensive care capacity must have in place plans to support the retrieval or transfer of patients; supporting hospitals must have to support patient transfers by providing suitably skilled transfer teams for each patient needing to be moved within Critical Care Operational Delivery Network areas and beyond.	Met / unmet	2=Fully met		
4	All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but not exclusively intensive care patients, should the intensive care areas become unusable for any reason.	Met / unmet	2=Fully met	Patients will be taken to Theatres/Recovery or the day surgery unit depending upon the i	
5	All hospitals must have a lock-down plan that includes all intensive care areas, preventing unauthorised access.	met / unmet	2=Fully met	Yes to Critical Care	
6	All hospitals must have a recovery plan to ensure a rapid return to normality once the incident is closed. This must include adequate rest and psychological support for staff.	met / unmet	2=Fully met	Business Continuity plans in place Dedicated Psychologist working in Critical Care Team	
7	Action cards must be available for use on activation of plan and must include information and communication routes that are to be used.	met / unmet	2=Fully met	Action Cards included in major incident and fire plans	
RECOMMENDATIONS					
1	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response (EPRR) leads and clinical colleagues to create the intensive care response to a major incident, hospital evacuation or mass casualty plans.	met / unmet			
2	Intensive care should have access to emergency planning and response training including strategic/crisis leadership.	met / unmet			
3	Intensive care service staff should participate in the local and regional multidisciplinary exercises including 'table top' and 'live' exercises to further refine local and regional plans and communication routes between organisations and networks.	met / unmet - within the last 2 years	0=Not met		
4	Intensive care leads should work with their EPRR team to facilitate exercises in the evacuation of very dependent patients from any part of their hospital. This should include practice use of ski sheets, and other patient handling aids, as well as rehearsing the decision making and forward planning required by shift leads to support a controlled, staged evacuation.	met / unmet - within the last 2 years	0=Not met		
5	Intensive care staff should be prepared to take a central leadership role in any major incident and should be prepared to send teams forward to the Emergency Department, as well as any corporate hold areas and incident.	met - plans in place to enable to do so, unmet - no plans	0=Not met	Would participate as designated in local major incident response	
6	The plan to double the number of intensive care beds should include an inventory of where equipment is to come from, where the beds should be located and who should staff them. This should be near the permanent critical care unit, where possible allowing the normal functioning of the hospital around it.	met / unmet	0=Not met	Inadequate logistics to double capacity	
7	Advance consideration of staff workforce requirements, including mutual aid from colleagues in neighbouring hospitals should form part of the intensive care service planning.	met / unmet	2=Fully met		
8	Staff welfare should be actively supported during an incident and critical care staff access to informal, immediate debrief or later formal counselling.	met - plan in place, unmet - no plan in place	2=Fully met		
9	Clinical standards should be maintained as long as possible, critical incident reporting encouraged and contemporaneous note kept to enable quality post-incident lessons to be investigated, communicated and learnt.	met - within plan , unmet - not in plan	0=Not met		
6.3		High Consequences Infectious Diseases: Initial Isolation and Management			
STANDARDS					
1	Each critical care unit must ensure there are local contingency plans for the initial isolation and management of critically ill patients with suspected HCIDs. These plans must be regularly practiced and reviewed, including the use of table-top exercises and simulations.	Met - plan in place and tested within 2 years, partially met - plan in place but not tested within 2 yrs, unmet - no plan	2=Fully met		
2	Units must liaise with local Directors of Infection Prevention and Control to ensure the correct personal protective equipment (PPE) is procured and sufficient stocks are readily available for use by appropriately trained intensive care staff in the event it is required.	met / unmet	2=Fully met		
RECOMMENDATIONS					
1	A consultant in Intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience preparations, incorporating plans for the appropriate isolation and management of suspected patients with HCID.	met / unmet	0=Not met		
2	A clinical area where critically ill patients with suspected high consequence infectious diseases may be isolated, either within the unit or elsewhere, should be prospectively identified. Ideally plan to utilise negative pressure rooms with anterooms where available.	met / unmet	1=Partially met	Limited side rooms	
3	All clinical equipment used in the management of a patient with a HCID should be dedicated to that patient alone. Equipment should be single use where possible.	met - within a plan to do so, unmet - no plan	2=Fully met		
4	Training should be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provided. This should incorporate annual fit testing of respiratory protective equipment (e.g. FFP3 masks).	met - annual fit testing done unmet - not annual fit testing	2=Fully met		
5	Critical care staff providing care for a patient with a suspected or confirmed HCID should be dedicated to the care of that patient on a clinical shift and should not provide concurrent care for other patients, thus limiting the risk of cross-infection.	met - within plan to do so, unmet - no plan	2=Fully met		
6	Contingency planning should incorporate plans for holding securely the large volume of clinical waste resulting from clinical care including discarded contaminated PPE. Once a HCID is confirmed, further advice on correct disposal of the waste will be provided.	met - within plan to do so, unmet - no plan	2=Fully met	Hospital plan	
7	Patients with a suspected viral haemorrhagic fever should be risk assessed in accordance with the Advisory Committee on Dangerous Pathogens Viral Haemorrhagic Fever (ACDP VHF) Risk Assessment algorithm and investigations to exclude malaria normally undertaken. In line with local procedures.	met - local procedure in place, unmet - no local procedure			
8	Patients with suspected airborne HCIDs should be risk assessed according to national guidelines where they exist (disease-specific e.g. MERS guidance collections 3,4 or generic airborne HCID guidelines as appropriate).	met - local procedure in place, unmet - no local procedure	2=Fully met		
9	Following recognition of a patient with a suspected HCID, all local infectious disease and/or microbiology and virology services should be notified and advice sought, including guidance on obtaining appropriate diagnostic clinical specimens, b) Local clinicians should liaise with the Imported Fever Service (note this service is available to clinicians across the UK) for further clinical advice and to facilitate access to specialist diagnostics as required, and c) all suspected cases should be reported immediately to local health protection authorities (e.g. the local Health Protection Team).	met - local procedure in place, unmet - no local procedure	2=Fully met		
10	Critical care units accepting inter-hospital transfers should perform a risk assessment prior to transfer if a patient is being transferred from a country with known HCID outbreaks or countries where there is a significant risk of specific HCIDs, refer to national guidance (disease-specific or generic HCID guidance).	met - local procedure in place, unmet - no local procedure	2=Fully met		
6.4		Surge and Business Continuity Planning			
STANDARDS					
1	Adult critical care units (in England) must submit twice-daily information on their bed capacity through NHS Pathways Directory of Services (DoS).	met / unmet / NA ( if non English units)	3=Not applicable to Unit		
2	Each organisation with an adult critical care unit must have their own escalation plan and business continuity plan.	met / unmet	2=Fully met		
RECOMMENDATIONS					
1	Unit managers and senior clinical staff should develop plans and checklists for scenarios such as: a) supply chain disruption (road/fuel crisis, extreme weather, industrial action or civil disturbances), b) Infrastructure failures (intermittent power cuts or 'brownouts', failure of water or heating), c) interruption of normal staffing patterns (e.g. transport disruption, school closures). Checklists should include, for example, which drugs and consumables would run out first if supplies are disrupted.	met / unmet	2=Fully met		
2	Plans should also include options for: a) Unit evacuation, both internally and externally to other sites in the event of major infrastructure failure, or other events (e.g. fire) which threaten the ongoing operation of intensive care facilities, b) Capability for accommodating intensive care patients if the unit is evacuated from another site.	met / unmet ( repetition )	1=Partially met	Limited options	
3	As lack of critical care capacity is frequently the bottleneck in other surge-events, managers and clinicians should have identified areas within their acute hospital sites to allow for expansion of critical care capacity. This may include use of operating theatres, recovery and augmented higher care areas, or upgrading Level 2 critical care areas to permit mechanical ventilation and Level 3 care.	met / unmet	2=Fully met		
4	If increased activity is anticipated, the increase in requirement for consumables should be quantified using the concept of 'days of supply' (i.e. what is needed to run one intensive care bed for a 24-hour period). This should include consideration of oxygen and air supplies.	met - within plan , unmet - not in plan	2=Fully met	Hospital plan	
5	Expansion may also require consideration of essential equipment and possible alternatives.	met - within plan , unmet - not in plan	2=Fully met		

## An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



### Introduction

In June 2019, the Intensive Care Society (ICS) and Faculty of Intensive Care Medicine (FICM) released the second edition of Guidelines for the Provision of Intensive Care Services (GPICS). The first edition of GPICS (2015) built on the earlier Core Standards for Intensive Care Units (2013) and has become the definitive reference source for the planning, commissioning and delivery of Adult Critical Care Services in the UK. Many units have found the GPICS standards and recommendations to be invaluable in developing successful business cases to enhance their local services and improve patient care. GPICS has also been used as the benchmark by which local services are peer reviewed and assessed by healthcare regulators, such as the Care Quality Commission (CQC). The ICS and FICM have worked in collaboration to develop this tool kit to help individual units to compare their services to the latest version of GPICS. The standards and recommendations are presented in Excel format with a drop down option of 'met', 'partially met', 'unmet' or 'not applicable to this service' next to each guideline. The tool kit also allows units to produce a PDF summary page which provides a useful overview of their responses.

This tool kit is not stand-alone and should be used alongside the full GPICS document which is available via the link below. We recommend that the toolkit is completed in collaboration with members of the multi-disciplinary team, so that each section is completed by individuals who are best placed to make an accurate assessment. We are aware that defining compliance with standards and recommendations is difficult and have deliberately left this to the judgment of local clinicians and managers.

We see the further development of this tool kit as an iterative process, working with individuals and networks to improve and refine its functionality. If you have any suggestions or comments please contact us at [info@ics.ac.uk](mailto:info@ics.ac.uk). We hope you find this tool kit useful.

[Click here to go to the full GPICS document online](#)

or double-click on the embedded PDF ( you may need to switch to Windows to view after opening)>>

[Click here to view the Instructions sheet](#)

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# An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



## Instructions

### 1. To add your unit name to the summary page please enter it here:

Critical care unit name:  
Operational Delivery Network (ODN) /Region  
Date (dd/mm/yyyy)

Glangwili General Hospital  
Wales  
30/06/2023

### 2. Filling in the sheet

Do not fill anything in on summary of scores sheet. On every other sheet, every box that is blue requires a number to be inputted as follows:

0 = Not met 1 = Partially met 2 = Fully met

3 = Not Applicable to your ICU

### 3. Navigating the sheets

To get to a sheet either click on the sheet name tab at the bottom of the screen, or from the Summary of scores, click on the text that you want to go to.

### 4. Creating a PDF

To create a PDF summary of the gap analysis of your ICU click on the button below (macros must be enabled for it to work).



Summary of the gap analysis of your ICU compared to the GPICS v2 Report date:

Section	Description	STANDARDS			RECOMMENDATIONS		
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Fully Met
1	CRITICAL CARE SERVICES: STRUCTURE						
1.1	Levels of Critical Care	0%	0%	100%	0%	0%	0%
1.2	Outcomes	0%	75%	25%	0%	67%	33%
1.3	Level 2 and 3 Physical Facilities	0%	0%	50%	0%	13%	63%
1.4	Clinical Information Systems	0%	20%	80%	70%	30%	0%
1.5	Clinical Equipment	13%	13%	75%	0%	0%	100%
1.6	Cardiothoracic Critical Care				0%	0%	0%
1.7	Neurocritical Care	0%	0%	0%	0%	0%	0%
2	CRITICAL CARE SERVICE: WORKFORCE						
2.1	Medical Staffing	0%	40%	60%	0%	0%	100%
2.2	Registered Nursing Staff	18%	9%	73%	20%	0%	80%
2.3	Workforce, Induction & Training of Medical and Nursing Staff	0%	27%	73%	18%	64%	18%
2.4	Advanced Critical Care Practitioners						
2.5	Pharmacists	38%	25%	25%	60%	20%	20%
2.6	Physiotherapists	25%	25%	50%	73%	18%	9%
2.7	Dieticians	0%	25%	75%	33%	33%	33%
2.8	Speech and Language Therapists	0%	50%	0%	63%	38%	0%
2.9	Occupational Therapists	33%	33%	33%	100%	0%	0%
2.10	Psychologists	0%	0%	100%	0%	42%	58%
2.11	Healthcare Scientists Specialising in Critical Care						
2.12	Support Staff	10%	30%	60%	0%	60%	40%
2.13	Smaller Remote and Rural Critical Care Units						
3	CRITICAL CARE SERVICES: PROCESS						
3.1	Admissions, Discharge and Handover	18%	27%	55%	0%	0%	0%
3.2	Capacity Management	14%	29%	57%	20%	40%	40%
3.3	Critical Care Outreach and Rapid Response Systems	0%	0%	100%	0%	29%	57%
3.4	Infection Control	0%	17%	50%	0%	17%	83%
3.5	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology	0%	17%	83%	14%	14%	57%
3.6	Rehabilitation	29%	14%	57%	29%	14%	43%
3.7	Intensive Care Follow Up	50%	50%	0%	91%	9%	0%
3.8	The Patient and Relative Perspective	29%	14%	57%	30%	10%	60%
3.9	Staff Support	0%	0%	100%	0%	0%	100%
3.10	Inter and Intra Hospital Transfer of Critically Ill Patients	0%	13%	88%	8%	8%	85%
3.11	Care at the End of Life	0%	0%	100%	11%	11%	78%
3.12	Organ Donation	0%	0%	100%	0%	29%	71%
3.13	Legal Aspects of Capacity and Decision Making	100%	0%	0%	0%	100%	0%
4	CRITICAL CARE SERVICES: CLINICAL CARE						
4.1	Respiratory Support	0%	10%	90%	75%	0%	25%
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	50%	50%	57%	14%	29%
4.3	Renal Support	0%	0%	100%	0%	0%	80%
4.4	Gastrointestinal Support and Nutrition	0%	60%	40%	30%	0%	70%
4.5	Liver Support				22%	22%	56%
4.6	Cardiovascular Support	50%	33%	17%	67%	0%	33%
4.7	Echocardiography and Ultrasound	73%	0%	27%	89%	0%	11%
4.8	Neurological Support	14%	0%	86%	31%	0%	69%
4.9	Burns						
4.10	Care of the Critically Ill Pregnant (or Recently Pregnant) Woman	14%	14%	71%	40%	20%	40%
4.11	Care of the Critically Ill Child in an Adult Critical Care Unit						
4.12	Standardised Care of the Critically Ill Patient	20%	0%	80%	20%	0%	80%
5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS						
5.1	Research and Development	0%	0%	100%	0%	0%	100%
5.2	Audit and Quality Improvement	60%	0%	40%	33%	50%	17%
5.3	Clinical Governance	20%	20%	50%	50%	50%	0%
5.4	Critical Care Networks	0%	0%	100%	0%	0%	10%
5.5	Critical Care Commissioning	0%	0%	100%			
6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS						
6.1	Fire	10%	20%	50%	33%	67%	0%
6.2	Major Incidents	29%	43%	29%	56%	0%	22%
6.3	High Consequence Infectious Diseases: Initial Isolation and Management	0%	0%	100%	10%	10%	70%
6.4	Surge and Business Continuity Planning	50%	0%	50%	0%	20%	80%

Section 1		CRITICAL CARE SERVICES: STRUCTURE	Level description	Choose level	Comments
1.1					
Levels of Critical Care					
STANDARDS					
1	All patients admitted to a critical care unit must be included in a national clinical audit programme in which Levels of Care data are collected.		met / not met	2sFully met	
2	Level of Care classification must not be used in isolation to decide upon a patient's requirements.		met/ not met	2sFully met	
RECOMMENDATIONS					
	None.			3sNot applicable to Unit	
1.2					
Outcomes					
STANDARDS					
1	Critical care units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.		met - comprehensive programme with multiprofessional involvement, partially - programme but limited multiprofessional involvement, not met - no review	1sPartially met	
2	The unit must participate in a National Audit Programme for Adult Critical Care.		See section 1.1	2sFully met	
3	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care.		met / not met	1sPartially met	
4	Critical care units should participate in a programme of hospital-acquired infection surveillance to monitor and benchmark rates of catheter-related bloodstream infections, antimicrobial use and frequency of multi-resistant infections as infection in Critical Care Quality Improvement Programme (ICQIP).		Met / unmet	1sPartially met	
RECOMMENDATIONS					
1	The UK intensive care community should encourage and develop a validated methodology to review referrals to intensive care and evaluate decision making and subsequent outcomes relating to intensive care admission and referral.		National measure		
2	Units should develop a consistent approach to patient-centred decision-making, evaluating burdens and benefits of admission to intensive care, and be able to demonstrate this through the audit of pre-admission consultation, agreed ceilings of therapy, and time-limited treatment trials.		met - all admissions audited and reviewed, partially met, some audit evidence of this process, not met - no audit information / no review of admissions	2sFully met	
3	Longer-term mortality should be collected on all patients admitted to critical care.		met - collected on all patients, partially met - intermittent audit / review, not met - not reviewed	1sPartially met	
4	The UK intensive care community should encourage and develop validated measures of longer-term patient- and family-centred outcomes beyond mortality, including measures of functional ability, socioeconomic consequences, and carer burden.		National measure		
5	The UK intensive care community should encourage and develop validated measures of quality of care relating to end of life and bereavement.		National measure		
6	Critical care units should consider systematic assessment of patient and family experiences and demonstrate how these are used to guide improvement.		met - quarterly assessment, partially met - 1-2 yearly, not met - not done	1sPartially met	
1.3					
Level 2 and 3 Physical Facilities					
STANDARDS					
1	Critical care facilities must comply with national standards.		met / not met	2sFully met	
2	All new build units must comply with HBN 04-02.		met / not met / not applicable	3sNot applicable to Unit	
3	Medicines and fluid storage must comply with HBN 00-03.		met / not met		
RECOMMENDATIONS					
1	Existing units that do not comply should have a timeline to establish when national standards will be met.		met - time line and evidence to suggest progress, partially met - timeline but no evidence of progress, not met - no timeline / not applicable if standards met	2sFully met	
2	Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.		met/not met	2sFully met	
3	The unit should have enough beds and resources to obviate the need to transfer patients to other critical care units for non-clinical reasons.		met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2sFully met	
4	When planning or redeveloping a critical care area, Document HBN 04-02 should be considered.		met, partially met, not met, not applicable	3sNot applicable to Unit	
5	Critical care units should incorporate sufficient storage for medicines (including refrigerated and controlled drugs), IV fluids (including renal replacement) and parent fluids. Storage areas/rooms should be secure and appropriately temperature controlled for all medicines. ICU designs also, need to account for how selected medicines, including patient's own drugs, will be securely stored and readily accessible near the patient's bedside.		met, partially met, not met, not applicable	2sFully met	
6	It is recommended that critical care areas that have undergone recent new unit planning and building are contacted by those embarking on a new build to share experiences and learning.		met, partially met, not met, not applicable	3sNot applicable to Unit	
7	Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and dignity needs, and staff and visitor areas. Consideration should also be given to the patient's recovery and rehabilitation needs, including the potential for long-stay patients to spend periods outside.		met, partially met, not met, not applicable	1sPartially met	
8	Critical care units should be inspected as part of the peer-review process, including the review of the building and facilities. Feedback should include any concerns or highlight any success to lineframes.		met - peer reviewed, feedback included, partially met - peer review, no feedback, not met - no peer review	2sFully met	
9	Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners.		National/regional measure		
1.4					
Clinical Information Systems*					
*If no CIS then Not Applicable					
STANDARDS					
1	The CIS must comply with the set of common specifications, frameworks and implementation guides that support interoperability as specified with the NHS Interoperability Toolkit ( <a href="https://digital.nhs.uk/services/interoperability-toolkit">https://digital.nhs.uk/services/interoperability-toolkit</a> ).			2sFully met	
2	CIS procurement and customisation must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system. This should include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineering, the CDO (Chief Clinical Information Officer) and ICT specialists.		met, partially met, not met, not applicable	2sFully met	
3	The CIS must have a rigorous business continuity access (BCA) plan and resilience system so that critical patient information remains available and system downtime must not compromise patient safety in any way. There must be a process to ensure that sufficient staff trained in BCA contingency measures are available 24/7.		Met = full BCP present and tested, partially = some aspects not expected to continue as usual or BCP untested, not met = no documented BCP	1sPartially met	
4	Where patient data management systems (PMS) or electronic patient record (EPR) systems are used, there must be access to a dedicated workstation computer at each bed space. An appropriate number of both mobile and fixed workstations must be available to facilitate timely patient care by medical, nursing and allied staff on ward rounds and on an ad hoc basis.		Met = workstation for every bedspace plus additional workstations for mobile staff, partially met = insufficient mobile workstations, not met = absence of workstation at every bedspace (even if mobile stations available) or absence of any mobile workstations.	2sFully met	
5	The CIS must have robust implementation and ongoing training programmes to support all staff in its clinical and management use. These should be provided by the NHS organisation in partnership with the vendor company. Due consideration should be given to how this training will be provided to new starters and locum staff. There should be a mechanism by which any specialist involved in the patient's care while on the critical care unit has access to all pertinent information and is able to document in such a way as to facilitate care. This is particularly important when critical care and hospital documentation systems are distinct.		Met = training provided to all staff requiring it including new starters, >90% on first day of clinical duty or before, partially met >80% but <90% trained on first day of starting, not met < >80% trained on day 1	2sFully met	
RECOMMENDATIONS					
1	Critical care units should consider using a CIS.		met / not met	2sFully met	
2	CIS should be part of an electronic health record. The specification should include high-resolution data capture from patient monitoring, infusion devices, ventilators, cardiac output measurement, temperature management devices, intra-aortic balloon pumps, extra-corporeal life support (ECLS) devices, blood gas analysers and renal replacement therapy (RRT) devices. A CIS should be capable of customizable display of this information along with clinical notes.		Met = >50% of device types ever used linked to system, partially met = 30-80% of all devices linked, not met = <80% of devices linked (ie we wouldn't expect a unit using 2 IABPs a year to link them, but would expect a unit using them monthly to link them)	0sNot met	
3	The CIS should be connected to the hospital's patient information system for demographic and admission/discharge data, to laboratories for results, to radiology for reports and to other key software, e.g. National Critical Care Audit Systems and Hospital Electronic Prescribing and Medication Administration (HEPMA) for electronic data sharing. The CIS should be able to collect and share electronically Critical Care Minimum Data Sets (CCMDS) and national audit data to facilitate electronic generation of reports and audit. In the event of replacing existing CIS, it must be possible to access archived patient records in a user-friendly format.		Met = clinical staff do not need to routinely log in to another system to obtain results required to care for patients, partially met = clinical staff have to log into 1 additional system regularly, not met = staff have to access >1 additional system to obtain routine information required for patient assessment	1sPartially met	
4	Investigation ordering should be fully integrated and recorded, and include electronic prescribing of drugs and fluids and ordering of laboratory and radiology services.		Met = captures all required data, Unmet = unable to capture any information regarded as essential to review patient	0sNot met	
5	Daily summary plans should capture electronically activity data from the rest of the CIS, with the addition of free-hand text for healthcare professionals treating and visiting the patients.		Met = provides care-specific worklists and alerts, partially met = either alerts or worklists not provided comprehensively, unmet = unable to provide worklists or does not provide alerts (could probably do with splitting)	1sPartially met	
6	The CIS should be capable of forming worklists for individual members of the critical care team to allow patient- and staff-based lists of tasks to be completed. The CIS should include the ability to alert when tasks are near due, due and overdue, and record and audit performance.		Met = alerts provided in real time in format required by unit, partially met = some alerts but not all those required or can only be provided in a suboptimal medium, not met = no dashboard facility	0sNot met	
7	There should be a functionality within the database to alert, within a short timeframe, lack of compliance with care bundles and specifically for physiological abnormalities that are undesirable or life threatening. These alerts should be via dashboards displayed clearly within the unit and also via text or email to appropriate or named key devices carried by healthcare staff.		Met = single log in provided computer operating system already logged in, not met = user has to enter ID more than once to access	0sNot met	
8	The CIS should include customizable transfer/discharge summary, pulling key information from diagnoses, intensive care management, clinical notes, tabs and medication.		Met = 100 % alerts received and acted upon, partially met 85-100% received, not met = no robust mechanisms or not able in evidence	1sPartially met	
9	Flexibility through assessing care records online or through mobile devices should be possible.		Met = versatile system where users have been able to create decision support algorithms as required, partially met = some pre specified decision support provided but limited additional configuration by end user, Not met = no decision support available	0sNot met	
10	The CIS should handle authentication and authorisation through Single Sign On, including the use of RFID/Smart cardiobionics.				
11	The system should provide capacity to evolve sophisticated electronic decision support systems, to facilitate patient safety and quality. The CIS should be capable of feeding data to other life-health solutions for remote monitoring and advice on patient management.				
1.5					
Clinical Equipment					
STANDARDS					
1	All equipment must conform to the relevant safety standards and must be regularly serviced and maintained in accordance with the manufacturer's guidance.		met / not met	2sFully met	
2	Uninterruptable power supply adequate to provide at least one hour of continuity of any critical equipment without battery back-up must be provided.		met / not met	2sFully met	
3	There must be a programme in place for the routine replacement of capital equipment.		met / not met	0sNot met	
4	All staff must be appropriately trained and competent and familiar with the use of equipment. Up-to-date training records must be maintained to demonstrate that all staff (medical, nursing, AMP and support staff) have completed this provision.		Met = >85% trained staff for all equipment, partially 75-85% trained staff all equipment, not met < 75% or no clear record	2sFully met	
5	There must be a mechanism for the replacement of equipment. The replacement of equipment on the critical care unit in collaboration with the electro-biomedical engineering (EBME) provider and the organisation's overarching replacement of equipment must be available either in-house or on a contracted basis to ensure equipment is appropriately serviced. Regardless of the model of support, EBME personnel must have the appropriate skills and equipment to service the equipment used.		Met / not met	0sNot met	
6	EBME support must be available either in-house or on a contracted basis to ensure equipment is appropriately serviced. Regardless of the model of support, EBME personnel must have the appropriate skills and equipment to service the equipment used.		Met = >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record	2sFully met	
7	Equipment must be uniquely identified and listed on an appropriate asset register along with details of its life cycle and service history/requirements to facilitate planned maintenance and replacement.		met - >80% equipment, partially 75-80% all equipment, not met < 75% or no clear record	2sFully met	
8	There must be documented procedures for decontamination (cleaning, disinfection and sterilisation as appropriate, depending on equipment risk category and sensitivity of devices). Appropriate sterile services must be provisioned so that national standards are followed for the re-sterilisation of endoscopes and reusable.		Met = >2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents	2sFully met	
9	Critical care units must have appropriate systems in place to ensure an adequate supply of consumables.		met - policy in place, partially met, no policy but can evidence, not met - no policy and / or no evidence	2sFully met	
10	There must be robust mechanisms for reporting adverse incidents resulting from the use of clinical equipment. Serious incidents involving clinical equipment may also need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).		Met = 100 % alerts received and acted upon, partially met 85-100% received, not met = no robust mechanisms or not able in evidence	1sPartially met	
11	The MHRA may issue safety alerts pertaining to medical devices, as may device manufacturers from time to time. There must be designated role and robust mechanism for ensuring that such alerts are cascaded to staff and acted upon as appropriate.		Met = >2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents	2sFully met	
12	Sufficient equipment must be available to meet the service demand to enable treatment provision (basic and specialist monitoring, ventilation, renal replacement therapy, information technology facilities etc.) in an appropriate timeframe to meet patient need. Consideration must be given to the need to provide additional capacity in times of acute demand.		Met = all advanced techniques reported within 6 hours of event (inc verbal and provisional reports), Partially 6-24h, Not met > greater than 24h delay	2sFully met	
13	Magnetic resonance imaging (MRI) compatible equipment must be provided for use where mechanically ventilated patients are to undergo MRI investigation. These must be clearly labelled and staff must be adequately trained.		Met / not met / not applicable	2sFully met	
14	Where advanced monitoring techniques are used (e.g. diagnostic electroencephalography, cardiac output monitors, intracranial pressure/other invasive neuromonitoring), there must be provision of appropriately trained staff to adequately interpret the results in a timely manner and to deal with likely complications of their use where appropriate.		Met / not met	2sFully met	
15	Immediate access to point of care blood gas analysis and glucose/ketone analysis on a 24/7 basis must be provided.		Met / not met	2sFully met	
16	Where equipment is to be trialled on a loan basis for evaluation purposes, it is essential that adequate indemnity and governance arrangements are in place in case of injury to other patients or staff from potentially unfamiliar equipment, and the supplier should provide adequate training to ensure correct use. The EBME provider should facilitate this process by liaising the equipment for safety as well as evaluation services and maintenance implications.		met / not met	1sPartially met	
RECOMMENDATIONS					
1	Standardisation of equipment should be encouraged both within the critical care unit and in other areas where intensive care may need to be delivered.		Met = all C.A areas or the regional use same monitoring / ventilators / portable ventilators / NIV / monitoring sets, Partially met = 1 item different, Not met = >1 item different (specialist equipment used in only 1 area not	2sFully met	
2	The provision of diagnostic ultrasound equipment should be guided by the likely patient population and staff expertise. At very least, there must be immediate access to sufficient ultrasound equipment to ensure that intravascular catheters can be placed safely and in a timely manner, even in emergent circumstances.		met / not met	2sFully met	

1.6 Cardiothoracic Critical Care				
*Not applicable to non Cardiothoracic Critical Care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of GPCs.	met / not met		3=Not applicable to Unit
2	Each cardiothoracic critical care unit must have designated lead consultant with training in cardiothoracic intensive care. This should be recognised in their job plan and they should be involved in multidisciplinary service planning and governance within the unit.	met / not met		3=Not applicable to Unit
3	Each cardiothoracic critical care unit must have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service.	met / not met		3=Not applicable to Unit
4	There must be a resident doctor or ACP and a resident cardiac surgeon. There must be on-site 24/7 access to a doctor or ACP with advanced airway skills. The resident team must be trained in Cardiac Surgery Advanced Life Support (ICALS) and be capable of emergency chest re-opening 24/7.	met / not met		3=Not applicable to Unit
5	Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complies with national standards. There should be a clear escalation pathway from post-operative care to intensive care.	met / not met		3=Not applicable to Unit
6	The care of patients falling outside the protocolised care pathways must be reviewed by a multidisciplinary team led by a consultant trained in cardiac Intensive Care Medicine.	met / not met		3=Not applicable to Unit
7	Ventilated patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	met / not met		3=Not applicable to Unit
8	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care.			3=Not applicable to Unit
9	There must be a critical care pharmacist for every cardiothoracic critical care unit, supported by sufficient pharmacy technical staff.	met / not met		3=Not applicable to Unit
10	All cardiothoracic critical care units must participate in local and national audit. For example, for units in England, Wales and Northern Ireland, this is participation in the ICNARC ARIHC (Assessment of Risk in Cardiothoracic Intensive Care) programme - the national clinical audit for cardiothoracic critical care units.	met / not met		3=Not applicable to Unit
11	Trans thoracic and transoesophageal echocardiography must be immediately available.	met / not met		3=Not applicable to Unit
RECOMMENDATIONS				
1	The patient monitoring and physical support requirements in a cardiothoracic critical care unit should be no less than the requirements of patients cared for in a general (Level 3) critical care unit.	met / not met		3=Not applicable to Unit
2	Cardiac and thoracic surgery post-operative care is carried out in a dedicated environment with each component located in close proximity.			3=Not applicable to Unit
3	The cardiothoracic critical care unit should have in place agreed clinical criteria for the appropriate case-mix and arrangements for escalation to a general critical care facility as required.	met = clear written protocol, partially met = occurs in practice but referral/acceptor dependent, not met = escalation does not/cannot occur		3=Not applicable to Unit
4	ACCPs, with adequate training and appropriate support, can provide a safe, sustainable alternative to medical staff in the cardiothoracic critical care unit.	Statement		
5	Each day, a consultant in charge of the cardiothoracic critical care unit should coordinate input from members of the various teams in the immediate post-operative period.	met / not met		3=Not applicable to Unit
6	Perfusion services should be readily available.	met / not met		3=Not applicable to Unit
7	Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an active part in shaping services and analysing quality. Patient mortality audit is currently in the public domain for each unit and each member of the MDT should have an understanding of how their own role contributes to patient outcomes.	met / not met		3=Not applicable to Unit
1.7 Neurocritical Care*				
*NOT Applicable if non neurocritical care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in the relevant chapters of GPCs.	Met / not met		3=Not applicable to Unit
2	Neurocritical care units should have access to investigation facilities and appropriate clinical expertise for the following: a) diagnostic radiology (24-hour access to CT, access to MRI for ventilated subjects, and diagnostic angiography), b) access to biochemistry and microbiology services to analyse cerebrospinal fluid (CSF), c) neurophysiology (including electroencephalography (EEG) and evoked-response diagnosis and monitoring). Access to continuous 24-hour EEG monitoring is highly desirable.	met - all available, partially - some available		3=Not applicable to Unit
3	All cases requiring immediately lifesaving neurosurgery must be admitted to the local neurosurgical centre irrespective of the initial availability of neurocritical care beds.	fully met - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met		3=Not applicable to Unit
4	Patients with a Glasgow Coma Scale (GCS) score of ≤ 8 following a head injury at any time must have access to specialist treatment from neuroscience unit.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)		3=Not applicable to Unit
5	As per NICE QST4, eligible patients must have assessment for in-patient rehabilitation if new cognitive, emotional, behavioural or physical difficulties persist for more than 72 hours.	met / not met		3=Not applicable to Unit
6	In addition to general rehabilitation, neurologically impaired patients must have access to specialist neuro-rehabilitation services.	met = have access immediately once ready for discharge from acute centre, partially met = have access but discharge delays >48h for >20% patients, not met = no access or delays > 4 weeks to access neuro rehab		3=Not applicable to Unit
7	Neurocritical care must have resources to support mechanical thrombectomy in line with NICE IPG 548.	met - 24/7, partially - 5/7 per week, not met - available less than less		3=Not applicable to Unit
8	Neurocritical care must have resources to support regional networks for the safe and timely management of patients with subarachnoid haemorrhage.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)		3=Not applicable to Unit
9	Patients must be cared for by a multi-professional intensive care team with specialist expertise and experience in managing critically ill neurological patients using agreed protocols based on the best evidence available.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)		3=Not applicable to Unit
10	Care of critically ill neurological patients must fully integrate involvement of admitting specialties (neurology, neurosurgery, spinal surgery), and diagnostic/interventional specialties (neuroradiology and neurophysiology).			3=Not applicable to Unit
11	When calculating central perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.			
RECOMMENDATIONS				
1	Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care.	met / not met		3=Not applicable to Unit
2	Both the patient and family of the patient on neurocritical care should be offered support and guidance in the disease process and longer-term outcomes using specialist nurses and psychologists.	met = readily available at any point in pathway, partially met = available but not necessarily during critical care stav, not met = no psychological provision		3=Not applicable to Unit
3	Multimodal monitoring of patients with neurological injury should be consistent with international consensus recommendations.			3=Not applicable to Unit
4	Early and formal involvement of the neurorehabilitation team as part of the multidisciplinary team should be sought to optimise outcomes and facilitate transitions of care.	met = neurorehab consult within first week after injury (may be specialist physio or practitioner or consultant), partially met = neurorehab meets prior to transfer, not met = no input in acute setting		3=Not applicable to Unit
5	Specialist equipment needs to be freely available to facilitate the acute rehabilitative needs of all brain and spinal injured patients while on neurocritical care.			3=Not applicable to Unit
6	Neurocritical care units must be part of a regional network of care, with agreed rational transfer and repatriation protocols that ensure rapid acceptance of patients for specialist care, and transfer back to referring hospitals or onwards for further specialist long-term care when the need for specialist neuroscience care no longer exists.	met = meet full recommendation with audit data - partially - meet recommendation but no audit data, not met - no networks / poor network		3=Not applicable to Unit
7	Follow up and audit of outcomes from neurocritical care should include a measure of functional recovery at a minimum of six months.	met / not met		
8	Regular neurocritical care morbidity and mortality meetings should be undertaken involving all members of the multidisciplinary team, including the admitting specialties, allowing structured judgement case review.	met = quarterly or more frequent MDT involvement, partially = less frequent or less MD, not met = no MDM		3=Not applicable to Unit
9	Patients requiring intensive care for acute neurosurgical and neurological diseases in non-specialist centres should have direct communication to expertise in specialist neuroscience centres.	met/not met		3=Not applicable to Unit



3	After successful completion of clinical and academic PgDip ACCP requirements, including Non- Medical Prescribing, ACCPs should apply to the FICM for ACCP Membership.	Met = all ACCPs have FICM, partially met, = at least 50% have FICM not met = <50%	3=Not applicable to Unit	
4	It is recommended that employing units should only appoint FICM-associated ACCPs to ensure a standard knowledge base, minimum skillset and that FICM ACCP curriculum competencies have been met.	Met = all ACCPs have FICM competencies partially met = 50% have FICM competencies, not met = <50%	3=Not applicable to Unit	
5	While working autonomously, the ACCP will always work within a multi-professional team led by a consultant who is trained in ICM.		3=Not applicable to Unit	
6	It is recommended that critical care units employing ACCPs have transparent ACCP standard operating procedures and outcomes, and that any incidents are reviewed as part of the unit's governance arrangements.	Met = SOP in place, not met = no SOP	3=Not applicable to Unit	
7	It is recommended that the management of ACCPs forms a tripartite arrangement between an ICM consultant, ICU clinical supervisor and professional lead such as a senior nurse or AHP from the ACCP's base profession.	Met/not met	3=Not applicable to Unit	
8	Continuing professional development (CPD/appraisal) for ACCPs should be undertaken according to the FICM CPD/appraisal guidance on an annual basis.	Met/not met	3=Not applicable to Unit	
2.5 Pharmacists				
STANDARDS				
1	There must be a designated intensive care pharmacist for every critical care unit.	met / not met	2=Fully met	
2	There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and 2 for every Level 2 bed for a 5/7 a week service.	met = 0.1 bed, partially = 0.05-0.1 per bed, not <0.05	1=Partially met	
3	Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020.	met - 7 days per week, partially met 5 days per week.	1=Partially met	
4	The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy.	met / not met	0=Not met	
5	Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so (Advanced Stage I) must have access to an Advanced Stage II (excellence level) intensive care pharmacist for advice and referral.	met / not met	0=Not met	
6	As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays). Attend = dips into ward round(s), as appropriate and discuss issues.	met = 5 days per week, partially met - 3-5 days per week, not met - less than less or not on ward round.	2=Fully met	
7	There must be sufficient patient-facing pharmacy technical staff to provide supporting roles.	met / un met	0=Not met	
RECOMMENDATIONS				
1	To maintain the continuity of the service during annual leave, sick leave and training leave, additional appropriate resources will be required (20% minimum is recommended).	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no cover or on call type cover only	1=Partially met	
2	Intensive care pharmacists should undergo an independent, recognised process to verify competence level.	met / not met	0=Not met	
3	Senior specialist intensive care pharmacist support should, preferably, be provided within the organisation but may be provided from a critical care network or on a regional basis.	met / not met / not applicable	2=Fully met	
4	A peer-to-peer practitioner visit should occur at least once a year to ensure training issues are identified and to help maintain the competence of small teams and sole workers. This supports General Pharmaceutical Council (GPhC) revalidation.	met - yearly, partially met 1-3 yearly, not met - not done or > 3 yearly	0=Not met	
5	Where a team of intensive care pharmacists is in place, there should be a structured range of expertise, from trainee to Fellow level.	met / not met	0=Not met	
6	Intensive care pharmacists are encouraged to become active independent prescribers.	Statement		
2.6 Physiotherapists				
STANDARDS				
1	Physiotherapists must participate in opportunities for integrated decision making and dissemination of clinical information. This may include handovers, consultant-led multidisciplinary ward rounds, MDT meetings, team briefings or operational and patient safety briefings.	met / not met	1=Partially met	Limited capacity within the service to
2	The critical care MDT must have an identifiable lead physiotherapist who will be accountable for clinical service delivery, provide training and mentorship to junior staff, and oversee clinical governance and quality assurance.	met / not met	1=Partially met	Limited ability to produce adequate gov
3	All physiotherapy staff must receive appropriate competency-based training to ensure delivery of high-quality physiotherapy intervention within critical care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover.	met / not met	2=Fully met	
4	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care, ensuring compliance with both clinical and professional guidelines and standards.	met - fully met standard 7 days per week, partially met - meet standard 5 day per week, not met	0=Not met	Most standards met 5 days but signific
5	Respiratory physiotherapy must be available to critical care patients 24 hours a day and seven days a week. This includes the provision of an out of hours/on-call service which may utilise specialist and non-specialist intensive care staff.	met / not met	2=Fully met	
6	Physiotherapists, as part of the multidisciplinary team, must ensure the completion of a comprehensive clinical assessment of those at risk of or with identified physical and non-physical morbidity within four days of admission to intensive care and before discharge from intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation goals.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	
7	Patients receiving rehabilitation will be offered therapy by the multidisciplinary team across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	met - 7 days per week, partially met 5 days per week,	0=Not met	Unable to consistently provide prescrip
8	Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team(s) following discharge from intensive care. This should include the holistic individualised structured rehabilitation plan.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	Same Team
RECOMMENDATIONS				
1	The service provision should be based upon the overall patient case-mix taking into account acuity, dependency and complexity of the clinical case-mix. Staff resources and capability should be appropriately matched both in knowledge, skills, and number to deliver comprehensive respiratory care to the patient. However, further work is recommended of paramount importance exploring demand-capacity models to robustly determine physiotherapy staffing ratios in intensive care. The suggested ratio would be one WTE physiotherapist to four ICU Level 3 beds.	met 1 WTE to four level 3 beds ( or equivalent level 2 ), partially met 0.5-1.0 WTE per four level 3 beds, not met < 0.5 per four level 3 beds	0=Not met	WTE Funded as establishment
2	Physiotherapy services should provide assessment and intervention for physical rehabilitation seven days per week.	met 7 days per week, partially met 5 days per week, not met < 5 days per week	0=Not met	Unable to consistently provide prescrip
3	The value and role of Therapy Support Workers or Rehabilitation Assistants should be considered as part of either the intensive care physiotherapy or multidisciplinary workforce.	Statement		
4	Competency/capability frameworks should be in place encompassing all Agendas for Change (AC) bands applicable to the local service. This should reflect relevant national competency and professional development frameworks. A local training and development programme should exist to align with these frameworks.	met / not met	0=Not met	
5	Clear role specifications should exist for intensive care physiotherapists who have reached the level of Advanced Practice according to the Health Education England Framework.	met / not met	0=Not met	
6	The intensive care physiotherapy service should have a clear local operational policy and care standards for service provision which reflects both national guidance and standards and local variations.	met / not met	0=Not met	
7	The intensive care physiotherapy service or, where appropriate, as part of the MDT, should have robust and evidence-based clinical guideline/standard operating procedures surrounding airway clearance interventions and specialist rehabilitation interventions including early mobilisation of patients in intensive care.	met / not met	1=Partially met	
8	The lead physiotherapist, or appropriate deputy, should participate in all relevant local (and where appropriate, regional) intensive care operational delivery, governance and quality improvement groups. This may include governance meetings, service improvement work-streams, morbidity and mortality review meetings, business continuity meetings, operational or clinical management meetings. This should also include active participation/collaboration with their regional Critical Care Operational Delivery Network.	met / not met	1=Partially met	Due to capacity unable to attend many
9	The physiotherapy intervention(s), as part of the patient's individualised, structured rehabilitation plan, should be matched to the acuity, dependency and complexity of the patient, considering the patient's clinical needs and tolerance to intervention. This should align with the individualised, patient-centred rehabilitation goals and a holistic rehabilitation approach should be taken across a 24-hour period.	met / not met	0=Not met	Unable to adapt treatment times to fit v
10	Physiotherapists should play a key collaborative role in the coordination and delivery of ventilation and tracheostomy weaning plans, including post-extubation and post-decannulation care. Additionally, physiotherapists should be a core part of the multidisciplinary delivery of non-invasive ventilation in intensive care.	met / not met	0=Not met	Inconsistent between consultant appn
11	Targeted airway clearance interventions should only be considered in selected patients when clinically indicated. Routine secretion clearance therapy for all invasive-ventilated patients is not recommended.	met / not met	2=Fully met	
12	Where a local intensive care follow-up clinic/voices exists, a physiotherapist should contribute to this service.	met / not met	0=Not met	no service
2.7 Dietetics				
STANDARDS				
1	Critical care units must have access to dietitian five days a week during working hours	met / not met	2=Fully met	
2	There must be a dietitian as part of the critical care multidisciplinary team. If the critical care dietitian is working alone, they must be at the level of advanced practice. Where a dietitians must have communication and swallowing impairment assessed by a Speech and Language clinical practice level 4 to ensure an appropriate range of expertise within the team and to have overall responsibility for the service provision.	met = dedicated named dietitian(s) / not met	2=Fully met	
3	Intensive care dietitian(s) must have satisfied local or national competency requirements and be able to undertake a nutrition assessment and implement an appropriate nutrition support plan for critically ill patients. If working at advanced clinical practice level, dietitians must be able to demonstrate application of the documented capabilities outlined in the multi-professional framework for advanced clinical practice in England.	met / not met	2=Fully met	
4	Intensive care dietitian(s) must work collaboratively contributing to consultant-led ward rounds, MDT meetings, and have regular consultant communication where nutritional goals, risks and data are discussed as per the NICE CG83.	met / not met	2=Fully met	
5	Intensive care dietitian(s) must lead on the development and implementation of any local nutrition support guideline(s).	met / not met	2=Fully met	
6	Intensive care dietitian(s) must contribute to appropriate strategic meetings and clinical governance activities, including leading regular nutrition-related audits and acting on the results, plus undertaking quality improvement projects that demonstrate the impact of dietetics on service delivery, quality and effectiveness.	met / not met	2=Fully met	
7	Intensive care dietitian(s) must provide ongoing education and training for other healthcare professionals.	Met = comprehensive nutrition teaching programme for other staff, Partially = evidence of ad hoc teaching by dietitian, Not met = no dietician led teaching	1=Partially met	
8	Intensive care dietitian(s) must provide a structured handover to a ward dietitian when patients are discharged from the critical care unit, considering nutrition-related morbidity as per the NICE Quality Standard.	Met = >75% patients, Partially 50-75%, Not <50%	1=Partially met	
RECOMMENDATIONS				
1	There is a staffing level of at least 0.05-0.1 WTE per critical care bed to provide the dietetics service is recommended.	Met = >0.05, Partially = 0.025-0.05, Not <0.025	1=Partially met	
2	Intensive care dietitian(s) provide extended scope practitioner roles such as inserting feeding tubes, using indirect calorimetry to determine energy expenditure and supplementary prescribing where appropriate.	Met = all listed, Partially = some, Not = none	0=Not met	
3	Intensive care dietitian(s) should consider undertaking and disseminating nutrition-related research to widen the evidence base.	Statement		
4	Intensive care dietitian(s) should consider joining national (Critical Care Specialist Group of the British Dietetic Association) and international intensive care and nutrition-specific societies (Intensive Care Society, European Society for Intensive Care Medicine, European Society for Parenteral and Enteral Nutrition, etc.).	met / not met	2=Fully met	
5	Intensive care dietitian(s) should represent dietetics on national and international society committees and guideline development groups.	Statement		
6	Intensive care dietitian(s) working at an advanced level should have or be working towards a master's level award.	Statement		
2.8 Speech and Language Therapists				
STANDARDS				
1	Critical care units must have access to a speech and language therapist five days a week during working hours.	met = 5 days, partially >=3 days, not <3 days	1=Partially met	There is no dedicated SLT services in
2	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	Met = >98%, partially met > 80%		
3	All critically ill patients who have communication and/or swallowing difficulties (dysphagia) must have timely access to an SLT service.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours		
4	All Speech and Language Therapists working in intensive care must be appropriately trained, competent and familiar with the use of relevant equipment.	met / not met	1=Partially met	Limited amount of SLT's with appropo
RECOMMENDATIONS				
1	The critical care SLT service is provided by a minimum of 0.1 WTE (whole time equivalent) per bed	met = 0.1, partially 0.05-0.1, not <0.05	0=Not met	



2	Patients should have access to a communication aid according to individual need in order to facilitate patient interaction and rehabilitation.	met = always available inc advanced devices, partially = available but may not have same day access or simple devices only, not met = no access (apart from simple white boards/signs)	1=Partially met	
3	Speech and Language Therapists should contribute to a suitable tracheostomy or non-invasive ventilation weaning plan for complex or long-stay patients.	met / not met	0=Not met	
4	SLT are available seven days a week.	met 7 days per week, partially met 5 days per week, not met, less than 5 days or sporadic service	0=Not met	
5	FES should be available for Speech and Language Therapists to use in assessment and management of dysphagia in intensive care patients.	met - FES available 5 days/week, partially met - adhoc availability, not met - no service	0=Not met	SLT are developing a FES service, h
6	Speech and Language Therapists should work as an integral member of the multidisciplinary team on the critical care unit, contributing to all multidisciplinary ward rounds, tracheostomy teams, clinical governance groups, audit, research, education and policy development.	met - SLT attend daily ward rounds 5 days a week, partially met - available on request, not met = no service	1=Partially met	SLT are developing a FES service, h
7	Swallowing and communication recommendations and treatment plans should be included in any medical handover when the patient is transferred from intensive care to another unit or ward.	met (included in standardised handover process) or not met	1=Partially met	
8	Patients who are being considered for risk feeding should have access to an SLT assessment in order to clarify their level of aspiration risk and optimum oral feeding consistencies.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours	0=Not met	We have not had referrals asking for S
<b>2.9 Occupational Therapists</b>				
<b>STANDARDS</b>				
1	Critical care units must have access to occupational therapy services 5 days a week during working hours.	met = 5 day a week access, partially met = < 5 days/week, not met = no service or on call service from other depts only	1=Partially met	although it is not no service at all the se
2	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient; rehabilitation plans should be updated accordingly.	See 2.6.7	0=Not met	Occupational therapy not part of MDT 1
3	All occupational therapy staff working in a critical care environment must adhere to the Royal College of Occupational Therapists' Code of Ethics and Professional Conduct (COT 2015) and the Professional Standards for Occupational Therapy Practice (COT 2017).	met / not met	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	There should be an identifiable lead occupational therapist with appropriate experience, who will be accountable for service provision and development.	met / not met	0=Not met	
2	The occupational therapy clinical lead should be responsible for supporting learning opportunities, training and clinical supervision for junior staff providing occupational therapy services in intensive care.	met / not met	0=Not met	
3	The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation plans that address the complex functional, cognitive and psychosocial needs of the patient cohort.	met / not met	0=Not met	
4	Occupational therapy staff on the critical care unit should be able to assess and provide non-pharmacological treatment for those patients who present with delirium.	met (OT involved in management of delirium in ICU) partially = involved but no routine review of patients with delirium or not met	0=Not met	
5	Occupational therapists should be involved in intensive care follow-up clinics to assess and facilitate appropriate referrals rehabilitation or specialist services and to address any long-term physical and non-physical impairment affecting occupational performance.	met /not met	0=Not met	for more complex patients who have h
<b>2.10 Psychologists</b>				
<b>STANDARDS</b>				
1	All patients must be screened daily for delirium using a validated instrument.	met = > 95% screened, partially met > 80%, not met = < 80% or no audit data	2=Fully met	
2	Non-pharmacological strategies must be in place to prevent and reduce delirium.	met - there is a local delirium guideline detailing non pharmacological strategies. Not met	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	Psychologists should ensure that delirium is accurately assessed by nurses using a validated instrument, and that when delirium is detected, risk factors are reviewed and corrected by the MDT. They should advise on non-pharmacological strategies to prevent and reduce delirium at the ward level (by improving the environment) and patient level (to facilitate orientation and engagement).	met / not met	2=Fully met	
2	Psychologists should ensure that patients and relatives receive psychological education to explain the psychological impact of intensive care, drugs, procedures and environment. This can be delivered in person or via information leaflets.	met / not met	1=Partially met	
3	NICE CG83 and QS156 stipulate that patients should receive assessments and interventions for psychological as well as physical problems throughout the intensive care pathway. These should be delivered or supervised by qualified psychologists.	met = triggered or routine assessment available for all patients, partially = only available at certain points in pathway (ICU/ward follow up), Not met = not available at all	2=Fully met	
4	Psychologists should organise short psychological assessments for all awake, alert patients in intensive care using a validated measure such as the Intensive Care Psychological Assessment Tool.	met = >75% suitable patients assessed, partially 50-75%, not <50% (or no audit data)	1=Partially met	
5	If a patient is screened as being at risk of future psychological morbidity, psychological support should be offered by psychologists or other appropriately trained staff (e.g. nurses or psychology trainees) to give patients the opportunity to express their needs and feelings, and to have those feelings validated and normalised.	met/not met	2=Fully met	
6	All patients bound to be at risk of psychological morbidity (following the short assessment) should receive a comprehensive assessment before discharge from critical care. Psychologists should ensure that psychological needs, support and goals are included in the individualised structured rehabilitation programme that is formally documented and handed over at the time of transfer to general wards.	met = 75% assessed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met = not assessed	1=Partially met	
7	The psychologist should advocate (in conjunction with hospital outreach and mental health teams) for a system to be in place for at-risk intensive care patients to receive psychological support on general wards.	met/not met	1=Partially met	
8	Psychologists should contribute to the information (verbal and written) patients and relatives receive to help them continue their personal rehabilitation plans and to know who to contact if they need support after leaving hospital.	met/not met	2=Fully met	
9	Psychologists should participate in the follow-up reviews that intensive care patients receive in the community or at outpatient clinics. As part of the critical care unit MDT, the psychologist should provide: a) Training for staff to increase knowledge and understanding of psychological reactions, delirium, environmental stressors and psychological outcomes of critical illness, b) Consultation with the multidisciplinary team on communication, sleep, effects of sedation, anxiety, stress, mood, delirium, family issues and holistic care plans, c) Psychological support for families. Relatives may need support to cope with the shock of a family member becoming critically ill and being admitted to the critical care unit, as well as stress and exhaustion from caring for a patient during a long-term admission. They may also need bereavement support if their family member dies in the critical care unit.	met = always available at FU clinic, partially = available by referral, not met = not available	3=Not applicable to Unit	
10	During patients' rehabilitation and recovery period, the psychologist should provide: a) Consultation with outreach and general ward staff regarding psychological support for intensive care patients, b) Tailored evidence-based interventions for persisting morbidity such as anxiety, depression or PTSD; these should be offered by psychologists in a well-resourced follow-up service and should include trauma-focused cognitive behavioural therapy, c) Where funding for this is not available, referrals of patients directly to psychological therapy services, or recommendations for GPs to make referrals to these services, or advice to patients on how to access local psychosocial services, and d) Drop-in support groups for intensive care patients and their families after discharge from hospital, held in the hospital or community.	met - all elements, partially = some, not = none (could be split)	2=Fully met	
11	Employers have a duty of care to support staff working in a stressful environment such as intensive care, where burnout is highly prevalent. Workplace stress should be addressed at organisational, team and individual levels. Psychologists should consult with intensive care leadership on systemic issues influencing staff well-being. Additionally, psychologists should run or oversee staff support programmes including one-to-one sessions, drop-in groups or reflective rounds according to staff wishes and availability, as well as proactive sessions for senior managers.	met = all elements, partially = some, not = none (could be split)	2=Fully met	
12	To develop this coordinated service for patients, families, and staff, critical care units should employ a senior HCPC-registered practitioner psychologist. Large critical care units should have access to a WTE, and smaller units should have access to a psychologist with dedicated time for intensive care to deliver the points above.	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1=Partially met	
13		met/not met	2=Fully met	
<b>2.11 Healthcare Scientists Specialising in Critical Care</b>				
<b>STANDARDS</b>				
1	Critical Care Scientists must comply with the professional standards of behaviour and practice set out in Good Scientific Practice (GSP).	met/not met	3=Not applicable to Unit	
2	Critical Care Scientists responsible for management of medical devices and point of care diagnostic services must comply with the standards by the Medicines and Healthcare Products Regulatory Agency (MHRA) and the International Organisation for Standardisation (ISO) standard (22870:2016).	met/not met	3=Not applicable to Unit	
3	Critical Care Scientists voluntarily registered with the Health and Care Professions Council (HCPC) must meet the Standard of Proficiency and comply with the Standards of Conduct, Performance and Ethics.	met = are registered and comply / not met	3=Not applicable to Unit	
4	Critical care units receiving trainee healthcare scientists for training in intensive care must comply with the requirements for training set for them by the National School of Healthcare Scientist (NSHCS).	met / not met	3=Not applicable to Unit	
<b>RECOMMENDATIONS</b>				
1	The Critical Care Scientists should successfully complete an approved training programme, either via accredited specialist training or as part of the Scientist Training Program (STP) commissioned by the National School of Healthcare Science (NSHCS) and should be registered with the HCPC.	met/not met	3=Not applicable to Unit	
2	The Critical Care Scientists should work collaboratively to be a dynamic member of the multidisciplinary team, assisting in the provision of high quality, patient-centred care within the critical care environment.	met = embedded in dept, partially = available but not embedded, not	3=Not applicable to Unit	
3	The Critical Care Scientists should draw on specialist knowledge to provide advice to medical, nursing and wider multidisciplinary team working in a critical care setting about the safe and effective use of medical devices used within the critical care environment, including monitoring, diagnosis, and therapeutic technologies supporting critically ill patients.	met / not met	3=Not applicable to Unit	
4	The Critical Care Scientists should develop and support research activities, including facilitating evidence based practice and implementation of the latest technologies and software into the critical care environment.	met / not met	3=Not applicable to Unit	
5	The Critical Care Scientists should provide effective management and support for medical devices, including advising on optimal clinical settings and troubleshooting, resulting in focused, efficient and high-quality care.	met = evidence eg logs or equipment testing available / partially = happens but no evidence, not met	3=Not applicable to Unit	
6	The Critical Care Scientists should contribute to the educational needs of the multidisciplinary team, including delivering training, mentorship and educational support.	met = evidence of involvement in teaching and training / not met	3=Not applicable to Unit	
7	The Critical Care Scientists should demonstrate flexibility and adaptability to work across diverse pathways of patient care and clinical services that are both routine and highly specialised.	Statement		
8	The Critical Care Scientists should work safely and effectively within their scope of practice and ensure they do not practice in areas where they are not proficient.	met/not met	3=Not applicable to Unit	
9	As part of the multidisciplinary team, the Critical Care Scientists should contribute to the strategic direction, planning and delivery of critical care services.	met (ideally evidence eg attend dept meetings)/ not met	3=Not applicable to Unit	
10	The Critical Care Scientists should engage with the Society of Critical Care Technologies (SCCT) as their professional body in order to work in collaboration with the Academy for Healthcare Science and the NSHCS.	met/not met	3=Not applicable to Unit	
<b>2.12 Support Staff</b>				
<b>STANDARDS</b>				
1	All support staff must have clearly identifiable roles with specific competencies.	met / not met	1=Partially met	? Competences
2	All support staff must have a period of induction and supernumerary status.	met / not met	2=Fully met	
3	All support staff must be appropriately trained, competent and familiar with the use of equipment.	met / not met	2=Fully met	
4	All support staff must be included within the intensive care team and be updated on key unit issues and developments.	met / not met	2=Fully met	
5	Support staff roles must be clearly identifiable to colleagues, patients and visitors to the department, either by uniform and/or name badges.	met / not met	2=Fully met	
6	Intensive care areas must develop healthcare support worker roles to assist registered nurses in delivering direct patient care and in maintaining patient safety.	met / not met	2=Fully met	
7	Healthcare support workers must complete the Care Certificate and adhere to the Code of Conduct for healthcare support workers.	met / not met	0=Not met	? Care certificate ask Sandra
8	Administrative roles must be developed to ensure all clinical staff are free to give direct patient care, and supported with essential data collection.	met / not met	1=Partially met	
9	Each intensive care area must have sufficient staff responsible for the cleanliness of the environment.	met / not met	2=Fully met	
10	Where direct care is augmented using support staff (including unregistered nurses), appropriate training and competence assessment of those staff are required.	met / not met	1=Partially met	Ask Sandra
<b>RECOMMENDATIONS</b>				
1	All staff should be encouraged to attend further training and/or education to support their development.	met / not met	2=Fully met	
2	Each critical care area should have healthcare support workers 24/7 to assist nursing staff in delivery of direct patient care.	met = all shifts covered, partially = 75% covered, not <75%	1=Partially met	

3	Each critical care area should have ward clerk/nurse/cleaner cover seven days per week.	met = 7/7, partially 5/7, not = no receptionist	1=Partially met
4	Each critical care area should have a dedicated housekeeper/cleaner seven days per week.	met = 7/7, partially 5/7, not = no dedicated staff	2=Fully met
5	Each critical care area should have a dedicated housekeeper/cleaner seven days per week.	met = full cover with leave cover, partially = less than recommended cover or no leave cover, not met = no dedicated cover	1=Partially met
2.13	<b>Smaller Remote and Rural Critical Care Units</b>	Only relevant for small number of units. An autopolguate feature of not applicable would be useful	
<b>STANDARDS</b>			
1	Network support must be in place to ensure smaller, remote and rural critical units meet these standards and recommendations.	met = active participation in network / not met	3=Not applicable to Unit
2	The critical care service must be led by consultants trained in Intensive Care Medicine (ICM).	met / not met	3=Not applicable to Unit
3	There must be access to appropriate advice from a consultant in ICM at all times.	met = 24/7 access to advice / not met	3=Not applicable to Unit
4	Dedicated daytime critical care must be provided by a consultant trained in ICM with no other commitments.	met = 7/7, partially = 5/7 (or involves covering other areas at same time)	3=Not applicable to Unit
5	There must be a doctor or ACCP with advanced airway skills resident within the hospital 24/7.	met / not met	3=Not applicable to Unit
6	There must be a 24/7 dedicated resident on the critical care unit.	met / not met	3=Not applicable to Unit
7	There must be structured handover between day-time and night-time staff supported by standardised policies for practice.	met / not met	3=Not applicable to Unit
8	Appropriate CPD must be supported by the employer and undertaken by all professionals who deliver intensive care.	met / not met	3=Not applicable to Unit
9	Regional transport arrangements (road and air) must be put in place to allow timely, safe transfer of patients with an appropriate level of monitoring, staffing and skills.	met / not met	3=Not applicable to Unit
10	All critical care units, including Level 2 units, must enter data into national databases such as ICNARC or SICSAQ.	met / not met	3=Not applicable to Unit
<b>RECOMMENDATIONS</b>			
1	Network support should be explicit, resourced and supported by all the Healthcare Organisations, Boards, networks and regions involved, and recognised in job planning.	met / not met	3=Not applicable to Unit
2	Units should consider the development of telemedicine techniques for clinical decision making and educational support, in conjunction with their regional network.	Statement	
3	Remote critical care units should implement appropriate joint clinical governance procedures with both networked units and transfer services to include case-based review, critical incident analysis, and joint educational sessions.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit
4	Where an intensive care pharmacist or healthcare professional, such as a physiotherapist or dietician, cannot be effectively delivered locally in a small unit, advice should be accessible from specialist colleagues through network support. Appropriate training bodies should be identified and used to meet local needs and ensure compliance with national standards.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit

Section 3	CRITICAL CARE SERVICES: PROCESS		Level description	Level	Comments
3.1 Admission, Discharge and Handover					
STANDARDS					
1	The decision to admit to the critical care unit and the management plan must be discussed with the duty consultant in Intensive Care Medicine.	Met = >95%, partial = >90%, not <90% or not data	2	3-Fully met	
2	There must be documentation in the patient record of the time and decision to admit to critical care.	< 85% met, 75-85 partially met, < 75% or no data not met	1	Partially met	
3	Unplanned admissions to the critical care unit must occur within four hours of making the decision to admit.	Met = >95%, partial = >90%, not <90% or no data	1	Partially met	
4	Patients must have a clear and documented treatment escalation plan.	Met >85%, partial 80-90%, not <80 or no audit evidence	2	3-Fully met	
5	Patients must be reviewed, in person, by a consultant in Intensive Care Medicine as urgently as the clinical state dictates and always within 12 hours of admission to critical care.	96% of the time - Met, <95% or no data - not met	2	3-Fully met	
6	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2	3-Fully met	
7a	Consultant in Intensive Care Medicine-led ward rounds must occur twice a day (including weekends and national holidays).	< 85% met, 75-85 partially met, < 75% or no data not met	1	Partially met	
7b	The nurse in charge should be present in person for the ward round.	< 85% met, 75-85 partially met, < 75% or no data not met	2	3-Fully met	
8	Patients discharged from critical care must have access to an intensive care follow-up programme.	met / not met	2	3-Fully met	
9	Discharge from critical care to a general ward must occur within four hours of the decision and must occur between 07:00hrs and 21:00hrs.	met = >80%, partially = 60-80%, not <60%	3	Not met	
10	There must be a standardised handover procedure for medical, nursing and A&P staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation prescription.	met / not met	2	3-Fully met	
11	Patients undergoing specialist care must be repatriated to a healthcare organisation closer to their home when clinically appropriate to continue their rehabilitation, and this must occur within 48 hours of the decision to repatriate.	< 85% met, 75-85 partially met, < 75% or no data not met	3	Not met	
RECOMMENDATIONS					
None					
3.2 Capacity Management					
STANDARDS					
1	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care patients must be prioritised, such that patients requiring critical care support are admitted without delay (within four hours after decision to admit and completion of essential resuscitation/imaging) and patients no longer requiring critical care are discharged within four hours.	>80% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not data	1	Partially met	
2	The final decision on utilisation of critical care beds and staff (which includes moving staff to help in other areas of the hospital at times of need) rests jointly with the duty consultant and the duty nurse in charge of the critical care unit. Under no circumstances should clinical decisions be overridden by non-clinical operational management issues.	met / not met	2	3-Fully met	
3	Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans.	met / not met	2	3-Fully met	
4	Hospital boards must demonstrate regular oversight of the use of critical care escalation and the provision of intensive care outside of the critical care unit.	met / not met	2	3-Fully met	
5	Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit.	met / not met	2	3-Fully met	Consultant to Consultant discussions
6	Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios.	met / not met	1	Partially met	
7	Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duty intensive care consultants and duty nurses in charge to coordinate the usage of intensive care beds across the network.	met / not met / not applicable	3	Not applicable to Unit	Mutual Aid Document
8	Regional pandemic escalation plans must include trigger levels for agreed critical care admission criteria and thresholds for restriction of planned activity to assist neighbouring critical care units.	met / not met / not applicable	3	Not applicable to Unit	HB Escalation Plan and Mutual Aid Document
9	Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units to include escalation and, if required, prioritisation of transfers over local elective activity.	met / not met / not applicable	3	Not applicable to Unit	
10	Regional Intensive Care Networks must ensure that a system to record capacity across the network is in use, and that this is updated regularly.	met / not met / not applicable	3	Not applicable to Unit	
11	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	Met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2	3-Fully met	
RECOMMENDATIONS					
1	Critical care units should determine the emergency capacity they require to meet Standard 1 locally, based on their admission and occupancy data. The capacity to cope with the predicted emergency workload can then be managed by ensuring an appropriate number of beds available for emergency admissions before accepting elective admissions.	met / not met	3	Not met	
2	Acute hospitals will require at least one critical care bed per 36 acute hospital beds; hospitals undertaking a large amount of complex major surgical procedures are likely to need significantly more than this.	Met = 1:35 or greater, partially 1:45-1:35	2	3-Fully met	
3	Training should be provided to nursing staff in areas used for critical care escalation.	met = comprehensive documented training plan in place, partially = some training but not comprehensive	1	Partially met	
4	When using alternative areas of the hospital to provide critical care capacity, there should be adequate senior nursing and medical input such that the standards of care provided to those patients meet the standards provided to the patients within the critical care unit.	met = immediate access to ICU resident / registrar / nurse in charge for advice + twice daily consultant ward round	2	3-Fully met	Placed significant pressure on staffing
5	Decisions to proceed with major elective surgery should take into account current occupancy, provision of emergency capacity over the next 24 hours and, at times of regional network escalation, the emergency capacity in neighbouring units.	met / not met	1	Partially met	
6	Critical care units may find it useful to develop a statistical model locally that provides predictable data on the number of emergency admissions they should plan to accommodate in each 24-hour period, and use this model to assist decision making on when it is safe to proceed with planned elective work.	Statement			
3.3 Critical Care Outreach and Rapid Response Systems					
STANDARDS					
1	There must be a hospital wide, standardised approach to the detection of the deteriorating patient and a clearly documented escalation process.	met / not met	2	3-Fully met	HB Policy and Critical Care Outreach
2	All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical deterioration in all non-pregnant adult patients over 16 years. The National Early Warning Score (NEWS-2) is the recommended for call systems as the more efficient and effective. Using a common score ensures that staff operate the same language across the patient pathway and enhances the benefits of an early warning system. As part of a multi-trigger system, other triggers such as urine output/ acute kidney injury alerts, cause for concern and patient/carer Call for Concern, should be considered as they will enhance the recognition of the deteriorating patient.	met / not met	2	3-Fully met	
RECOMMENDATIONS					
1	Each hospital should have a graded clinical response strategy consisting of three levels: low, medium and high. Each level of response should detail what is required from staff in terms of observational frequency, skills and competence, interventional therapies and senior clinical involvement. It should define the speed and urgency of response, including a clear escalation policy to ensure that an appropriate response always occurs and is available 24/7.	met / not met	2	3-Fully met	HB Policy and Critical Care Outreach
2	Each organisation should ensure patients receive care from appropriately trained critical care outreach, rapid response or equivalent teams. The critical care outreach (CCO)/Rapid Response staff should have annual competency-based assessment of core and additional specific competencies from a local or regional programme. This should relate to first line clinical assessment and intervention, be clearly outlined and clearly reflect the Department of Health (DH) competencies for the recognition and response to the acutely ill patients in hospital.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	2	3-Fully met	HB Policy and Critical Care Outreach
3	There should be accessible educational support for registered and non-registered ward staff in caring for the acutely ill ward patient in line with recorder and first responder level as outlined in the DH competencies for the recognition and response to the acutely ill patients in hospital. Staff looking after Level 1 and enhanced care area patients should be trained following the National Competency Framework for Level 1 and Enhanced Care Areas.	met / not met	1	Partially met	RRALS/RESUS to address
5	Organisations should aim to deliver Comprehensive Critical Care Outreach as outlined by the seven core elements and have an operational policy that defines the remit of the CCO/Rapid Response or equivalent team within the organisation, in regard to these seven core elements.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	1	Partially met	PREPARE - Moving towards a Amber/Green system
6a	All patients should be reviewed by the CCO team (or equivalent) following discharge from the critical care unit to the ward.	Met = < 85%, partially met 85-75%, unmet > 75% or no data	2	3-Fully met	
6b	All CCO teams should participate in the National Critical Care Outreach Activity Outcome Dataset.	met / not met	1	Partially met	Data being collected but not reported Nationally as there is no overarching body
6c	Each organisation should develop audit tools to assess utilisation of their track and trigger and graded response system with clear governance procedures for action of poor compliance healthcare organisation-wide. This should be undertaken in combination with an audit of compliance against the standards within NICE CG502 and must be fed back to healthcare organisation Boards and Critical Care Networks where relevant.	met / not met			RRALS/RESUS to address
7a	Each hospital should be able to provide a CCO/rapid response team, or equivalent, that is available 24 hours per day, seven days a week.	met / not met	2	3-Fully met	
7b	There should be regular review of service provision to facilitate proactive approaches in order to match service configuration against local demands and activity. These should be reflected in the operational policy. There should be a nominated lead of service at healthcare organisation Board level with appropriate communication cascade.	met / not met	1	Partially met	National standards used to assess service. Operational policy in place. Dr. M
3.4 Infection Control					
STANDARDS					
1	Staff must follow safe insertion and maintenance procedures for intravascular and urinary catheters, and remove them when not required to minimise the risk of infection.	met = policy and training in place with daily care bundle checklist and audit data, partially = no formal daily checklist or no audit, not met = no policy	2	3-Fully met	
2	Infection control procedures must be documented and agreed by the multi-professional team.	met - policy in place not met - no policy	2	3-Fully met	
3	The WHO Five Moments of Hand Hygiene must be observed. Hand contamination is often due to contact with the environment rather than directly with the patient.	Handwashing audits - Met = < 95%, partially met 95-85%, unmet > 85%	1	Partially met	
4	Cleaning of the environment must be undertaken by trained staff and subject to audit and quality control, with particular attention to high contact surfaces. Duties of cleaning and nursing staff, in cleaning specific surfaces, should be clearly defined.	met = policy in place with regular audit data and systematic reports, partially = policies in place but only ad hoc audits, not met = anything else	2	3-Fully met	Credits for Cleaning
5	There must be surveillance systems in place for audit and feedback of nosocomial infection, reporting to the national scheme where applicable, for example, reporting central venous catheter-related bloodstream infection to the Public Health England Infection in Critical Care (Public Involvement Programme (PICKIP)).	met = supply data to ICQOP (or equivalent) - partially met - locally monitored, not met - not regularly monitored			Check with infection control. A data is always completed.
6	The principles of antibiotic stewardship must be adhered to in consultation with the microbiology team.	met = documented every consumable microorganism upon admission to ward or ICU, not met = no documentation of every consumable microorganism upon admission to ward or ICU			Use a weekly microbiology ward round. Can call for advice when needed but no
RECOMMENDATIONS					
1	Patients should be screened for carriage of MRSA and/or carbapenemase-producing organisms according to locally determined proportion. Sensitivity of risk factor algorithms is generally low and universal screening is preferable in highly endemic regions.	met - done > 95% of the time - partially met 85-95% of the time, unmet - <85% or no data or not done	2	3-Fully met	All admissions screened.
2	Patients with MRSA carriage or infection should receive topical suppression to reduce shedding and, if possible, single-room isolation.	met / unmet	2	3-Fully met	MRSA protocol commenced, side room where possible otherwise barrier nursing
3	Patients with diarrhoea and airborne infections should take precedence over others in allocation of single-room isolation. Patients with suspected or confirmed influenza should be placed in single rooms appropriate for respiratory isolation.	met / not met	2	3-Fully met	
4	Design of new units should include infection control specialists as part of the planning team. In particular, the bed spacing, proportion of single rooms and provision of sinks should be considered according to patient case-mix, national guidelines and prevalence of multi-resistant infections.	met / not met / not applicable	3	Not applicable to Unit	
5	The intensive care team should have access to an infection control and prevention team led by a microbiologist who can offer timely review and advice. Ideally, this should be part of timetabled microbiology rounds during the week. The microbiologist will advise on the onset and duration of antimicrobial chemotherapy in accordance with local formulary as a part of antibiotic stewardship.	met / not met	2	3-Fully met	Weekly rounds and on-call 24/7.
6	Infection control nursing staff or intensive care nurses with infection control training should be available to provide day-to-day advice on prevention of spread of infection, isolation priority and procedures and decontamination. Allocation of patients to single-room isolation for known or suspected infection should be reviewed on admission and frequently thereafter.	met / not met	1	Partially met	Not available at weekends
7	There should be a means of continuous improvement in infection prevention and control, for example using surveillance and feedback.	met = formal audit and review process in place / unmet	2	3-Fully met	
3.5 Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology.					
STANDARDS					
1	There must be daily input from microbiology.	Met = 7/7, partially, 5/7 plus on call, unmet if less	1	Partially met	Weekly ward rounds. Available when needed?
2	There must be local antimicrobial prescribing guidelines in accordance with the principles of antimicrobial stewardship.	met / not met	2	3-Fully met	HB Policy
3	Clear protocols must be in place for management of massive haemorrhage including the role of laboratory services.	met / not met	2	3-Fully met	HB Protocol



4	Acutely ill patients must have access to diagnostic radiology services at all times including timely access to a radiologist.	met / not met	2=Fully met	
5	All imaging investigations must be reported within an agreed timeframe relevant to the investigation by someone appropriately trained. All imaging investigations need to be accompanied by a formal, permanently recorded report covering the entirety of the investigation.	met / not met	2=Fully met	
6	There must be seven-day availability of radiology services, appropriate to the specialties being cared for, to allow timely investigation of critically ill patients. This would include, for example, ultrasound and CT-scanning to aid sepsis diagnosis and source control; and in neurocritical care units, access to interventional radiology.	met = full service 7/7, partially = 7/7 service but some elements not always available (eg 7/7 reporting but interventional service only daytime), unmet = <7/7 service	2=Fully met	Occasionally there have been times where radiological intervention has not been
RECOMMENDATIONS				
1	Microbiology advice should be from an adequately senior clinician, and oral, face-to-face interaction is encouraged.	Met / not met	2=Fully met	
2	Critical or unexpected results of clinical pathology, microbiology or radiological investigations should be actively communicated to a responsible clinician according to local fail-safe policies.	policy in place = met, no policy = not met	2=Fully met	HB Policy
3	Urgent clinical chemistry and haematology advice should be available within 60 minutes from an appropriate specialist and a radiologist should be immediately contactable to support the management of acutely ill patients at all times.	met / not met	2=Fully met	HB Policy
4	All point of care laboratory devices used to assist clinical decision making should be subject to appropriate quality assurance mechanisms, agreed by laboratory and end-users.	met = fully centralised lab standard QA process in place with audit evidence, partially = some QA process with intermittent audit, unmet = no laboratory standard QA process	2=Fully met	
5	Clear protocols for access to radiology services that are not available on site (e.g. interventional radiology, MRI in ventilated patients) should be available.	met / not met	3=Not applicable to Unit	
6	Liaison psychiatry services should be available in all acute hospitals with a single point of referral. Emergency mental health referrals should be seen within one hour of referral and urgent mental healthcare referrals within 24 hours of referral (within the liaison team's usual operating hours).	met = available and meets time criteria, partially = available but not <1h <24h, not met = not available	1=Partially met	
7	Patients who have self-harm, irrespective of the apparent motivation, should have a comprehensive psychosocial assessment. This should generally be the responsibility of the liaison psychiatry service and should not be delayed until after medical treatment is complete unless the patient's treatment is necessary, or the patient is unresponsive or otherwise incapable of being assessed.	met / not met	3=Not met	Patients must be medically fit for crisis team assessment
8	Liaison professionals should be available to advise on issues around mental capacity and there should be working arrangements detailing who is responsible for assessing patients who may need to be detained under mental health legislation.	met / not met	2=Fully met	
3.6				
Rehabilitation				
STANDARDS				
1	The rehabilitation needs of all patients must be assessed within four days of admission to intensive care (or on discharge if sooner) and a rehabilitation plan outlined by all relevant therapy professions is clinically indicated.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) - unmet	2=Fully met	
2	Patients receiving rehabilitation must be offered therapy by the multi-professional team across a seven-day week and of a quantity and frequency appropriate to each therapy, in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	all rehab needs met 7 days a week = met, all rehab needs met 5 days per week = partially met, rehab needs not met consistently = unmet	1=Partially met	
3	All patients must be screened for delirium at least daily, and when changes or fluctuations in behaviour occur, in the event of a positive delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors discussed.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) - unmet	2=Fully met	
4	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) - unmet	3=Not met	
5	Patients who stay in critical care for more than four days and are at risk of morbidity must have their ongoing rehabilitation needs addressed at post discharge follow-up, or in the community setting, at two to three months after discharge from critical care. At this point, additional referrals to any necessary services can be made.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) - unmet	3=Not met	
6	Adults at risk of poor quality recovery must have an individualised rehabilitation plan documented in their formal handover of care when transferred from critical care to a general ward. All members of the care team must be aware of this. Patient involvement in setting this rehabilitation plan should be encouraged as far as feasible and appropriate.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) - unmet	2=Fully met	
7	Adults who were in critical care and at risk of poor quality recovery must be given information to explain what they can do to help their recovery. This information should be provided, at the latest, before discharge from hospital.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) - unmet	2=Fully met	
RECOMMENDATIONS				
1	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per week, provision should be made for other therapy services to be provided as needed at weekends.	met 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet	1=Partially met	
2	Specialist rehabilitation co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to ensure that assessments, referrals and documentation are completed and transferred to ongoing services and teams.	met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doesn't exist	3=Not met	
3	The role of therapy support workers or rehabilitation assistants should be considered as part of the rehabilitation team; these roles may be uni-professional or multi-professional in nature and recruited from nursing or allied health backgrounds. These may enable enhanced delivery and increased efficiency of rehabilitation service delivery, as well as ongoing rehabilitation to be delivered following discharge from critical care. Further work is required to determine the appropriate models of these roles.	Statement		
4	Rehabilitation outcomes should be monitored and progression made using outcome measures appropriate for the stage of recovery, individual therapy, and dependent on local resources (including personnel, equipment, and finance).	met = rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially = on only, unmet = no expression monitoring	2=Fully met	Check with Monon and Tom
5	The rehabilitation plan that forms part of the handover of care on discharge from critical care should address all relevant domains for individual patients including, but not restricted to, physical, functional, communication, social, spiritual, nutritional and psychological.	met / not met	2=Fully met	
6	To facilitate the rehabilitation component of the formal handover of care on discharge from critical care to a general ward, weekly multidisciplinary rehabilitation ward rounds should be led by a senior member of the critical care multi-professional team and result in an update to the rehabilitation goals. These should be set in conjunction with the patient and/or carer where appropriate.	met / not met	3=Not met	
7	Expectations of both patients and families should be identified regularly and addressed in a consistent manner by the most appropriate senior member of the team. All patient and family communication should be centrally documented to ensure that it can be accessed easily by all team members.	met / not met	2=Fully met	
8	For high-risk/complex patients, capturing the experience for the patient and family in a manner that they can reflect upon and engage with during the time spent in hospital should be considered. This may take the form of diaries, either paper or electronic, and may include photos, videos and written information. This material may be collected prospectively or retrospectively depending on the desire of patient and family.	met / not met	2=Fully met	
3.7				
Intensive Care Follow Up				
STANDARDS				
1	Patients with higher risk of morbidity related to critical illness must be given information about ongoing rehabilitation goals in the community.	met = all patients provided with rehab goals, partially = selected patients, unmet = none	1=Partially met	
2	Patients discharged from the critical care unit must have access to an intensive care follow-up programme, which can include review of clinical notes, patient questionnaires to assess recovery and an outpatient clinic appointment two to three months' post hospital discharge if required for specific patients.	met / not met	3=Not met	
RECOMMENDATIONS				
1	The follow-up programme should be formally and clearly communicated to the patient and their relatives on discharge from critical care, and again on discharge from hospital. Primary care should also be informed through the discharge summary.	met = all patients, partially = selected patients, unmet = none	3=Not met	
2	The follow-up programme should ensure the delivery of structured and supported self-directed rehabilitation to all patients at critical care discharge and at hospital discharge.	met = all patients, partially = selected patients, unmet = none	3=Not met	
3	A minimum 20-30 minute follow-up appointment should be offered two to three months after hospital discharge if appropriate. The follow-up team should include an intensive care consultant, intensive care nurse, clinical psychologist, physiotherapist, dietician and occupational therapist according to the individual patient's needs.	met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none	3=Not met	
4	Selection of patients for follow up should be based on length of stay (more than three days) or at increased risk (e.g. following anaesthesia, or post-pneumonia intensive care). Self-selection of patients should also be facilitated.	met / not met	3=Not met	
5	Follow up should involve actively seeking common physical sequelae, such as weakness, weight loss and sexual dysfunction, and the consequences of critical care unit-related procedures (e.g. tracheostomy).	met / not met	3=Not met	
6	Review of current medication should be performed and rationalised with input from pharmacy if required.	met / not met	3=Not met	
7	Psychological sequelae (such as anxiety, depression, nightmares and post-traumatic stress disorder) should be sought via screening tools e.g. Hospital Anxiety Depression Scale (HADS), and UK Post Traumatic Stress Syndrome score (UK PTSS-14). This could be facilitated by review of clinical notes with patients and family or patient diary, use of screening questionnaires and review by a clinical psychologist.	Met = screening process in place for psychological seq for all patients, partially = for selected patients, unmet = no screening	3=Not met	
8	Following structured review, appropriate referrals to other services may be required and should be arranged where required.	met= referral from clinic / not met = referral via GP	3=Not met	
9	A bereavement follow-up service should be offered where explanations of diagnoses, treatments and support can be provided.	met / not met	3=Not met	
10	The establishment of a critical care patient and relatives support group should be encouraged.	met / not met	1=Partially met	Established pre COVID but not sustained during
11	Patients and relatives should be surveyed regularly and this information should be utilised to assess rehabilitation and follow-up services.	see other standards	3=Not met	
3.8				
The Patient and Relative Perspective				
STANDARDS				
1	All patients must be regularly assessed for the presence of pain which should be managed with a protocolised multimodal analgesic regimen.	met = all elements done, relatives provided with written info, Partially met = some elements done or not at all families, not met = not done	2=Fully met	
2	The effects of delirium must be explained to patients and their families and this should be emphasised in follow-up visits post critical care.	met = Unit has guideline/protocol for delirium prevention/management that includes these measures and is included in induction training for staff / not met	1=Partially met	
3	Written information about delirium must be provided.	met = guideline in place and done, partially met = some elements but not comprehensive or systematically applied, not met = not done	2=Fully met	
4	Critical care staff must offer patients ways to help improve the quality of their sleep, for example eye masks and ear plugs. Staff must try to minimise light and noises during the night.	met = written and >75% families having a formal documented communication, partially 50-75%, unmet = no written info and/or <50% having formal communication	3=Not met	
5	Patients and families must be given high quality verbal and written information while the patient is in critical care (such as information about the patient's treatment, what the patient might experience and how they might feel) and when they leave the unit (to help explain what has happened to the patient and what might help them in their recovery). Each unit must have such documents readily available and needs for patients and relatives. Young visitors and their parents will need specific support.	met = SLT involved and have full range of communication aids available / partially met = limited access to speech and language / not met	3=Not met	
6	Patients must be given help to communicate (e.g. speaking valves for patients with a tracheostomy, voice boards or flash cards).	met / not met	2=Fully met	
7	Critical care units must have policies about how to safeguard vulnerable adult patients.	met / not met	3=Not met	
8	Units must obtain regular feedback about the care that patients and relatives received during their critical care admission in order to learn from and act on the feedback received.	met / not met	3=Not met	
RECOMMENDATIONS				
1	Intensive care patients should have a patient diary.	met = >80% patients >48h stay, partial = only longer stay or <80%, unmet no diary	2=Fully met	
2	Understanding the individual who has become critically ill is important to help their treatment and recovery. A 'This is Me' board or document for each patient is very beneficial and should be used if possible.	met / not met	1=Partially met	
3	Intensive care and ward staff should have training in what intensive care is like for patients and relatives and what challenges patients face while in intensive care and during their rehabilitation. Asking former patients and relatives to help with this training is beneficial.	met / not met	3=Not met	
4	Intensive care staff should let relatives know how they can help the patient, for example by talking to or reading to the patient (even if the patient is unconscious or sedated), as a familiar voice can be reassuring. Relatives should also be allowed to help with simple aspects of caring for the patients, if they would like to, such as applying hand cream or brushing hair. Written information should be provided for relatives.	met / not met	2=Fully met	
5	Intensive care staff should spend time talking to the patient and relatives, seeing how they feel, asking about any worries they have and checking their understanding of any information that has been given. Clear information should be given to relatives regarding when they can visit.	met / not met	2=Fully met	
6	A room should be provided for relatives to wait in or have time away from the unit. This room should be comfortable and its facilities regularly reviewed. Feedback should be sought from families whether additional facilities and support are required.	met = relatives room, partially met, relatives room but poor facilities, not met = no dedicated relatives room	2=Fully met	
7	On discharge from the critical care unit, patients should be given the contact details of the healthcare professionals who are co-ordinating the patient's rehabilitation pathway.	met / unmet	3=Not met	
8	All patients should be visited by a critical care outreach team, who can help with the transition from Critical Care to ward this transition.	met / not met	2=Fully met	
9	Intensive care patients should have access to formal support provided by the critical care service after they leave. ie critical care followup / outreach services.	met / not met	2=Fully met	
10	Critical care units should provide relatives of patients who died in intensive care the opportunity of a follow-up meeting with an ICU staff member to discuss any questions they may have about their relative's time on the unit. Families may be given a leaflet after their relative dies in order that they can arrange a meeting at a later date if they wish to. It can also include other sources of support. Some units hold memorial services for relatives.	met / not met	3=Not met	Work underway to develop bereavement pathway supported by Clinical Psych
3.9				
Staff Support				
STANDARDS				
1	All units must have policies in place to support staff engagement and retention.	met / not met	2=Fully met	
2	Induction and escalation policies must be clearly identified for all staff groups.	met / not met	2=Fully met	
3	100% of new staff must receive a job-specific induction to the unit.	met / not met	2=Fully met	
4	Workplace equity within staff groups must be transparent (e.g. rostering, annual leave policies, job plans). Staff must be aware of the policies.	met / not met	2=Fully met	

5	Staff well-being is an organisational priority. Units must monitor and regularly review metrics of staff well-being as quality indicators (e.g. sickness rates).	met - quarterly , partially met 1-2 yrs, unmet - not monitored or more than 2 yearly intervals	2-Fully met	
6	All staff must have opportunities for personal development reviews including annual appraisals.	met - > 85% of staff appraised / PDP done, Partially met 75-85% not met < 75% of staff	2-Fully met	
7	All staff working in critical care must be able to access the Freedom to Speak Up Guardian.	met / not met	1-Not applicable to Unit	Not specifically to this title - but regular meetings to encourage feedback.
8	Staff must be provided with adequate resources consistent with other GPCSC standards to deliver their job role, e.g. adequate staffing, access to facilities for nutrition and hydration, adequate equipment.	Statement		
9	Staff rostering must comply with Health and Safety Executive recommendations for sleep and rest.	met / not met	2-Fully met	
10	Units must provide adequate workplace facilities for staff breaks, which are separated from areas for relatives.	met / not met	2-Fully met	Need to improve size of break rooms
<b>RECOMMENDATIONS</b>				
1	All staff engaged in a managerial or leadership role should have access to appropriate mentoring and/or coaching services to support them in their role.	met / not met	2-Fully met	
2	All units should promote healthy rest and sleep policies for staff required to work overnight.	met / not met	2-Fully met	
3	All staff members should have access to an independent, professional psychological support service, which provides counselling services.	met / not met	2-Fully met	
4	All staff members should have self-referral access to an occupational health service and rapid access physiotherapy services.	met / not met	2-Fully met	
5	All units should provide frequent opportunities for shared learning, clinical communication, and reflection, to reduce professional isolation. This includes routine clinical practice (e.g. multidisciplinary rounds, mortality and morbidity meetings), as well as specific reflective events (e.g. Schwartz Centre Rounds, debriefing following medical emergencies).	met / not met	2-Fully met	
6	All staff should have ergonomic clinical work areas with appropriate access to light and control of noise.	met / not met	2-Fully met	
7	All staff should be supported to maintain a healthy lifestyle, e.g. provision of advice on diet and exercise.	met / not met	2-Fully met	
8	All units should conduct regular (at least annual) reviews of organisational policy on staff health and well-being.	met / not met	2-Fully met	HB wide policy
<b>3.10 Inter and Intra Hospital Transfer of Critically Ill Patients</b>				
<b>STANDARDS</b>				
1	Transfer to other critical care units for non-clinical reasons must be avoided where possible.		2-Fully met	
2	Appropriate equipment must be available to undertake a safe transfer and to manage complications/adverse events which may occur during a transfer. All equipment used for patient transfers must conform to the relevant safety standards, be regularly serviced, and checked immediately before use.	met / not met	2-Fully met	
3	All staff involved in a patient transfer must be trained, competent and familiar with the use of equipment.	met / not met	2-Fully met	
4	Where patient transfers result in a change of team managing the patient during or following a transfer, an appropriate and documented handover must be undertaken between the teams to ensure good continuity of care. This should include providing copies of the clinical record.	met / not met	2-Fully met	
5	A named intensive care consultant must take overall responsibility for the decision to transfer a patient and the level of support required, but does not necessarily have to undertake the transfer.	met / not met	2-Fully met	
6	Inter-hospital transfers must be undertaken in a timely fashion according to the patient's clinical condition.	met / not met	2-Fully met	
7	For inter-hospital transfers, there must always be a named consultant who will take responsibility for the patient on arrival at the receiving hospital. This must be agreed prior to the transfer being undertaken.	met / not met	2-Fully met	
8	Where patients have completed specialist care and ongoing intensive care needs can be provided in the patient's home, hospital transfer must take place within 48 hours of referral to the receiving hospital.	Percentage occurring within 48 hours of decision. Met > 85%, partially met 75-85%, not met < 75% of the time or no data collected.	1-Partially met	
<b>RECOMMENDATIONS</b>				
1	Transfers should follow the advice and protocols presented in the latest ICS transfer guidance.	met - meet standard, partially met, dont meet standard but risk assessment in place , not met - dont meet standard and no risk assessment	2-Fully met	
2	The reason for any transfer should be documented in the patient's notes. This should include an assessment of potential benefits against risks. Transfer decisions should only be made by consultant intensive care team members, and this information should also be documented.	met = documented 90%, partially met 80-90%, unmet <80% or no data or not a consultal decision	2-Fully met	
3	An adequately stocked and regularly checked, dedicated transfer bag should be available for use during all patient transfers. This bag should contain appropriate drugs and equipment for interventions that might be required in transit. The transfer bag contents should be checked routinely (ideally daily and a log of checks maintained) or, if sealed with a tag, then a daily check that the seal is unbroken. The transfer bag must be restocked between uses to avoid delays when it is needed. Staff carrying out patient transfers should be familiar with bag layout and content.	met = checked with log and tagged, partially = daily check but not tagged or logged, unmet = no checking or significant deficiencies in it available	2-Fully met	Supported by Operating Theatre
4	The patient's vital signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy any physiological deterioration during the transfer.	met = audit evidence of obs or transfer forms, unmet = no evidence	2-Fully met	
5	Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be scrutinised within a robust audit system, allowing eventful or substandard transfers to be investigated and lessons learnt to be shared widely, as well as numbers and reasons for transfers.	met = use of a network wide agreed form or electronic recording system, unmet = no standard system	2-Fully met	
6	Where an adverse event occurs during a transfer, this should be reported and investigated using the healthcare organisation incident reporting system at the transferring unit. All learning should be widely shared.	met / not met	2-Fully met	
7	Every acute healthcare organisation should have a designated consultant and nurse who are responsible for maintaining standards of transfer of critical care patients, guideline production, training, governance, audit and reporting.	met - both, partially met - one, not met - none	1-Partially met	
8	Training in transfer medicine should be an integral part of Intensive Care Medicine training for doctors and nurses.	Statement		
9	Where multiple teams are involved in a patient's care, appropriate handover should be undertaken between the teams prior to transfer. This should not delay the transfer.	met / not met	2-Fully met	
10	The patient, where possible, and their next-of-kin should be informed of the decision to transfer and an explanation given to them of the need for transfer. This discussion should be documented.	met = 95%, partially = 80-95%, unmet <80% documented	2-Fully met	
11	There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area. The definition of 'delay' will vary according to the reason for the transfer. For patients being transferred from a specialist critical care unit to a general critical care unit at the completion of specialist care, a delayed transfer is one that has not been undertaken 48 hours after the time of referral to the general critical care unit.	met / not met	2-Fully met	
12	Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who are at a high risk of harbouring such infections both during transfer and in the receiving hospital; their availability should be such that this does not delay a patient transfer. Similarly, isolation facilities must be available for immunocompromised patients who require them.	met / not	2-Fully met	
13	Critical care units should have an agreement with their local ambulance providers in relation to the contracted transport provision for intensive care services, and to ensure these standards are met throughout the entire patient pathway.	met / not met	2-Fully met	
14	There should be a system for monitoring the quality of inter hospital transfers and governance arrangements which includes capture of numbers, reasons for transfer, incidents, delayed transfers and outcomes, audit measures and lessons should be widely shared.	met - well established processes, data available, partially met - reviewed, limited data available, not met - data unavailable or not at all	2-Not met	
15	There should be standardised network wide transfer documentation and training programmes.	met = both / partially met = one or the other / not met = neither		
16	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and prevent the adverse impact of transfers on the transferring unit due to loss of key staff.	Statement		
<b>3.11 Care at the End of Life</b>				
<b>STANDARDS</b>				
1	Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and communicated to patients and their loved ones. The latter being of particular relevance if patients lack capacity (below).	met = 98% with clear documentation, partially = 95-98% documented but gaps found in documentation on audit, unmet = <95% or major failures in what is documented	2-Fully met	
2	Decision making surrounding end of life care (EOLC) must be performed in accordance with relevant statutory requirements and professional guidance: a) Mental Capacity Act 2005 (MCA 2005), England and Wales, b) Adults with Incapacity Act (2000), Scotland, c) Mental Capacity Act (Northern Ireland) 2016, d) Human Tissue Act, England, e) General Medical Council's Good Medical Practice: Specifically, Treatment and Care Towards the End of Life, Good Practice in Decision Making.	met / not met	2-Fully met	
3	Declaration of death by cardiorespiratory or neurological criteria must be done in accordance with professional guidance.	met / not met	2-Fully met	
4	Consideration must be made as to whether organ and tissue donation can be offered to every dying patient, and where appropriate the specialist nurse-organ donation (SNOD) should be contacted.	met = considered with audit data on referral rates reviewed quarterly, partially = considered but no audit data or <70% referral rate, unmet = not done	2-Fully met	
5	In order to identify dying patients and respond to changes in their condition, those at high risk of dying must have their condition regularly reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.	Statement		
<b>RECOMMENDATIONS</b>				
1	Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying. Best practice dictates that those close to the patient should also be informed.	met / not met	2-Fully met	
2	Decision making related to care at the end of life should, wherever possible, involve patients and people close to them, as well as medical professionals. If the patient lacks capacity and there is no individual with Lasting Power of Attorney, responsibility for determining treatment rests with treating clinicians. Previous decisions should also be taken into account e.g. treatment escalation plans (TEP), BESTPACT (Recommendation: Patients Give for End-of-Life Care) and treatment.	met / not met	2-Fully met	
3	At least two consultants, supported by senior ICU nursing agreement, should contribute to the process of recommending withdrawal or withholding treatments. Such processes are decided on a case-by-case basis and clarity of communication can be improved by outlining likely benefits and benefits of action or cessation.	met - 7 days per week, partially met 5 days per week.	1-Not met	
4	Once patients are recognised as being in their final days/hours of life, therapeutic goals should be reviewed and accordingly altered to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn. The discussion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is intrinsic to palliative care in critically ill patients. This should be discussed with patients and families within that context. If initiated in emergent situations for incapacitated patients, DNACPR decisions should be discussed with patients' surrogates (as defined by the MCA or equivalent) at the earliest opportunity. The British Medical Association, Resuscitation Council UK and Royal College of Nurses have recently updated guidance on DNACPR.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	1-Partially met	
5	Dying patients should be managed by multi-professional teams that include senior medical and nursing staff from intensive care and reference teams. It may also include specialist palliative care teams.	met / not met	2-Fully met	
6	Therapeutic plans should be made and anticipatory medications prescribed for all patients in their final hours/days of life, enabling prompt symptom control. This includes therapeutic options for analgesia, dyspnoea, anxiety and agitation. Doses should be titrated for symptom relief based on explicit assessments. Where appropriate, the double effect of drugs used should be transparent to patients, staff and family.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	2-Fully met	
7	Care should address dying patients' need for spiritual and emotional support, and include that of their families and others close to them. The needs of loved ones to be with, care for and otherwise attend to dying patients should be met as far as is possible. If appropriate, religious or secular expertise should be sought (e.g. referral to chaplaincy, psychological services or patients' GPs). Staff should also have access to these support services.	met / not met	2-Fully met	
8	If death is considered to be very close, patients should not normally be transferred out of the critical care unit unless it is to facilitate (via discussion with patients and loved ones) significant improvements in care. If practical to do so, patients should be given the opportunity to die at home or in a hospice. All transfers should involve a handover of care and quality of care.	met / not met	2-Fully met	
9	Intensive care clinicians often have a responsibility for decision making and care of acutely unwell and deteriorating patients outside of the critical care unit. When reviewing such patients for potential treatment escalation, they should work with patients' clinical teams to ensure that decisions and communication regarding care at the end of life are made to the same standards as on the critical care unit.	met / not met	2-Fully met	
<b>3.12 Organ Donation</b>				
<b>STANDARDS</b>				
1	If a patient is close to death, doctors must explore with those close to them whether they had expressed any views about organ or tissue donation. Doctors must follow any national procedures for identifying potential organ donors and, in appropriate cases, for notifying the Specialist Nurse-Organ Donation (SNOD).	met = routinely done with collaborative requesting when possible, partially met = routinely done but not with collaborative requesting, unmet = poor results on referral rates	2-Fully met	
2	The National Institute for Health and Clinical Excellence guidance requires that the intensive care team caring for the patient should initiate discussions about potential organ donation with the SNOD whenever a patient meets the criteria for undertaking the tests, to confirm death using neurological criteria or when there is an intention to withdraw life-sustaining treatment in patients with a life-limiting or life-limiting condition which will, or is expected to, result in circulatory death.	met >85% of the time, partially met 75-85% of the time, un met <75% of the time or no data collected.	2-Fully met	
3	Critical care units must comply with the criteria for diagnosing death using neurological or circulatory criteria as set by the Academy of Medical Royal Colleges.	met / not met	2-Fully met	
4	All units must contribute data to the national potential donor audit.	met / not met	2-Fully met	
<b>RECOMMENDATIONS</b>				
1	Each acute hospital should have an Organ Donation Committee to oversee all aspects of deceased organ donation as recommended by the Department of Health's Organ Donation Taskforce. Funding for the committee's activities is provided by NHS Blood and Transplant (NHSBT).	met / not met	2-Fully met	
2	Each acute hospital should have a clinical lead for organ donation (CLiOD) funded by NHSBT, with responsibility to implement organ donation policies, promote the adoption of best practice guidelines and to address any local barriers to donation.	met / not met	1-Partially met	Clinical lead shared across 2 hospitals
3	Each critical care unit should have a dedicated SNOD employed by NHSBT to provide advice on all issues relating to donation, organise organ coordination, support the intensive care staff in donor management, complete the potential donor audit, engage in teaching and training and support donor families.	met / not met	1-Partially met	SNOD x 2 shared across 4 hospitals
4	Guidelines on end of life care and withdrawal of life-sustaining treatments (WLST) should be compliant with the Mental Capacity Act 2005, and based on the guidance provided by the General Medical Council, and should be followed irrespective of any potential for organ donation. Determining best interests at the end of life should include an assessment of a patient's preferences and wishes regarding organ donation. Guidance on decisions regarding WLST in patients with devastating brain injury (DBI) should be based on the recommendations of FICMWS and other professional bodies.	met / not met	2-Fully met	
5	A planned and collaborative approach to the family for organ donation between the intensive care team and the SNOD team should be routine practice as recommended by NICE in 2016.	met / not met	2-Fully met	

6	Consultants in Intensive Care Medicine should actively manage brain stem dead consented donors to optimise organ quality and increase the number of organs successfully retrieved and transplanted. Donor optimisation care bundles or protocols should be available and used.	met / not met	2=Fully met	
7	The intensive care team should manage resources flexibly to facilitate organ donation and/or end of life care for patients outside the critical care unit whenever appropriate.	met / not met	2=Fully met	
3.13 Legal Aspects of Capacity and Decision Making				
STANDARDS				
1	Units must have regular, minuted, multidisciplinary team meetings to review cases where dispute have or may have arisen.	met / not met	2=Not met	
2	All patients must be presumed to have capacity to consent or withhold consent.	Statement		
3	If the patient has made a valid and applicable Advance Decision Refusing Treatment (ADRT), it must be respected (although an ADRT does not have formal legal standing in Scotland, they are likely to be highly persuasive to the court).	Statement		
4	Final determination of capacity for a specific treatment must be made by the treating clinician and documented.	Statement		
5	If a patient has capacity, their decision must be respected, even if the treating clinician considers the decision to be unwise.	Statement		
6	Patients who lack capacity must only be treated in their best interests (England & Wales) or if it is of benefit to the patient (Scotland).	Statement		
7	Determination of best interests/benefit must involve consultation between the treating consultant and individuals close to the patient (family and friends).	Statement		
8	The aim is to achieve consensus between team and family/friends as to what is in the best interests/benefit to the patient. When there is continued disagreement about best interests/benefit, the treating clinician must not act unilaterally.	Statement		
9	If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application must be made.	Statement		
RECOMMENDATIONS				
1	A written departmental protocol for resolution of disagreements should be in place. Disagreements may be within the team, between different clinical teams or between team and family/friends.	met / not met	1=Partially met	Hospital policy on raising concerns from families
2	An ADRT that does not meet the criteria to be formally legally binding should nevertheless be taken into account as part of the best interests assessment as a strong indication of the patient's wishes and opinions.	Statement		
3	In situations of intractable disagreement, mediation should be considered prior to approaching the Court of Protection (England & Wales)/Court of Session (Scotland). NHS Resolution or the Civil Mediation Council provide access to individual mediators or recognised experts.	Statement		
4	Independent Mental Capacity Advocates (IMCA) should be consulted (in England and Wales) when a patient is 'unbefriended'. This only applies when there is no one who can be consulted about best interests, i.e. no family or friends. IMCAs should not be consulted because there is dispute about best interests between the medical team and family.	Statement		

Section 4		CRITICAL CARE SERVICES: CLINICAL CARE		Level description	Level	Comments
4.1 Respiratory Support						
STANDARDS						
1	Units must have access to sufficient modern invasive and non-invasive ventilators which will support pressure/volume controlled ventilation, titration of inspired oxygen concentration, support spontaneous ventilation and allow application of PEEP	met / not met		2+Fully met		
2	Pulse oximetry, capnography, ECG, blood pressure monitoring and ventilator alarms must be used for all ventilated patients whose trachea is intubated	met / not met		2+Fully met		
3	An accurate height must be measured on admission for every patient requiring invasive mechanical ventilation to calculate predicted body weight (PBW) and corresponding target tidal volume to allow protective ventilation (limiting PBIW in those with ARDS or at risk of ARDS)	met / not met		2+Fully met		
4	Units must have evidence based, written guidelines covering the use of non-invasive ventilation, the management of ARDS, prevention of ventilator associated pneumonia and sepsis from ventilation including the use of sedation	met	guidelines for all and review date within last 3 years, partially met - one or more guidelines missing or not reviewed within the last 3 years, not met - limited guidelines and/ or older than 3 years	1+Partially met		
5	Referral pathways for patients with severe but potentially reversible acute hypoxicemic respiratory failure must be in place with Regional Extra-corporeal Membrane Oxygenation-capable (ECMO) Centres	met / not met		2+Fully met		
6	Units must have written guidelines on the indication, risks and practice of prone positioning in hypoxicemic respiratory failure	met / not met		2+Fully met		
7	Units must have immediate access to point-of-care testing to enable arterial blood gas analysis	met	met needs machine on site or within easy reach, with a backup within 1 mile or within 30 minutes, partially met - no ABG machine with backup machine 5-30 minutes away or 24/7 on call repairs within 30 mins, unmet = no on	2+Fully met		
8	Standard operating procedures, including checklists, should be developed for intubation, extubation, bronchoscopy, prone positioning, tracheostomy and any high risk/invasive procedures	met	guidelines for all and review date within last 3 years, partially met - one or more guidelines missing or not reviewed within the last 3 years, not met - limited guidelines and/ or older than 3 years	2+Fully met		
9	Non-invasive ventilation must be considered and available for patients with acute hypoxicemic respiratory failure	met / not met		2+Fully met		
10	High-flow nasal oxygen must be available for the management of patients with acute hypoxicemic respiratory failure	met / not met		2+Fully met		
RECOMMENDATIONS						
1	Total volume (ml/kg PBW), plateau airway pressures and cumulative fluid balance should be monitored and recorded daily in all patients requiring invasive ventilation	met	all recorded daily, partially met - one / two not recorded daily, not met - more than two not recorded	2+Fully met		
2	Audit of compliance with ARDS, ventilator associated pneumonia and weaning guidelines should be undertaken quarterly	met / not met		0+Not met		
3	Units should have standardised systems to monitor VAP rates and antibiotic resistance patterns	met / not met		0+Not met		
4	There is insufficient evidence at present to inform clinicians about the role of Extracorporeal Carbon Dioxide Removal (ECCO2R) in acute hypoxicemic respiratory failure and ARDS. Patients should only receive ECCO2R within the governance framework set out in NICE guidance	met / not met		0+Not met		
4.2 Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services						
STANDARDS						
1	Level 3 units must have access to a regional home ventilation and weaning unit. Arrangements must be in place to collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex weaning problems to the Regional Centre	met / not met		2+Fully met		
2	Units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity	met / not met		1+Partially met		
RECOMMENDATIONS						
1	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or neurological co-morbidities. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure	met / not met		0+Not met		
2	Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietitian members	met	full MDT routinely used, partial = 1-2 MDT professions not routinely involved	1+Partially met		
3	These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols	met	protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols in place/not reviewed in last 2 years	0+Not met		
4	Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and resources to provide these services as described in the section of this document on rehabilitation (Chapter 3.6)	met / not met		0+Not met		
5	The use of non-invasive ventilation (NIV) as a bridge to spontaneous breathing should be considered in selective groups. Resources and staff in NIV should be available in all units managing patients with prolonged ventilation needs	met / not met		2+Fully met		
6	Early discussion with regional domiciliary ventilation services should occur in any patient with chronic neuromuscular impairment, and in those requiring more than 21 days of ventilation. Regional weaning centres should offer advice to referring units to assist with weaning	met / not met	NA if no regional weaning service	0+Not met		
7	The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation centres and protocols should be in place to aid these decisions	met / not met	NA if no regional weaning service	2+Fully met		
4.3 Renal Support						
STANDARDS						
1	Critical care units must have the necessary facilities and expertise to provide acute RRT for patients with AKI on a 24/7 basis	met / not met		2+Fully met		
2	Patients receiving acute RRT, where the cause of AKI is unclear or where RRT will be needed on intensive care discharge, must be discussed with the local renal team as per the NICE guideline	met / not met		2+Fully met		
3	Patients receiving acute RRT must be cared for by a multi-professional team that is trained and experienced in delivering and monitoring RRT	met / not met		2+Fully met		
4	Acute RRT for patients with progressive or severe AKI must be started before the onset of life-threatening complications associated with renal dysfunction	met / not met		2+Fully met		
RECOMMENDATIONS						
1	The decision to initiate RRT should be based on the condition and prognosis of the patient as a whole, and not on isolated urea or creatinine values as per Kidney Diseases Improving Global Outcomes (KDIGO) recommendations and the NICE guideline	met / not met		2+Fully met		
2	Where life-threatening complications of AKI occur, such as intractable hyperkalaemia, RRT should be started emergently unless a clinician has made note to escalate therapy	met / not met		2+Fully met		
3	Patients with end-stage renal failure who are not in a renal unit/dialysis centre and require urgent RRT may require critical care admission. In such cases, there should be close liaison with the regional renal service regarding transfer and vascular access	met / not met		2+Fully met		
4	Continuous and intermittent RRT should be considered as complementary therapies for AKI. The choice of therapy should be based on patient status, expertise of the clinical staff and availability of machines	met / not met		2+Fully met		
5	The dose of RRT should be prescribed at the beginning of the RRT session. It should be reviewed daily and tailored to the needs of the patient	met	met = clear standardised RRT prescription with evidence of daily review and audit, partial = done but not clearly evidenced, no audit, unmet = no standardised RRT prescription	2+Fully met		
6	The decision to use anticoagulation to maintain circuit patency and the choice of anticoagulant should be based on the potential risks and benefits in an individual patient, the expertise of the clinical team and the options available. KDIGO guidelines suggest using regional citrate anticoagulation for CRRT rather than heparin in patients who do not have contraindications for citrate	met	citrate anticoagulation should be available Met/unmet	2+Fully met		
7	Bicarbonate, rather than lactate should be used as a buffer in dialysate and replacement fluid for acute RRT	met / Partially met	met = daily prescription chart but compliance not audited / not met			
8	Drug dosing may need adjusting whenever RRT is started or the RRT prescription is altered. Close collaboration with an intensive care pharmacist with suitable experience in AKI and the effects of RRT is essential	met / not met		2+Fully met		
9	Patients treated with acute RRT should receive standard enteral nutrition as long as there are no significant electrolyte abnormalities or fluid overload refractory to RRT	met / not met		2+Fully met		
10	When discharged from critical care, the accepting team and GP should be informed that the patient had received RRT for AKI while in intensive care so that appropriate follow-up arrangements can be made	met / not met		2+Fully met		
4.4 Gastrointestinal Support and Nutrition						
STANDARDS						
1	The type and position of nasogastric feeding tubes (NGTs) used for enteral feeding, hydration and/or drug administration, must comply with NICE improvement guidelines	met / not met		2+Fully met		
2	Intensive care services must have a nutrition support guideline with institutional strategies to promote nutrition delivery and to overcome EN intolerance. It is suggested that it should include: a) Measures to minimise the risk of EN aspiration, b) Criteria for the use of prokinetic medications, c) Criteria for naso-jugal feeding, d) Criteria for use of parenteral nutrition, e) Consistent times for stopping and restarting EN around anaesthetic, surgical or bedside procedures and f) A protocol for initiation of nutrition without weaning for a defined start	met	met = clear guideline in place meeting these criteria, partial = guideline in place with some omissions or >3y since review, unmet = no guideline or fails many of these criteria	1+Partially met	New guidelines is underway as part of all Wales ICU systems	
3	Intensive care services must have guidance in place relating to the identification of, and nutrition support for, those at risk of re-feeding syndrome	met	met = clear guideline in place meeting these criteria and audit evidence, partial = guideline in place with some omissions or >3y since review or no audit evidence, unmet = no guideline or fails many of these criteria	1+Partially met	Guidance needs updating	
4	Intensive care services must ensure that there is access to a range of parenteral nutrition bags which include vitamins, trace elements and minerals. A standard bag of parenteral nutrition must be available within 24 hours	met	met = all elements listed, partial = TPM available but limited range, unmet = not available or a single standard bag only available	1+Partially met	Limited range	
5	Intensive care services must have access to a range of enteral nutrition products to include: a) Low electrolyte, b) High protein, c) Fluid restricted and d) Tolerance (semi elemental)	met / not met		2+Fully met		
RECOMMENDATIONS						
1	Nutritional status and risk should be assessed on admission, and energy, protein and micronutrient needs determined by a critical care dietitian or clinician with appropriate specialist training or experience	met / not met		2+Fully met		
2	It is recommended that nutrition support (PN if EN is not possible) should be instigated within 48 hours in patients expected not to be on a full oral diet within three days	met / not met		2+Fully met		
3	Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them	met / not met		2+Fully met		
4	Efforts need not be made to cover full energy targets with EN or PN until clinical stability has been achieved. Delivering a calorie load which exceeds energy expenditure appears harmful and should be avoided, whereas hypocaloric nutrition may be safe initially	met / not met		2+Fully met		
5	The energy content from certain drugs (e.g. Propofol, IV glucose and citrate anti-coagulation renal replacement therapy) should be accounted for in total caloric provision	met / not met		2+Fully met		
6	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines	met / not met		2+Fully met		
7	Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly infusion rate of EN to optimise delivery after interruptions	met / not met		0+Not met	Will be part of WIGS	
8	There should be access to nasal bridges to secure NGTs in agitated patients and guidelines for their use and aftercare	met / not met		0+Not met	No bridges in HB	
9	Nutrition support targets should be included in the rehabilitation of critically ill patients	met / not met		2+Fully met		
10	There should be bowel management guidelines which include: a) Regular monitoring and documentation of bowel habits (frequency & type), b) Minimising the use of drugs that can cause constipation or diarrhoea, c) The need for rectal examinations and treating faecal loading/impaction, d) When to use laxatives, enemas and suppositories, e) Management of ileus	met	met = bowel management guideline and audited, partially met = protocol but not audited, unmet = no guideline	0+Not met	No guidelines in place for this	
4.5 Liver Support						
STANDARDS						
1	Contact with regional liver and/or liver transplant centre must be made early following admission to a critical care unit of a patient with ACUTE liver failure. Advice about management, prognosis and possible transfer can be discussed	Statement				
2	Patients with ALF must be managed in a liver transplant centre if liver transplantation is clinically indicated	Statement				
RECOMMENDATIONS						
1	Patients with liver failure plus any other organ dysfunction should be managed in a critical care environment. Attention should be made to cardiovascular support, control of coagulopathy, acid or relative hypocalcaemia, early renal and metabolic support	met / not met		2+Fully met		
2	Sepsis is very common in patients with liver failure and intravenous antibiotics should be prescribed in any patient with a suggestion of sepsis on admission to critical care. The choice of antibiotic will be driven by knowledge of local microbiological flora and resistance patterns	met / not met		2+Fully met		
3	The use of prophylactic blood products and other procoagulant products prior to interventions should be avoided. In general, patients with liver failure develop a balanced coagulation disorder. Both pro- and anti-coagulant protein production is reduced. Viscoelastic tests, such as thromboelastography or ROTEM, may help in management	met	met = thromboelastography available, partially, principles followed but no TE available, unmet	1+Partially met		
4	Patients with ALF should have access to plasma exchange therapies	met / not met / not applicable		0+Not met		
5	Where there is no immediate access to haemofiltration, haemodiafiltration or haemodialysis, severe hyponatraemia, severe metabolic acidosis, severe hypertension being a recognised complication in patients with ALF. Strategies to monitor and manage ICH should be available in	met / not met / not applicable		2+Fully met		
6	Advice should be sought from a specialist hepatologist for help with diagnosis, specific therapies and prognosis	met / not met		2+Fully met		
7	Centres managing liver failure and liver trauma should have access to interventional radiologists	met / not met / not applicable		3+Not applicable to Unit		
8	Links should be made with regional centre providing transjugular intrahepatic portosystemic shunt (TIPS) for patients with bleeding varices	met / not met		0+Not met		

9	Units that manage patients with liver failure should have 24-hour access to both diagnostic and therapeutic upper GI endoscopy services.	met = both, unmet if not available or no intervention available	1=Partially met	
10	Drug dosing may need adjusting in patients with liver failure. Close collaboration with an intensive care pharmacist with suitable experience in liver failure is essential.	met / not met	2=Fully met	
<b>4.6 Cardiovascular Support</b>				
<b>STANDARDS</b>				
1	Electrocardiography, chest X-Ray and transthoracic echocardiography (includes focused echo) although expertise may not be in unit and could be provided by other specialty such as cardiology, must be available at all times at the patient's bedside.	met = all available, partial = echo availability in hospital 24/7 but not always on unit, unmet = no echo available	1=Partially met	
2	A consultant cardiologist must be available at all times either locally or through a formal network.	met / not met	1=Partially met	
3	Adults with acute heart failure must be reviewed within 24 hours of admission by a dedicated specialist heart failure team (or equivalent), and their management should follow the guidelines detailed in the NICE Quality Standards.	met / not met	0=Not met	
4	Protocols for immediate transfer to a facility able to provide percutaneous revascularisation of patients presenting a myocardial infarction must be in place.	met / not met	2=Fully met	
5	The intensive care team must facilitate the implementation of national standards, guidelines and pathways pertaining to the patients with a cardiac disease to be delivered in addition to the other organ support being provided.	met / not met	0=Not met	
6	The advanced management of patients with acute valvular insufficiency or acute heart failure secondary to valve disease must be guided in consultation with a local cardiologist and the specialist cardiological surgical unit.	met / not met	0=Not met	
<b>RECOMMENDATIONS</b>				
1	A validated method for advanced haemodynamic assessment with a skilled operator in both the practical use of the device and interpretation of the data it provides should be available at all times.	met / not met	2=Fully met	
2	An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.	met / not met	0=Not met	
3	Local protocols in the use of vasoactive drugs should be in place, although there is little evidence to support the use of any single agent to practice.	met / not met	0=Not met	
<b>4.7 Echocardiography and Ultrasound</b>				
<b>STANDARDS</b>				
1	The gold standard investigation is a comprehensive study, performed and reported by a fully trained clinical specialist.	Statement		
2	A more limited study, focusing on a specific clinical question, is appropriate in many instances. This must be performed by a trained and competent practitioner.	met / not met	0=Not met	
3	Individuals who scan and report independently must be trained to a level that is appropriate for their clinical practice.	met / not met	0=Not met	
4	The service must have a nominated lead consultant with dedicated time in their job plan that is sufficient to reflect the demands of the service and associated equipment processes.	met / not met	0=Not met	
5	Ultrasound equipment must be readily available, serviced regularly and up to date. There must be sufficient equipment to ensure immediate access for ultrasound guided vascular access at all times. Linear, curvilinear and phased array probes are required to provide a comprehensive ultrasound service.	met=immediate availability (ie on unit) of ultrasound machine for vascular access and rapid access of machine for focused echocardiography / partially = not all elements eg only 1 machine on a large unit / not all probe types met	2=Fully met	
6	Infection control measures must be adhered to at all times.	met / not met	2=Fully met	
7	The disinfection and storage of transoesophageal echocardiography probes must follow national guidelines. A record must be retained in order to identify and track patients after device usage in the event of future complication/infection.	met / not met / not applicable (no TOE)	2=Fully met	
8	All images must be securely stored for quality assurance purposes with appropriate data governance. Retention on the ultrasound machine storage capacity is not a secure method.	met = all images are stored, reviewed by trained echo specialist and uploaded to PACS, partial = uploaded but not reviewed or reviewed but non centralised storage, unmet = images not safely archived in PACS	0=Not met	
9	Whenever scans are performed to inform clinical decision making, a structured report must be generated and stored in the patient record.	met = structured report and audited, with > 90% compliance, partially met reported but not structured, not audited or < 90% compliance, and met = < 90% reported/document in notes	0=Not met	
10	Training scan reports must not be stored in the patient record unless someone suitably trained verifies the document first.	met / not met	0=Not met	
11	Quality improvement, audit, and peer review activity must occur regularly.	Fully met = peer review process at least monthly, partially met = peer review less frequently, not met = no regular system of peer review (includes ad hoc peer review)	0=Not met	
12	Transoesophageal echocardiography (TOE) must be immediately available in all cardiothoracic critical care units and those units providing extra-corporeal circulatory support.	met / not met / not applicable (no TOE)	0=Not met	
<b>RECOMMENDATIONS</b>				
1	All critical care units should be able to ensure the provision of point-of-care ultrasound.	met / not met	2=Fully met	
2	The service should be supported by a fully trained link-person within the cardiology and radiology departments, as appropriate.	met / not met	0=Not met	
3	Individuals who participate should regularly attend their institutional ultrasound meetings.	met / not met	0=Not met	
4	Individuals who scan and report independently should keep a personal logbook of their images and reports.	met / not met	0=Not met	
5	Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to more advanced accreditation.	met / not met	0=Not met	
6	Images and reports should be uploaded together to the same archive used by the host institution's cardiology or radiology department, as appropriate. Reports should identify the focused nature of the investigation and the clinical context. Scans undertaken as part of research should not be archived before they have been verified by a trainer.	met / not met	0=Not met	
7	Regional networks and electronic image systems should be created to allow for prompt access to review scans by a specialist with Level 2 accreditation or equivalent, when this is required.	met / unmet	0=Not met	
8	Consideration should be given to the development of fully qualified physiologists with dedicated intensive care commitment and experience under post supervision to deliver echocardiography services within intensive care.	met / not met / not applicable	0=Not met	
9	Regular replacement of ultrasound equipment is required to ensure it remains up to date. Normal guidance states that electrical equipment is replaced every seven years, however ultrasound equipment may need to be updated more frequently to keep up with technological advances.	met / not met	0=Not met	
<b>4.8 Neurological Support</b>				
<b>STANDARDS</b>				
1	Adult patients with refractory convulsive status epilepticus must be admitted to critical care and have EEG monitoring established the primary endpoint of treatment before the suppression of epileptic activity on EEG.	met = continuous EEG or processed EEG available on unit, not met, no EEG / Processed EEG available	0=Not met	
2	Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infarction must be considered for cardiopulmonary bypass with follow-on primary percutaneous coronary intervention if indicated.	met / not met	2=Fully met	
3	Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must perform the initial spinal cord injury centre consultation within four hours of diagnosis to establish a neuroprognosis of care.	met / not met	2=Fully met	
4	Previously fit adults, admitted to critical care following a primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation.	met / not met	2=Fully met	
5	Adults under the age of 16 with middle cerebral artery infarction admitted to intensive must have access to a decompressive craniectomy, according to a specialist neurosurgical centre.	met / not met	2=Fully met	
6	Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice.	met / not met	2=Fully met	
7	Prognostication in hypoxic-ischaemic brain injury after resuscitation from cardiac arrest should follow the European Advisory Statement on Neurological Prognostication in comatose survivors of cardiac arrest.	met = able to fully follow partially met = able to undertake some additional testing beyond CT, unmet = unable to meet any additional investigations	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	Protocols should be available to deliver post-resuscitation care to comatose survivors following cardiac arrest as per the Resuscitation Council (UK) guidelines.	met / not met	2=Fully met	
2	The management of traumatic brain injury should follow national and international best practice guidance.	met / not met	2=Fully met	
3	Management of patients with prolonged disorders of consciousness should follow national guidance.	met / not met	2=Fully met	
4	Patients with perceived devastating brain injury should be admitted to the critical care unit to aid prognostication as per national guidance.	met / not met	2=Fully met	
5	Intracerebral haemorrhage should be managed in accordance with international guidance with particular attention to the reversal of anticoagulation and acute control of blood pressure.	met / not met	2=Fully met	
6	The management of suspected viral encephalitis or acute meningitis in adults should follow national guidance.	met / not met	2=Fully met	
7	The management of patients with ventilatory insufficiency due to neuromuscular disease should follow BTS/SCS guidelines.	met / not met	2=Fully met	
8	The management of decompensated acute inflammatory neuropathy should follow best practice guidance.	met / not met	2=Fully met	
9	Autoimmune encephalitis should be suspected and investigated in all adults presenting with the internationally described criteria proposed to identify this disorder.	met / not met	0=Not met	
10	Adults admitted with an acute neurological problem should have access to daily consultation or advice from neurology specialists, if appropriate to the management.	met = as per recommendation, partially met = less frequently than daily consultation, no telemedicine, unmet = difficult to access neurology advice	0=Not met	
11	Critical care units caring for patients with neurological pathology should have agreed venous thromboembolism (VTE) policies that balance the risk of recurrent haemorrhage with the need to provide prophylaxis against VTE.	met / not met	0=Not met	
12	Fever control to normothermia following traumatic brain injury, aneurysmal subarachnoid haemorrhage, ischaemic stroke, or haemorrhagic stroke may improve outcome.	a temperature controlling device with a closed feedback loop must be available met / not met	2=Fully met	
13	Appropriate patients with acute ischaemic stroke should be referred for mechanical thrombectomy in accordance with national commissioning policy.	met = referral pathway in place 24/7 partially met = referral pathway less than 24/7, unmet = no referral pathway	0=Not met	
<b>4.9 Burns</b>				
Burns units only				
<b>STANDARDS</b>				
1	Staffing models must promote joint care between burn and critical care teams as this may improve safety and confer a significant survival benefit.	met / not met	3=Not applicable to Unit	
2	A burns theatre must be located in immediate proximity (preferably within 50 metres) to any service providing critical care for burn injured patients.	met / not met	3=Not applicable to Unit	
3	Burn injured patients who require critical care must be managed by consultants in Intensive Care Medicine who have an appropriate level of training in this field and have acquired the relevant knowledge and skills needed to care for these patients.	met / not met	3=Not applicable to Unit	
4	Burn injured patients must be cared for in an appropriate service as determined by the National Burn Care Referral Guidance.	met / not met	3=Not applicable to Unit	
5	Transfer of critically ill burn patients between services must comply with Intensive Care Society guidelines.	met / not met	3=Not applicable to Unit	
<b>RECOMMENDATIONS</b>				
1	All burns over 20% total body surface area (TBSA) should have access to thermally controlled single-bedded cubicles.	met / not met	3=Not applicable to Unit	
2	Fibre-optic bronchoscopy should be used to assess inhalation injury.	met / not met	3=Not applicable to Unit	
3	Services providing critical care level care should be co-located with a major trauma centre. Where this is not the case, mechanisms for ensuring appropriate integration with trauma centre care should be in place.	met / not met	3=Not applicable to Unit	
4	In specialist centres, clinical guidelines should include: a) Fluid resuscitation and management of associated complications, b) Assessment and management of burns to the face and airway, c) Management of smoke inhalation injury and its sequelae, including carbon monoxide and cyanide poisoning, d) Recognition and management of the acutely unwell and deteriorating burn injured patient including burn specific criteria for the diagnosis of sepsis, e) Management of hypothermia and hypotension, f) Management of burn wound infections including antimicrobial stewardship, g) Nutritional assessment, h) Rehabilitation. These guidelines should be subject to periodic review and update.	met = all guidelines and reviewed within 3 years, partially met = one / two missing guidelines or not reviewed within 3 years, not met = more than two missing or not reviewed within 3 years	3=Not applicable to Unit	
5	The implementation of end of life care as a result of burn injury should only be made following assessment by at least two consultants, one of whom should be a specialist burn unit surgeon.	met / not met	3=Not applicable to Unit	
6	There should be a nominated lead consultant for burns, who participates in network and national morbidity and mortality audit meetings.	met / not met	3=Not applicable to Unit	
<b>4.10 Care of the Critically Ill Pregnant (or Recently Pregnant) Woman</b>				
<b>STANDARDS</b>				
1	Any critical care unit that admits antenatal women over 20 weeks' gestation must have rapid access to obstetric and paediatric services able to attend in an emergency. There must be a clear plan and equipment immediately available for performing a perimortem caesarean section in the event of maternal cardiac arrest, with appropriate neonatal resuscitation equipment.	met / not met	2=Fully met	
2	An obstetric team (normally a consultant obstetrician, a consultant obstetric anaesthetist and a midwife) must review all pregnant women admitted to critical care at least once in every twenty-four hour period.	met = as per standard, partially met = less frequent, unmet = difficult to achieve	2=Fully met	
3	In antenatal ICU admissions, when fetal viability is a possibility, a health care professional trained in neonatal resuscitation must be available within 10 minutes and a senior neonatologist or paediatrician must be able to attend within 30 minutes.	met / not met	2=Fully met	
4	All critical care units that admit pregnant or recently pregnant women must have a named lead clinician for maternal critical care (MCCO). The main function of this role is to be the point of liaison between critical care and obstetric services (including obstetric anaesthetics).	met / not met	1=Partially met	

5	Breast feeding (including the use of breast pumps) must be encouraged and supported in all post-natal women admitted to critical care.	met / not met	2=Fully met	
6	Women who require care that falls outside Enhanced Maternal Care (EMC) must be referred as soon as possible to the general critical care service. The route of escalation to critical care services must be clearly defined.	met / not met	3=Not applicable to Unit	
7	Critical care outreach or equivalent must be available and provide clinical support and education into EMC.	met / not met	0=Not met	
8	Critically ill pregnant or recently pregnant women who undergo intra or inter-facility transfer must be transferred in accordance with standards equivalent to the Intensive Care Society's Guidelines for the Transport of the critically ill adult	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Level 3 antenatal ICU admissions and post-natal admissions that are anticipated to last more than 48 hours should be considered for transfer to a regional or supra-regional critical care unit with experience in MCC.	met / not met	2=Fully met	
2	Physical contact between a mother and her baby should be maintained during post-natal critical illness, even if the mother is unconscious. This contact and other events of the admission should be recorded in a critical care diary which can be used in psychological rehabilitation after critical illness.	met / not met	2=Fully met	
3	All women admitted to critical care should be offered an appointment in a critical care follow-up clinic or a post-natal review, which includes input from a critical care specialist.	met / not met	0=Not met	
4	Recognition of EMC should be incorporated into midwifery pre & post registration curricula and feature in obstetric, anaesthetic and critical care training programmes.	Statement		
5	Healthcare professionals looking after critically ill women should undergo regular, cross-specialty, multidisciplinary team training to encourage sharing of knowledge and skills and to promote teamwork and effective communication.	met / not met	1=Partially met	
6	Simulation-based training should be considered to assist healthcare professionals to develop the technical and non-technical skills for EMC.	met / not met	0=Not met	
7	Critical care networks should consider nominating specific units as the nominated regional or supra-regional unit for MCC.	met / not met	3=Not applicable to Unit	
8	Obstetric units delivering EMC or level 2 critical care should be members of a regional MCC network which itself should have a formal relationship with the local Critical Care Operational Delivery Network and Strategic Critical Network.	met / not met	3=Not applicable to Unit	
9	MCC quality indicators should be monitored, using data reported through the ICNARC Case Mix Programme and the Scottish Intensive Care Society Audit Group and used to improve local performance.	met / not met	3=Not applicable to Unit	
4.11 Care of the Critically Ill Child in an Adult Critical Care Unit				
STANDARDS				
1	Critically ill children under 16 years old must only be admitted to and stay on an adult critical care unit if a PICU bed is unavailable, or when there is an expected short duration of critical care as an older child with overflow or short-term needs.	met / not met	3=Not applicable to Unit	
2	Admission must be discussed and agreed by the local consultant in Intensive Care Medicine, local consultant paediatrician and the consultant in paediatric intensive care medicine (this may be the paediatric intensivist/transport team coordinator).	met / not met	3=Not applicable to Unit	
3	A nominated lead intensive care consultant and lead nurse in the adult critical care unit must be responsible for intensive care policies, procedures and training related to the care of children.	met / not met	3=Not applicable to Unit	
4	An adult critical care unit that may provide care for critically ill children must have an appropriately equipped area for providing paediatric critical care.	met / not met	3=Not applicable to Unit	
5	Medical staff with responsibility for the resuscitation and airway management of the critically ill child on an adult unit must have up-to-date competencies in advanced paediatric life support and advanced airway management. This medical cover may be provided by anaesthetists or consultants in Intensive Care Medicine according to local arrangements.	met / not met	3=Not applicable to Unit	
6	Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer of critically ill children and the provision of paediatric critical care must be available.	met / not met	3=Not applicable to Unit	
7	Escalation, end of life and organ donation decisions must be discussed in collaboration with the regional consultant in paediatric intensive care (this may be the regional paediatric transport team consultant), under a shared care and shared responsibility model.	met / not met	3=Not applicable to Unit	
8	There must be collaborative working between the adult critical care unit and the regional PICU to ensure that staff are supported to work outside their normal core competencies. There must be 24/7 access to paediatric medical and paediatric nursing advice.	met - as per standard, partially met - no formal arrangement, unmet - not anticipated to happen	3=Not applicable to Unit	
9	A local consultant paediatrician and consultant in paediatric intensive care medicine must be available for advice at all times.	met / not met	3=Not applicable to Unit	
10	There must be 24-hour access for parents/carers to visit their child.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	A registered paediatric nurse should be available at all times to support the care of the child.	met / not met	3=Not applicable to Unit	
2	The child should be reviewed by a consultant paediatrician twice a day during their stay on the adult unit.	met - as per standard, partially met - visited as requested / required, unmet unlikely to achieve standard	3=Not applicable to Unit	
3	There should be access to specialist paediatric healthcare professional and pharmacy advice at all times.	met - as per standard, partially met - visited as requested / required, unmet unlikely to achieve standard	3=Not applicable to Unit	
4.12 Standardised Care of the Critically Ill Patient				
STANDARDS				
1	Patients must be assessed daily for risk of thrombotic disease and receive appropriate prophylaxis.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	2=Fully met	
2	Patients undergoing controlled mechanical ventilation must receive tidal volumes based on predicted body weight (PBW). Patients with ARDS must receive a tidal volume of less than or equal to 6 ml/kg PBW.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	0=Not met	
3	Ventilated patients must have respiratory function evaluated daily and undergo spontaneous breathing trials where appropriate.	met / not met - no SBTs	2=Fully met	
4	Sedation must be individualised to patient needs and the appropriateness of a sedation hold considered daily.	met / not met	2=Fully met	
5	All patients must be assessed regularly for evidence of pain, with analgesia optimised to minimise sedation requirements.	met / not met	2=Fully met	
6	All patients must be screened daily for evidence of delirium using a validated method such as the Confusion Assessment Method for the ICU (CAM-ICU) or the Intensive Care Delirium Screening Checklist (ICDSC).	met / not met	2=Fully met	
7	Indwelling intravascular catheters must be inspected daily for evidence of infection using a suitable scoring system e.g. Visual Infusion Phlebitis Score (Judson 1998) to guide necessity for removal.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	2=Fully met	
8	The continued need for indwelling catheters (intravascular or urinary) must be considered daily.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	2=Fully met	
9	Monitoring of invasively ventilated patients must include continuous waveform capnography.	met / not met	0=Not met	
10	Care bundles must be in place for Intubation Associated Pneumonia (IAP) prevention, Central Venous Catheter (CVC) insertion and maintenance, and Peripheral Venous Catheter (PVC) insertion and maintenance.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	For patients without ARDS, a tidal volume of 4-6 ml/kg PBW and a peak/plateau pressure (depending on mode) of below 30 cmH2O should be targeted.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	2=Fully met	
2	A ventilated patient care bundle should be in place with appropriate mechanisms for ensuring adherence.	met / not met	0=Not met	
3	Ventilated patients should receive H2 receptor blockade (e.g. ranitidine) or a proton pump inhibitor for gastric protection until established on full enteral nutrition.	met / not met	2=Fully met	
4	Unless clinically contraindicated, ventilated patients should be nursed in a semi-recumbent position at 30 to 45 degrees.	met / not met	2=Fully met	
5	Where there is no contraindication, enteral nutrition (EN) should be initiated within 48 hours after admission to the ICU.	met / not met	2=Fully met	
6	When EN is not feasible or insufficient, parenteral nutrition should be started as soon as possible in patients with (or at high risk of) malnutrition, (which may be a combination of cachexia (disease related) and malnutrition (inadequate consumption of nutrients)).	met / not met	2=Fully met	
7	All sedated patients should have sedation levels monitored hourly using a scoring system such as the Riker Sedation-Agitation Scale or the Richmond Agitation-Sedation Scale to ensure sedation is minimised.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	2=Fully met	
8	Noise levels and patient interventions should be minimised overnight to facilitate natural sleep.	met / not met	2=Fully met	
9	A transfusion threshold of T0g/L should be used in general intensive care patients. A higher target Hb may be beneficial in patients with sepsis (in the first six hours), ischaemic stroke, traumatic brain injury with cerebral ischaemia, or acute coronary syndromes.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 80%, un met = no guideline or compliance < 50%	2=Fully met	
10	Critical care units should consider standardisation of drug concentrations in line with PICMIC5 guidance.	met / not met	0=Not met	

Section 5		CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS		Level description	Level	Comments
5.1		Research and Development				
STANDARDS						
1	All individuals participating in R&D activity must have completed Good Clinical Practice (GCP) training for research and keep this up to date.	met / not met		2-Fully met		
RECOMMENDATIONS						
1	Critical care units should nominate a lead for R&D activities who should coordinate activity and ensure it is carried out to UK Policy Framework for Research and Development.	met / not met or not applicable		2-Fully met		
2	Critical care units should participate in research networks, which are organised at Local Critical Care Network (LCCN) level through the regional National Institute of Healthcare Research (NIHR) Critical Care research network lead.	met / not met or not applicable		2-Fully met		
3	All research studies should be registered on the UK Critical Care Research Portfolio whenever they fulfil eligibility criteria.	met / not met or not applicable		2-Fully met		
4	Critical care units participating in research should provide information to patients, relatives, and surrogate decision-makers (SDMs) about research, research, for example through auditors, leaflets, or written consent, intensive care information resources.	met / not met or not applicable		2-Fully met		
5	Critical care units participating in research should have clear procedures for approaching patients, families and SDMs in a manner that minimises stress, but provides adequate information in a timely manner.	met / not met or not applicable		2-Fully met		
6	Critical care units participating in multiple research studies should have clear co-enrolment policies based on the UK co-enrolment guideline.	met / not met or not applicable		2-Fully met		
5.2		Audit and Quality Improvement				
STANDARDS						
1	Critical care units must have a structured and planned clinical audit programme to compare practice to published standards. There must be an identified lead for the audit programme.	met / not met		2-Fully met		
2	Critical care units must participate in a National Audit Programme for Adult Critical Care, such as the Scottish Intensive Care Society Audit Group (SIC-SAG) or Intensive Care National Audit and Research Centre (ICNARC) programmes.	met / not met		2-Fully met		
3	Critical care units must have a surveillance system in place for audit and feedback of nosocomial infection, for example, catheter-related bacteraemia and other blood stream infections, reported to the national scheme where applicable. Critical care units should also report the incidence of intubation-associated pneumonia. All units must participate in national audit programmes for nosocomial infections in intensive care, for example, Public Health England Infections in Critical Care Programme (ICOOP) and Scottish nosocomial infections in ICU audit programme.	met / not met		2-Not met		
4	Critical care units must measure night-time discharges in order to encourage and support local improvement to reduce night-time intensive care discharges.	Discharges after 21:59 as percentage of all eligible admissions - met <2% partially met, 2-4% not met-2%		2-Not met		Data not reviewed
5	Critical care units must obtain regular feedback about the care that patients and relatives receive during their critical care admission in order to learn from and act on the feedback received.	Met - annual process, partially met, undertaken every 1-2 years, unmet, never done or less than 2 yearly.		2-Not met		
RECOMMENDATIONS						
1	Units should have nominated medical and nursing leads for quality improvement and audit. Appropriate time should be made available in job plans for these duties. Time to participate in audit and quality improvement programmes should also form part of the job plans of all intensive care staff (medical, nursing, pharmacists, healthcare professionals and ancillary staff).	met/ unmet		2-Not met		
2	Hospitals should have a quality improvement (QI) programme in place for each critical care unit in their organisation. The programme should aim to deliver safe, efficient, effective, patient-centred, timely and equitable patient care, which is evidence based, and should follow recognised quality improvement methodologies.	met / unmet		1-Partially met		
3	Staff should be encouraged and supported to train in quality improvement methodology and all projects should be multidisciplinary, recognising the necessity for a team approach and the contribution of all staff groups.	met / unmet		1-Partially met		EQUIP programme available
4	Audit should be linked to QI programmes. Units should have robust data collection systems in place that support the collection of activity and quality data for local and national audit programmes.	Met - robust data collection and feedback for both local and national audit, partially met - robust data collection and feedback for national audit only, not met - no robust systems for data collection or		2-Not met		
5	Critical Care Networks should have a formal, multi-professional, peer-review programme in place for the units in their jurisdiction. Peer reviews should be based on published national standards, but are likely to include other areas that are agreed locally.	met / not met - not applicable		2-Fully met		
6	All critical care units must measure and report their delayed discharges, out of hours discharges, non-critical transfers and readmissions within 48 hours of discharge, as a potential indicator of resource pressures. It is recommended that units should also measure early discharges as they may be a marker of insufficient resources.	Met - submit all data to ICNARC / SIC-SAG data tools, partially met - one or more data submissions missing, not met - poor data compliance with ICNARC / SIC-SAG		1-Partially met		OTOC figures captured by RIS. Nil to other measure
5.3		Clinical Governance				
STANDARDS						
1	There must be an appropriately trained consultant and senior nurse identified as leads for clinical governance. The consultant must not be the clinical lead or clinical director for critical care.	met / not met		1-Partially met		Medical support under discussion
2	There must be a robust system in place for reporting, investigating, and learning from all patient safety incidents. Appropriate action plans must be formulated in response to incidents. Units should also learn from things that go well, a process described in excellence reporting.	met / not met		2-Fully met		
3	Units must hold regular structured multidisciplinary clinical governance meetings, where they discuss unit morbidity and mortality, including all deaths, critical incidents and near misses. A written record of actions taken and lessons learnt should be kept and a timely and reliable method for dissemination of shared learning should be in place. There should be clear structures in place for dissemination findings to staff, and delegates it care should lead to measurable change.	met - meets full standard with minimum of quarterly meetings, partially met - meets standard but less than quarterly, unmet - doesn't meet the standards		2-Not met		
4	Regular feedback must be obtained from service users and staff about the quality of care delivered, for example by the use of safety surveys and relatives' questionnaires.	met - undertake critical care led staff safety and relative surveys at least once a year, partially met is less frequently or only one group surveyed, Not met - no patient or staff survey		2-Not met		
5	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care. Appropriate actions must be taken whenever preventable factors are found.	met - mortality review process that includes all deaths in ICU / not met		2-Fully met		
6	All units must maintain a risk register that is regularly reviewed and updated by both senior managerial and clinical staff. The unit must have processes to ensure clinical staff are aware, in a timely fashion, of key learning points from national safety alerts and local learning (for example from patient safety incidents, excellence reports, patient concerns and complaints). Staff must also be able to easily access important information to inform patient care (for example information about medications and unit policies) whenever needed.	met - in place, quarterly review, partially met, in place less than quarterly review, unmet - not in place		1-Partially met		
7	Staff who have conducted reviews of patient safety incidents, root cause analysis and appreciative enquiry must be trained in the management of these processes so the review is conducted safely and constructively. Similarly, effective quality improvement requires staff that are trained in quality improvement methodologies.	met / not met		2-Fully met		
8	Each unit must have local safety standards for invasive procedures (including tracheostomy, bronchoscopy, central line and chest drain insertion and lumbar puncture). They must also have safe standards for the handover of information for patients going to have invasive procedures in other departments. These standards should include documentation of invasive procedures, handovers and information transfer, procedural verification, a safety briefing and time out, and a sign out and debriefing. An example of this process is the NHS England Safety standards for invasive procedures.	met / not met		2-Fully met		Critical Care LocSSIP in place
9	Critical care units must comply with reviews and visits by national organisations, (for example the CQC in England).	met / not met		2-Fully met		
RECOMMENDATIONS						
1	Intensive care staff should work with other clinical teams in the hospital with respect to joint learning from morbidity and mortality review and ensuring best practice around handovers of care.	met - done quarterly, partially met, done annually, not met, not done - use comments box		2-Not met		
2	Units should regularly review guidelines from professional organisations and other sources of evidence to ensure that the unit complies with best practice. These evidence sources should be translated into comprehensive locally agreed guidelines or Standard Operating Procedures.	met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed		1-Partially met		
3	The unit should identify key performance indicators (KPIs) that describe outcomes of their service. Such KPIs may be generic and common to most units, such as complication rates, e.g. delirium rates, pain scores or pressure sores. Alternatively, these may be unit specific, for example rates of emergency intubations on cardiac critical care units.	met / not met		2-Not met		
4	Staff should be recognised as the key resource in intensive care. A fully engaged, well-motivated well-trained and well-led workforce is essential to allow excellence in clinical care to flourish. Staff sickness rates, turnover rates and information from appraisal, staff feedback and exit interviews should all be monitored to ensure staff wellbeing.	Met - all staff wellbeing criteria stated are monitored, partially met - some criteria are monitored, not met - none of criteria are monitored.		1-Partially met		
5	Units should work with other units within their network, and nationally, to share learning, disseminate best practice, quality improvement and best benchmarking for peer review purposes. The governance of critical care units is tightly audited by outside agencies, including intensive care networks. The external responsibility for the oversight of governance arrangements varies between the different agencies.	met - Units participate in Network led program to share best practice and QI / not met		2-Not met		
6	The unit should be able to demonstrate that it is continuously working to improve patient care using recognised quality improvement techniques delivered by appropriately trained staff.	met- Unit have undertaken at least one local patient centric QI program in previous 12 months / unmet		1-Partially met		
5.4		Critical Care Networks				
STANDARDS		*These may not be applicable for countries which do not have networks				
1	Critical care ODNs must support the activity of provider healthcare organisations in service redesign and delivery of the commissioned pathway, quality improvements, innovation and standardisation of clinical practice. They provide a mechanism for peer review and benchmarking self assessment in the network.	met / not met / not applicable		2-Fully met		
2	Critical care ODNs must support commissioners in the delivery of their commissioning functions, through creating and delivering innovation, quality improvements and efficiency across the pathway, and developing, devising and supporting local strategies for adult critical care services across the geographical footprint, including advice on procurement.	met / not met / not applicable		2-Not applicable to Unit		
3	Critical care ODNs must support delivery of a resilient critical care service within a geographical area to meet emergency requirements.	met / not met / not applicable		2-Fully met		
4	Each provider of adult critical care must engage, contribute and participate in activities of their local critical care ODN and will contribute to the funding of their local ODN through a nationally agreed mechanism; this is currently a 10% CQUIN top slice, but may be supplemented by local agreements made in conjunction with key stakeholders through the ODN Executive Oversight Group Board.	met / not met / not applicable		2-Fully met		Unsure of funding model
5	The intensive care team in provider organisations must engage, contribute and participate in a critical care ODN, including audit activity, peer review and quality improvement processes.	met / not met / not applicable		2-Fully met		
RECOMMENDATIONS						
1	ODNs should take a whole-system, collaborative-provision approach to facilitate the delivery of safe and effective services across the patient pathway, with an emphasis on the quality and equity of access to service provision.	met / not met / not applicable				
2	ODNs should lead cross-organisational, multi-professional clinical engagement for the sharing of best practice and knowledge. They should both identify and implement improvements to enhance patient care, enabling the design of effective clinical flows and pathways of care for networked provision of services. This will allow for more local determination, innovation and efficiency across the pathway.	met / not met / not applicable				
3	ODNs should focus on quality and effectiveness through facilitation of comparative benchmarking and auditing of services, with implementation of required improvements. This should span the wider hospital system, to include dedicated critical care units, as well as resources to support acutely unwell patients on general wards. This includes rehabilitation of patients recovering from critical care in hospital and in the community.	met / not met / not applicable				
4	ODNs should create an operational model that allows effective work programmes for the delivery of local and regional priorities, review specification standards, national programme of care outcomes and outcome framework targets.	met / not met / not applicable				
5	ODNs should have robust governance arrangements that ensure functionality, working with both providers and commissioners, to enable the development of improved service standards to continually enhance the patient, family and care experience.	met / not met / not applicable				
6	ODNs should have a core management team capable of delivering the work of the network according to local requirements. They should provide clinical and executive management leadership to support the delivery of established network plans, enabling action in response to adverse situations or outlying practices. As a minimum, this would include senior management, lead medical and nursing roles and administrative support. These roles are independent of both the host organisation and the substantive employer where this is not the host.	met / not met / not applicable				
7	Each participating member organisation should ensure appropriate representation at critical care ODN meetings, task groups and other forums in accordance with the network's terms of reference. Through the baseline contract agreement (local or national), member organisations should comply with ODN standards, policies and guidelines.	met / not met / not applicable		2-Fully met		
8	Each adult critical care provider should adhere to requirements to measure and evaluate quality indicators and service delivery, in line with the national Adult Critical Care Service Specification (2009). This specification may be supplemented by additional requirements by the local ODN (for example GPCIS V2 standards and recommendations). Such supplemental standards should be agreed by the ODN through their local governance structure.	met / not met / not applicable				
9	ODNs should provide leadership support in network-wide emergency preparedness, have a role in clinical contingency planning and respond to increased demand through national, regional and local determination. ODNs should act on identified challenges as they arise, e.g. a local critical care bed crisis or large-scale major incidents.	met / not met / not applicable				
10	ODNs should encourage the positive engagement of adult critical care providers in their networks and support critical care units in developing their service to its maximum potential by implementing the recommendations outlined above.	met / not met / not applicable				
5.5		Critical Care Commissioning				
STANDARDS						
1	All units must comply with national commissioning arrangements in place in England, Wales, Scotland and Northern Ireland.	met / not met		2-Not applicable to Unit		
2	COMDS must be collected and reported in all designated Adult Critical Care locations in England.	met / not met / NA		2-Not applicable to Unit		
3	Data collection must commence from the date and time that the patient first occupies a designated critical care bed or, if in a non-designated critical care ward, the date and time that the patient first occupies a designated critical care area / not met - data is collected on critical care episodes delivered outside of designated critical care area / not met	Met - data is collected on critical care episodes delivered outside of designated critical care area / not met		2-Fully met		
4	Adult critical care reference cost submissions must assign costs to individual HRGs.	Statement				
5	All providers in England, Wales and Northern Ireland with adult critical care services must be members of a Critical Care Operations Delivery Network.	met / not met		2-Fully met		

RECOMMENDATIONS				
These recommendations may not be applicable to these units outside of England and Wales				
1	Collection of all 34 fields in CCMS is recommended. This should be done by dedicated trained personnel.	met / not met	Is/Not applicable to Unit	
2	There should be clinical oversight of the CCMS data entry/data submission to ensure accuracy of data.	met / not met	Is/Not applicable to Unit	
3	Preparation of reference costs should include experienced clinician involvement.	met / not met	Is/Not applicable to Unit	
4	Agreement should be in place to support early notification to a patient's COG for longer-stay patients who are likely to have complex home needs, such as home ventilation to aid discharge planning including the identification of a funding package.	met / not met	Is/Not applicable to Unit	
5	A lead commissioner should be identified with a commissioning forum for each critical care service.	met / not met	Is/Not applicable to Unit	



Section 6		CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS		Level description	Level	Comments
6.1	Fire					
STANDARDS						
1	All units must have well marked fire call points, fire extinguishers and oxygen shut-off valves.	Met or unmet		2-Fully met		
2	Each unit must have a specific fire evacuation policy in place, which takes account of: a) the layout of the building, including any need to negotiate stairs during an evacuation, b) the provision of ventilatory support, intravenous therapies and invasive monitoring for patients during such an evacuation, c) the fact that critical care staff may themselves be affected by a fire and therefore be unfit to continue working. Action cards summarising the evacuation procedures should be displayed within the unit, ideally next to fire call points, so that they can be referred to in an emergency.	Met or unmet		1-Partially met		Departmental fire plans currently being updated to include guidance from the Association of A
3	Recommendations for the safe use of oxygen cylinders must be adhered to at all times and include the safe use of oxygen cylinder bed brackets, b) the safe storage of oxygen cylinders and c) following the recommended sequence of events when turning on an oxygen cylinder.	Met / unmet		2-Fully met		
4	Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring and curtains.	Met / unmet		2-Fully met		
5	New units must be designed using Department of Health guidance and in conjunction with the Trust fire safety officer, with consideration given to the provision of: a) multiple exit routes, b) ski pad, ski sheets or other evacuation aids for all bed spaces which are readily available, c) adapting small bays rather than open areas and d) splitting ICU departments into separate clinical and non-clinical areas.	met / not met / not applicable		3-Not applicable to Unit		
6	Units must have a major incident plan in place which allows for the transfer in of multiple critical care patients from a neighbouring hospital's critical care unit should it need to carry out an emergency evacuation.	Met / unmet		2-Fully met		Major Incident plans in place, along with Business Continuity plans. Activity 18 relates to the at
7	Any problem with oxygen cylinders and associated equipment must be reported immediately to both the medical gas supplier and the Medicines and Healthcare products Regulatory Authority (MHRA).	Met / unmet		2-Fully met		
8	All staff must undergo regular training in fire prevention and fire procedures, to include training in-situ in the specific clinical areas in which they work. All staff must know: a) the location of fire call points within their own unit and how to operate them, b) the location of fire extinguishers within their unit and which type to use in the event of a fire. Medical and senior nursing staff must also know the location of the medical gas pipeline shut-off valves in their unit, how to operate them and the implications of doing so.	met = > 90% of staff compliant, partially met > 75%, not met < 75%		1-Partially met		Fire Training is mandatory, arranging unit specific training
9	All intensive care staff must be given basic training regarding the safe use of oxygen cylinders.	met = > 90% of staff compliant, partially met > 75%, not met < 75%				Sandra confirm details please
10	Local unit evacuation policies must be drawn up, with consideration for: a) other locations within the hospital where critical care might be provided or a temporary base, b) provision of equipment and drugs, c) evacuation cases at each bed space, d)riage of patients (the least unwell patients being evacuated first and the most unwell patients last), e) possible co-existing power and/or equipment battery failure, f) use of transport ventilators and hand ventilation if needed, g) temporary discontinuation of renal replacement therapy, and h) transfer of hospital notes especially if electronic patient monitoring is in use. In a major fire, it is possible that serial evacuations will be required with a staged move to the outside, and that the whole hospital may need to be evacuated.	Met / unmet		3-Not met		Departmental fire plans currently being updated to include guidance from the Association of A
RECOMMENDATIONS						
1	Evacuation policies should include liaison with the Bronze (Operational), Silver (Tactical) and Gold (Strategic) commanders in conjunction with the senior fire officer on scene. Timing of evacuation is crucial. If evacuation occurs too early, then patients may be harmed by a transfer. If evacuation occurs too late, then patients and staff may be harmed by the fire and smoke.			1-Partially met		Fire evacuation plan discusses Liaison with hospital fire response team. Patients evacuated on
2	Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be practised.	Met - tested annually, partially met tested daytime only and / or less than annually, unmet, not tested in the last 2 years		3-Not met		Fire evacuation exercises have been requested from the fire team. Current Covid situation m
3	Units should have a system whereby staff involved in a traumatic incident, such as a fire in the critical care unit, receive debriefing and are followed up for signs of a trauma stress reaction or Post Traumatic Stress Disorder (PTSD). The Trauma Resilience Management (TRM) system is a screening tool used in the military and more recently used successfully in healthcare which could be considered.	Met - system available / unmet - no system in place to do this		1-Partially met		Included in Fire Plan
4	Critical care networks should develop systems to support planning for, and management of, a major incident in one critical care unit within the network, so that other units can cooperate to accommodate all critically ill patients in this type of situation. A retrieval team approach with staff from neighbouring units travelling to the affected unit to transfer patients, should be planned. Liaison with neighbouring units and local ambulance services at all such plans is advised.	met / not met / not applicable		3-Not applicable to Unit		Local Business Continuity and Major Incident plans apply
6.2 Major Incidents						
STANDARDS						
1	All hospitals designated receiving hospitals with Level 3 critical care capability must be prepared to double their normal Level 3 ventilated capacity and to maintain this for up to 96 hours.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard		3-Not met		Inadequate logistics to double capacity
2	All non-designated supporting hospitals with Level 2 critical care capability must be prepared to double their normal capacity for Level 3 beds for general use and to support the receipt of patients from other receiving hospitals.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard		3-Not met		Inadequate logistics to double capacity
3	All hospitals with intensive care beds must have in place plans to support the retrieval or transfer of patients; supporting hospitals must have to support patient transfers by providing suitably skilled transfer teams for each patient needing to be moved within Critical Care. (Theatres/Intensive Carewards units and beyond).	Met / unmet		1-Partially met		
4	All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but not exclusively intensive care patients, should the intensive care areas become unusable for any reason.	Met / unmet		2-Fully met		Patients will be taken to Theatres/Recovery
5	All hospitals must have a look down plan that includes all intensive care areas, preventing unauthorised access.	met / unmet		1-Partially met		Yes to Critical Care
6	All hospitals must have a recovery plan to ensure a rapid return to normality once the incident is closed. This must include adequate rest and psychological support for staff.	met / unmet		2-Fully met		Business Continuity plans in place. Dedicated Psychologist working in Critical Care Team
7	Action cards must be available for use on activation of plan and must include information and communication routes that are to be used.	met / unmet		1-Partially met		Action Cards included in major incident and fire plans.
RECOMMENDATIONS						
1	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response (EPRR) leads and clinical colleagues to create the intensive care response to a major incident, hospital evacuation or mass casualty plans.	met / unmet				
2	Intensive care should have access to emergency planning and response training including strategic/crisis leadership.	met / unmet				
3	Intensive care service staff should participate in the local and regional multidisciplinary exercises including 'table top' and 'live' exercises to further refine local and regional plans and communication routes between organisations and networks.	met / unmet - within the last 2 years		3-Not met		
4	Intensive care leads should work with their EPRR team to facilitate exercises in the evacuation of very dependent patients from any part of their hospital. This should include practical use of ski sheets, and other patient handling aids, as well as rehearsing the decision making and transport decisions required by staff likely to support a controlled, staged evacuation.	met / unmet - within the last 2 years		3-Not met		
5	Intensive care staff should be prepared to take a central leadership role in any major incident and should be prepared to send teams forward as the Emergency Despatch Unit, as well as any resources, both staff and resources.	met - plans in place to enable to do so, unmet - no plans		3-Not met		Would participate as designated in local major incident response
6	The plan to double the number of intensive care beds should include an inventory of where equipment is to come from, where the beds should be located and who should staff them. This should be near the permanent critical care unit, where possible allowing the normal function of the hospital to proceed.	met / unmet		3-Not met		Inadequate logistics to double capacity
7	Advance consideration of staff workforce requirements, including mutual aid from colleagues in neighbouring hospitals should form part of the intensive care service objectives.	met / unmet		2-Fully met		
8	Staff welfare should be actively supported during an incident and critical care staff access to informal, immediate debrief or later formal counselling.	met - plans in place / unmet - no plan in place		2-Fully met		
9	Critical care should be maintained as long as possible, critical incident reporting encouraged and contemporaneous note kept to enable quality post-incident lessons to be investigated, communicated and learnt.	met - within plan / unmet - not in plan		3-Not met		
6.3 High Consequences Infectious Diseases: Initial Isolation and Management						
STANDARDS						
1	Each critical care unit must ensure there are local contingency plans for the initial isolation and management of critically ill patients with suspected HCIDs. These plans must be regularly practised and reviewed, including the use of table-top exercises and simulations.	Met - plan in place and tested within 2 years, partially met - plan in place but not tested within 2 yrs, unmet - no plan		2-Fully met		
2	Units must liaise with local Directors of Infection Prevention and Control to ensure the correct personal protective equipment (PPE) is procured and sufficient stocks are readily available for use by appropriately trained intensive care staff in the event it is required.	met / unmet		2-Fully met		
RECOMMENDATIONS						
1	A consultant in Intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience operations, incorporating plans for the appropriate isolation and management of suspected patients with HCIDs.	met / unmet		3-Not met		
2	A clinical area where critically ill patients with suspected high consequence infectious diseases may be isolated, either within the unit or elsewhere, should be prospectively identified. Ideally plans to utilise negative pressure rooms with anterooms where available.	met / unmet		1-Partially met		Limited side rooms
3	All clinical equipment used in the management of a patient with a HCID should be dedicated to that patient alone. Equipment should be sterile use where possible.	met - within a plan to do so, unmet - no plan		2-Fully met		
4	Training should be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provided. This should incorporate annual fit testing of ventilatory protective equipment (e.g. EPRR masks).	met - annual fit testing done unmet - not annual fit testing		2-Fully met		
5	Critical care staff providing care for a patient with a suspected or confirmed HCID should be dedicated to the care of that patient on a clinical shift and should not provide equipment care for other patients, thus limiting the risk of cross-infection.	met - within plan to do so, unmet - no plan		2-Fully met		
6	Contingency planning should incorporate plans for holding securely the large volume of clinical waste resulting from clinical care including decontaminated PPE. Once a HCID is confirmed, further advice on correct disposal of the waste will be provided.	met - within plan to do so, unmet - no plan		2-Fully met		Hospital plan
7	Patients with a suspected viral haemorrhagic fever should be risk assessed in accordance with the Advisory Committee on Dangerous Pathogens' Viral Haemorrhagic Fever (ACDP VHF) Risk Assessment algorithm and investigations to exclude malaria promptly undertaken, in liaison with local procedures.	met - local procedure in place, unmet - no local procedure		2-Fully met		
8	Patients with suspected airborne HCIDs should be risk assessed according to national guidelines where they exist (disease-specific e.g. EPRR guidance collections 4 or generic airborne HCID guidelines, as appropriate).	met - local procedure in place, unmet - no local procedure		2-Fully met		
9	Following recognition of a patient with a suspected HCID, a local infectious disease and/or microbiology and virology services should be notified and advice sought, including guidance on obtaining appropriate diagnostic clinical specimens. b) Local clinicians should liaise with the Imported Fever Service (note this service is available to clinicians across the UK) for further clinical advice and to facilitate access to specialist diagnostic as required, and c) all suspected cases should be reported immediately to local health protection authorities (e.g. the local Health Protection Team).	met - local procedure in place, unmet - no local procedure		2-Fully met		
10	Critical care units accepting international medical transfers should perform a risk assessment prior to transfer if a patient is being transferred from a country with known HCID outbreaks or countries where there is a significant risk of specific HCIDs; refer to national guidance (disease-specific or generic HCID guidance).	met - local procedure in place, unmet - no local procedure		2-Fully met		
6.4 Surge and Business Continuity Planning						
STANDARDS						
1	Adult critical care units (in England) must submit twice-daily information on their bed capacity through NHS Pathways Directory of Services (PDS).	met / unmet / NA (if non English units)		3-Not met		
2	Each organisation with an adult critical care unit must have their own escalation plan and business continuity plan.	met / unmet		2-Fully met		
RECOMMENDATIONS						
1	Unit managers and senior clinical staff should develop plans and checklists for scenarios such as: a) supply chain disruption (road/fuel crisis, extreme weather, industrial action or civil disturbance), b) infrastructure failures (intermittent power cuts or brownouts, failure of water or heating), c) interruption of normal staffing patterns (e.g. transport disruption, school closures). Checklists should include, for example, which drugs and consumables could run out and if supplies are disrupted.	met / unmet		2-Fully met		
2	Plans should also include options for: a) Unit relocation, both internally and externally to other sites in the event of major infrastructure failure, or other events (e.g. fire) which threaten the ongoing operation of intensive care facilities, b) the ability for accommodating intensive care patients evacuated from another site.	met / unmet (repetition)		1-Partially met		Limited options
3	As lack of critical care capacity is frequently the bottleneck in other surge-events, managers and clinicians should have identified areas within their acute hospital sites to allow for expansion of critical care capacity. This may include use of operating theatres, recovery and augmented higher care areas, or upgrading Level 3 critical care areas to permit mechanical ventilation and Level 3 care.	met / unmet		2-Fully met		
4	If increased activity is anticipated, the increase in requirement for consumables should be quantified using the concept of 'days of supply' i.e. what is needed to run one intensive care bed for a 24-hour period). This should include consideration of oxygen and air supplies.	met - within plan / unmet - not in plan		2-Fully met		Hospital plan
5	Expansion may also require consideration of essential equipment and possible alternatives.	met - within plan / unmet - not in plan		2-Fully met		

## An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



### Introduction

In June 2019, the Intensive Care Society (ICS) and Faculty of Intensive Care Medicine (FICM) released the second edition of Guidelines for the Provision of Intensive Care Services (GPICS). The first edition of GPICS (2015) built on the earlier Core Standards for Intensive Care Units (2013) and has become the definitive reference source for the planning, commissioning and delivery of Adult Critical Care Services in the UK. Many units have found the GPICS standards and recommendations to be invaluable in developing successful business cases to enhance their local services and improve patient care. GPICS has also been used as the benchmark by which local services are peer reviewed and assessed by healthcare regulators, such as the Care Quality Commission (CQC). The ICS and FICM have worked in collaboration to develop this tool kit to help individual units to compare their services to the latest version of GPICS. The standards and recommendations are presented in Excel format with a drop down option of 'met', 'partially met', 'unmet' or 'not applicable to this service' next to each guideline. The tool kit also allows units to produce a PDF summary page which provides a useful overview of their responses.

This tool kit is not stand-alone and should be used alongside the full GPICS document which is available via the link below. We recommend that the toolkit is completed in collaboration with members of the multi-disciplinary team, so that each section is completed by individuals who are best placed to make an accurate assessment. We are aware that defining compliance with standards and recommendations is difficult and have deliberately left this to the judgment of local clinicians and managers.

We see the further development of this tool kit as an iterative process, working with individuals and networks to improve and refine its functionality. If you have any suggestions or comments please contact us at [info@ics.ac.uk](mailto:info@ics.ac.uk). We hope you find this tool kit useful.

[Click here to go to the full GPICS document online](#)

or double-click on the embedded PDF ( you may need to switch to Windows to view after opening)>>

[Click here to view the Instructions sheet](#)



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# An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



## Instructions

### 1. To add your unit name to the summary page please enter it here:

Critical care unit name:  
Operational Delivery Network (ODN) /Region  
Date (dd/mm/yyyy)

Prince Philip Hospital  
Wales  
30/06/2023

### 2. Filling in the sheet

Do not fill anything in on summary of scores sheet. On every other sheet, every box that is blue requires a number to be inputted as follows:

0 = Not met 1 = Partially met 2 = Fully met

3 = Not Applicable to your ICU

### 3. Navigating the sheets

To get to a sheet either click on the sheet name tab at the bottom of the screen, or from the Summary of scores, click on the text that you want to go to.

### 4. Creating a PDF

To create a PDF summary of the gap analysis of your ICU click on the button below (macros must be enabled for it to work).

Summary of the gap analysis of your ICU compared to the GPICS v2 Report date:

Section	Description	STANDARDS			RECOMMENDATIONS		
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Fully Met
1	CRITICAL CARE SERVICES: STRUCTURE						
1.1	Levels of Critical Care	0%	0%	100%	0%	0%	0%
1.2	Outcomes	0%	50%	50%	0%	67%	33%
1.3	Level 2 and 3 Physical Facilities	0%	0%	50%	0%	13%	50%
1.4	Clinical Information Systems	0%	0%	100%	90%	10%	0%
1.5	Clinical Equipment	19%	13%	69%	0%	0%	100%
1.6	Cardiothoracic Critical Care				0%	0%	0%
1.7	Neurocritical Care	0%	0%	0%	0%	0%	0%
2	CRITICAL CARE SERVICE: WORKFORCE						
2.1	Medical Staffing	0%	20%	80%	0%	0%	100%
2.2	Registered Nursing Staff	10%	20%	70%	25%	0%	75%
2.3	Workforce, Induction & Training of Medical and Nursing Staff	0%	27%	73%	10%	70%	20%
2.4	Advanced Critical Care Practitioners						
2.5	Pharmacists	63%	13%	13%	80%	0%	20%
2.6	Physiotherapists	13%	38%	50%	70%	20%	10%
2.7	Dieticians	0%	38%	63%	33%	67%	0%
2.8	Speech and Language Therapists	0%	50%	0%	63%	38%	0%
2.9	Occupational Therapists	67%	0%	33%	100%	0%	0%
2.10	Psychologists	0%	0%	100%	0%	50%	50%
2.11	Healthcare Scientists Specialising in Critical Care						
2.12	Support Staff	10%	30%	60%	20%	40%	40%
2.13	Smaller Remote and Rural Critical Care Units	0%	0%	100%	0%	0%	100%
3	CRITICAL CARE SERVICES: PROCESS						
3.1	Admissions, Discharge and Handover	27%	27%	45%	0%	0%	0%
3.2	Capacity Management	14%	29%	57%	20%	60%	20%
3.3	Critical Care Outreach and Rapid Response Systems	0%	0%	100%	20%	0%	60%
3.4	Infection Control	0%	0%	50%	0%	17%	67%
3.5	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology	0%	0%	83%	14%	29%	43%
3.6	Rehabilitation	29%	29%	29%	29%	14%	14%
3.7	Intensive Care Follow Up	50%	0%	50%	0%	9%	0%
3.8	The Patient and Relative Perspective	29%	29%	43%	50%	10%	40%
3.9	Staff Support	0%	0%	100%	0%	0%	100%
3.10	Inter and Intra Hospital Transfer of Critically Ill Patients	0%	13%	88%	8%	8%	85%
3.11	Care at the End of Life	0%	0%	100%	11%	11%	78%
3.12	Organ Donation	0%	0%	100%	0%	29%	71%
3.13	Legal Aspects of Capacity and Decision Making	0%	100%	0%	0%	100%	0%
4	CRITICAL CARE SERVICES: CLINICAL CARE						
4.1	Respiratory Support	0%	10%	90%	75%	0%	25%
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	50%	50%	71%	0%	29%
4.3	Renal Support	0%	0%	100%	0%	0%	80%
4.4	Gastrointestinal Support and Nutrition	0%	60%	40%	30%	0%	70%
4.5	Liver Support				30%	10%	50%
4.6	Cardiovascular Support	50%	33%	17%	33%	0%	67%
4.7	Echocardiography and Ultrasound	64%	0%	27%	89%	0%	11%
4.8	Neurological Support	14%	0%	86%	31%	0%	69%
4.9	Burns						
4.10	Care of the Critically Ill Pregnant (or Recently Pregnant) Woman						
4.11	Care of the Critically Ill Child in an Adult Critical Care Unit						
4.12	Standardised Care of the Critically Ill Patient	10%	0%	90%	10%	0%	90%
5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS						
5.1	Research and Development	0%	0%	0%	0%	0%	100%
5.2	Audit and Quality Improvement	60%	20%	20%	33%	50%	17%
5.3	Clinical Governance	20%	20%	50%	50%	50%	0%
5.4	Critical Care Networks	0%	0%	100%	0%	0%	10%
5.5	Critical Care Commissioning	0%	0%	100%			
6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS						
6.1	Fire	10%	30%	50%	33%	67%	0%
6.2	Major Incidents	29%	43%	29%	56%	0%	22%
6.3	High Consequence Infectious Diseases: Initial Isolation and Management	0%	0%	100%	10%	10%	70%
6.4	Surge and Business Continuity Planning	50%	0%	50%	0%	20%	80%

Section 1		CRITICAL CARE SERVICES: STRUCTURE		Level description	Choose level	Comments
1.1						
Levels of Critical Care						
STANDARDS						
1	All patients admitted to a critical care unit must be included in a national clinical audit programme in which Levels of Care data are collected.		met / not met	2	Fully met	
2	Level of Care classification must not be used in isolation to decide upon a patient's requirements.		met/ not met	2	Fully met	
RECOMMENDATIONS						
	None.			3	Not applicable to Unit	
1.2						
Outcomes						
STANDARDS						
1	Critical care units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.		met - comprehensive programme with multiprofessional involvement, partially - programme but limited multiprofessional involvement, not met - no review	2	Fully met	
2	The unit must participate in a National Audit Programme for Adult Critical Care.		See section 1.1	2	Fully met	
3	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care.		met / not met	1	Partially met	
4	Critical care units should participate in a programme of hospital-acquired infection surveillance to monitor and benchmark rates of catheter-related bloodstream infections, antimicrobial use and frequency of multi-resistant infections as infection in Critical Care Quality Improvement Programme (ICQIP).		Met / unmet	1	Partially met	
RECOMMENDATIONS						
1	The UK intensive care community should encourage and develop a validated methodology to review referrals to intensive care and evaluate decision making and subsequent outcomes relating to intensive care admission and referral.		National measure			
2	Units should develop a consistent approach to patient-centred decision-making, evaluating burdens and benefits of admission to intensive care, and be able to demonstrate this through the audit of pre-admission consultation, agreed ceilings of therapy, and time-limited treatment trials.		met - all admissions audited and reviewed, partially met, some audit evidence of this process, not met - no audit information / no review of admissions	2	Fully met	
3	Longer-term mortality should be collected on all patients admitted to critical care.		met - collected on all patients, partially met - intermittent audit / review, not met - not reviewed	1	Partially met	
4	The UK intensive care community should encourage and develop validated measures of longer-term patient- and family-centred outcomes beyond mortality, including measures of functional ability, socioeconomic consequences, and carer burden.		National measure			
5	The UK intensive care community should encourage and develop validated measures of quality of care relating to end of life and bereavement.		National measure			
6	Critical care units should consider systematic assessment of patient and family experiences and demonstrate how these are used to guide improvement.		met - quarterly assessment, partially met - 1-2 yearly, not met - not done	1	Partially met	
1.3						
Level 2 and 3 Physical Facilities						
STANDARDS						
1	Critical care facilities must comply with national standards.		met / not met	2	Fully met	
2	All new build units must comply with HBN 04-02.		met / not met / not applicable	3	Not applicable to Unit	
3	Medicines and fluid storage must comply with HBN 00-03.		met / not met			
RECOMMENDATIONS						
1	Existing units that do not comply should have a timeline to establish when national standards will be met.		met - time line and evidence to suggest progress, partially met - timeline but no evidence of progress, not met - no timeline / not applicable if standards met	2	Fully met	
2	Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.		met/not met	3	Not applicable to Unit	
3	The unit should have enough beds and resources to obviate the need to transfer patients to other critical care units for non-clinical reasons.		met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2	Fully met	
4	When planning or redeveloping a critical care area, Document HBN 04-02 should be considered.		met, partially met, not met, not applicable	3	Not applicable to Unit	
5	Critical care units should incorporate sufficient storage for medicines (including refrigerated and controlled drugs), IV fluids (including renal replacement) and parent fluids. Storage areas/rooms should be secure and appropriately temperature controlled for all medicines. ICU designs also, need to account for how selected medicines, including patient's own drugs, will be securely stored and readily accessible near the patient's bedside.		met, partially met, not met, not applicable	2	Fully met	
6	It is recommended that critical care areas that have undergone recent new unit planning and building are contacted by those embarking on a new build to share experiences and learning.		met, partially met, not met, not applicable	3	Not applicable to Unit	
7	Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and dignity needs, and staff and visitor areas. Consideration should also be given to the patient's recovery and rehabilitation needs, including the potential for long-stay patients to spend periods outside.		met, partially met, not met, not applicable	1	Partially met	
8	Critical care units should be inspected as part of the peer-review process, including the review of the building and facilities. Feedback should include any concerns or highlight any success to lineframes.		met - peer reviewed, feedback included, partially met - peer review, no feedback, not met - no peer review	2	Fully met	
9	Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners.		National/regional measure			
1.4						
Clinical Information Systems'						
'If no CIS then Not Applicable						
STANDARDS						
1	The CIS must comply with the set of common specifications, frameworks and implementation guides that support interoperability as specified with the NHS Interoperability Toolkit ( <a href="https://digital.nhs.uk/services/interoperability-toolkit">https://digital.nhs.uk/services/interoperability-toolkit</a> ).			3	Not applicable to Unit	
2	CIS procurement and deployment must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system. This should include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineering, the CDO (Chief Clinical Information Officer) and ICT specialists.		met, partially met, not met, not applicable			
3	The CIS must have a rigorous business continuity access (BCA) plan and resilience system so that critical patient information remains available and system downtime must not compromise patient safety in any way. There must be a process to ensure that sufficient staff trained in BCA contingency measures are available 24/7.		Met = full BCP present and tested, partially = some aspects not expected to continue as usual or BCP untested, not met = no documented BCP	3	Not applicable to Unit	
4	Where patient data management systems (PMS) or electronic patient record (EPR) systems are used, there must be access to a dedicated workstation computer at each bed space. An appropriate number of both mobile and fixed workstations must be available to facilitate timely patient care by medical, nursing and allied staff on ward rounds and on an ad hoc basis.		Met = workstation for every bedspace plus additional workstations for mobile staff, partially met = insufficient mobile workstations, not met = absence of workstation at every bedspace (even if mobile stations available) or absence of any mobile workstations.	3	Not applicable to Unit	
5	The CIS must have robust implementation and ongoing training programmes to support all staff in its clinical and management use. These should be provided by the NHS organisation in partnership with the vendor company. Due consideration should be given to how this training will be provided to new starters and locum staff. There should be a mechanism by which any specialist involved in the patient's care while on the critical care unit has access to all pertinent information and is able to document in such a way as to facilitate care. This is particularly important when critical care and hospital documentation systems are distinct.		Met = training provided to all staff requiring it including new starters, >90% on first day of clinical duty or before, partially met >80% but <90% trained on first day of starting, not met < >80% trained on day 1	3	Not applicable to Unit	
RECOMMENDATIONS						
1	Critical care units should consider using a CIS.		met / not met	1	Partially met	
2	CIS should be part of an electronic health record. The specification should include high-resolution data capture from patient monitoring, infusion devices, ventilators, cardiac output measurement, temperature management devices, intra-aortic balloon pumps, extra-corporeal life support (ECLS) devices, blood gas analysers and renal replacement therapy (RRT) devices. A CIS should be capable of customizable display of this information along with clinical notes.		Met = >50% of device types ever used linked to system, partially met = 80-90% of all devices linked, not met = <80% of devices linked (ie we wouldn't expect a unit using 2 IABPs a year to link them, but would expect a unit using them monthly to link them)	0	Not met	
3	The CIS should be connected to the hospital's patient information system for demographic and admission/discharge data, to laboratories for results, to radiology for reports and to other key software, e.g. National Critical Care Audit Systems and Hospital Electronic Prescribing and Medication Administration (HEPMA) for electronic data sharing. The CIS should be able to collect and share electronically Critical Care Minimum Data Sets (CCMDS) and national audit data to facilitate electronic generation of reports and audit. In the event of replacing existing CIS, it must be possible to access archived patient records in a user-friendly format.		Met = clinical staff do not need to routinely log in to another system to obtain results required to care for patients, partially met = clinical staff have to log into 1 additional system regularly, not met = staff have to access >1 additional system to obtain routine information required for patient assessment	1	Partially met	
4	Investigation ordering should be fully integrated and recorded, and include electronic prescribing of drugs and fluids and ordering of laboratory and radiology services.		Met = captures all required data, Unmet = unable to capture any information regarded as essential to review patient	0	Not met	
5	Daily summary plans should capture electronically activity data from the rest of the CIS, with the addition of free-hand text for healthcare professionals treating and visiting the patients.		Met = provides care-specific worklists and alerts, partially met = either alerts or worklists not provided comprehensively, unmet = unable to provide worklists or does not provide alerts (could probably do with splitting)	0	Not met	
6	The CIS should be capable of forming worklists for individual members of the critical care team to allow patient- and staff-based lists of tasks to be completed. The CIS should include the ability to alert when tasks are near due, done overdue, and record and audit performance.		Met = alerts provided in real time in format required by unit, partially met = some alerts but not all those required or can only be provided in a suboptimal medium, not met = no dashboard facility	0	Not met	
7	There should be a functionality within the database to alert, within a short timeframe, lack of compliance with care bundles and specifically for physiological abnormalities that are undesirable or life threatening. These alerts should be via dashboards displayed clearly within the unit and also via text or email to appropriate or named key devices carried by healthcare staff.		Met = single log in provided computer operating system already logged in, not met = user has to enter ID more than once to access	0	Not met	
8	The CIS should include customizable transfer/discharge summary, pulling key information from diagnoses, intensive care management, clinical notes, tabs and medication.		Met = versatile system where users have been able to create decision support algorithms as required, partially met = some pre specified decision support provided but limited additional configuration by end user, Not met = no decision support available	0	Not met	
9	Flexibility through assessing care records online or through mobile devices should be possible.					
10	The CIS should handle authentication and authorisation through Single Sign On, including the use of RFID/Smart cardiobionics.					
11	The system should provide capacity to evolve sophisticated electronic decision support systems, to facilitate patient safety and quality. The CIS should be capable of feeding data to other life-health solutions for remote monitoring and advice on patient management.					
1.5						
Clinical Equipment						
STANDARDS						
1	All equipment must conform to the relevant safety standards and must be regularly serviced and maintained in accordance with the manufacturer's guidance.		met / not met	2	Fully met	
2	Uninterruptable power supply adequate to provide at least one hour of continuity of any critical equipment without battery back-up must be provided.		met / not met	2	Fully met	
3	There must be a programme in place for the routine replacement of capital equipment.		met / not met	0	Not met	
4	All staff must be appropriately trained and competent and familiar with the use of equipment. Up-to-date training records must be maintained to demonstrate that all staff (medical, nursing, AMP and support staff) have completed this provision.		Met = >85% trained staff for all equipment, partially 75-85% trained staff all equipment, not met < 75% or no clear record	2	Fully met	
5	There must be a mechanism in place for the replacement of equipment. Up-to-date training records must be maintained to demonstrate that all staff (medical, nursing, AMP and support staff) have completed this provision.		Met = not met	0	Not met	
6	EBME support must be available either in-house or on a contracted basis to ensure equipment is appropriately serviced. Regardless of the model of support, EBME personnel must have the appropriate skills and equipment to service the equipment used.		Met = not met	2	Fully met	
7	Equipment must be uniquely identified and listed on an appropriate asset register along with details of its life cycle and service history/requirements to facilitate planned maintenance and replacement.		met = >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record	2	Fully met	
8	There must be documented procedures for decontamination (cleaning, disinfection and sterilisation as appropriate, depending on equipment risk category and sensitivity of devices). Appropriate sterile services must be provisioned so that national standards are followed for the re-sterilisation of endoscopes and reusable.		met = >80% equipment, partially 75-80% all equipment, not met < 75% or no clear record	2	Fully met	
9	Critical care units must be able to provide appropriate systems in place to ensure an adequate supply of consumables.		Met = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents	2	Fully met	
10	There must be robust mechanisms for reporting adverse incidents resulting from the use of clinical equipment. Serious incidents involving clinical equipment may also need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).		met = policy in place, partially met, no policy but can evidence, not met - no policy and / or no evidence	2	Fully met	
11	The MHRA may issue safety alerts pertaining to medical devices, as may device manufacturers from time to time. There must be designated role and robust mechanism for ensuring that such alerts are cascaded to staff and acted upon as appropriate.		met = 100 % alerts received and acted upon, partially met 85-100% received, not met = no robust mechanisms or not able to evidence	1	Partially met	
12	Sufficient equipment must be available to meet the service demand to enable treatment provision (basic and specialist monitoring, ventilation, renal replacement therapy, information technology facilities etc.) in an appropriate timescale to meet patient need. Consideration must be given to the need to provide additional capacity in times of acute demand.		Met = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents	2	Fully met	
13	Magnetic resonance imaging (MRI) compatible equipment must be provided for use where mechanically ventilated patients are to undergo MRI investigation. These must be clearly labelled and staff must be adequately trained.		met / not met / not applicable	0	Not met	
14	Where advanced monitoring techniques are used (e.g. diagnostic electroencephalography, cardiac output monitors, intracranial pressure/other invasive neuromonitoring), there must be provision of appropriately trained staff to adequately interpret the results in a timely manner and to deal with likely complications of their use where appropriate.		Met = all advanced techniques reported within 6 hours of event (inc verbal and provisional reports), Partially 6-24h, Not met = greater than 24h delay	2	Fully met	
15	Immediate access to point of care blood gas analysis and glucose/ketone analysis on a 24/7 basis must be provided.		Met / not met	2	Fully met	
16	Where equipment is to be trialled on a loan basis for evaluation purposes, it is essential that adequate indemnity and governance arrangements are in place in case of injury to other patients or staff from potentially unfamiliar equipment, and the supplier should provide adequate training to ensure correct use. The EBME provider should facilitate this process by issuing the equipment for safety as well as evaluation services and maintenance facilities.		met / not met	1	Partially met	
RECOMMENDATIONS						
1	Standardisation of equipment should be encouraged both within the critical care unit and in other areas where intensive care may need to be delivered.		Met = all C&A areas or the routine use same monitoring / ventilators / portable ventilators / NIV / monitoring sets, Partially met = 1 item different, Not met = >1 item different (specialist equipment used in only 1 area not	2	Fully met	
2	The provision of diagnostic ultrasound equipment should be guided by the likely patient population and staff expertise. At very least, there must be immediate access to sufficient ultrasound equipment to ensure that intravascular catheters can be placed safely and in a timely manner, even in emergent circumstances.		met / not met	2	Fully met	

1.6 Cardiothoracic Critical Care				
*Not applicable to non Cardiothoracic Critical Care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of GPCs.	met / not met		3=Not applicable to Unit
2	Each cardiothoracic critical care unit must have designated lead consultant with training in cardiothoracic intensive care. This should be recognised in their job plan and they should be involved in multidisciplinary service planning and governance within the unit	met / not met		3=Not applicable to Unit
3	Each cardiothoracic critical care unit must have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service.	met / not met		3=Not applicable to Unit
4	There must be a resident doctor or ACP and a resident cardiac surgeon. There must be on-site 24/7 access to a doctor or ACP with advanced airway skills. The resident team must be trained in Cardiac Surgery Advanced Life Support (ICALS) and be capable of emergency chest re-opening 24/7.	met / not met		3=Not applicable to Unit
5	Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complies with national standards. There should be a clear escalation pathway from post-operative care to intensive care.	met / not met		3=Not applicable to Unit
6	The care of patients falling outside the protocolised care pathways must be reviewed by a multidisciplinary team led by a consultant trained in cardiac Intensive Care Medicine.	met / not met		3=Not applicable to Unit
7	Ventilated patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	met / not met		3=Not applicable to Unit
8	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care.			3=Not applicable to Unit
9	There must be a critical care pharmacist for every cardiothoracic critical care unit, supported by sufficient pharmacy technical staff.	met / not met		3=Not applicable to Unit
10	All cardiothoracic critical care units must participate in local and national audit. For example, for units in England, Wales and Northern Ireland, this is participation in the ICNARC ARIHC (Assessment of Risk in Cardiothoracic Intensive Care) programme - the national clinical audit for cardiothoracic critical care units.	met / not met		3=Not applicable to Unit
11	Trans thoracic and transoesophageal echocardiography must be immediately available.	met / not met		3=Not applicable to Unit
RECOMMENDATIONS				
1	The patient monitoring and physical support requirements in a cardiothoracic critical care unit should be no less than the requirements of patients cared for in a general (Level 3) critical care unit.	met / not met		3=Not applicable to Unit
2	Cardiac and thoracic surgery post-operative care is carried out in a dedicated environment with each component located in close proximity.			3=Not applicable to Unit
3	The cardiothoracic critical care unit should have in place agreed clinical criteria for the appropriate case-mix and arrangements for escalation to a general critical care facility as required.	met = clear written protocol, partially met = occurs in practice but referral/acceptor dependent, not met = escalation does not/cannot occur		3=Not applicable to Unit
4	ACCPs, with adequate training and appropriate support, can provide a safe, sustainable alternative to medical staff in the cardiothoracic critical care unit.	Statement		
5	Each day, a consultant in charge of the cardiothoracic critical care unit should coordinate input from members of the various teams in the immediate post-operative period.	met / not met		3=Not applicable to Unit
6	Perfusion services should be readily available.	met / not met		3=Not applicable to Unit
7	Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an active part in shaping services and analysing quality. Patient mortality audit is currently in the public domain for each unit and each member of the MDT should have an understanding of how their own role contributes to patient outcomes.	met / not met		3=Not applicable to Unit
1.7 Neurocritical Care*				
*NOT Applicable if non neurocritical care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in the relevant chapters of GPCs.	Met / not met		3=Not applicable to Unit
2	Neurocritical care units should have access to investigation facilities and appropriate clinical expertise for the following: a) diagnostic radiology (24-hour access to CT, access to MRI for ventilated subjects, and diagnostic angiography), b) access to biochemistry and microbiology services to analyse cerebrospinal fluid (CSF), c) neurophysiology (including electroencephalography (EEG) and evoked-response diagnosis and monitoring). Access to continuous 24-hour EEG monitoring is highly desirable.	met - all available, partially - some available		3=Not applicable to Unit
3	All cases requiring immediately lifesaving neurosurgery must be admitted to the local neurosurgical centre irrespective of the initial availability of neurocritical care beds.	fully met - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met =		3=Not applicable to Unit
4	Patients with a Glasgow Coma Scale (GCS) score of 5-8 following a head injury at any time must have access to specialist treatment from neuroscience unit.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)		3=Not applicable to Unit
5	As per NICE QST4, eligible patients must have assessment for in-patient rehabilitation if new cognitive, emotional, behavioural or physical difficulties persist for more than 72 hours.	met / not met		3=Not applicable to Unit
6	In addition to general rehabilitation, neurologically impaired patients must have access to specialist neuro-rehabilitation services.	met = have access immediately once ready for discharge from acute centre, partially met = have access but discharge delays >48h for >20% patients, not met = no access or delays > 4 weeks to access neuro rehab		3=Not applicable to Unit
7	Neurocritical care must have resources to support mechanical thrombectomy in line with NICE IPG 548.	met - 24/7, partially - 5/7 per week, not met = available less than less.		3=Not applicable to Unit
8	Neurocritical care must have resources to support regional networks for the safe and timely management of patients with subarachnoid haemorrhage.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)		3=Not applicable to Unit
9	Patients must be cared for by a multi-professional intensive care team with specialist expertise and experience in managing critically ill neurological patients using agreed protocols based on the best evidence available.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)		3=Not applicable to Unit
10	Care of critically ill neurological patients must fully integrate involvement of admitting specialties (neurology, neurosurgery, spinal surgery), and diagnostic/interventional specialties (neuroradiology and neurophysiology).			3=Not applicable to Unit
11	When calculating central perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.			
RECOMMENDATIONS				
1	Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care.	met / not met		3=Not applicable to Unit
2	Both the patient and family of the patient on neurocritical care should be offered support and guidance in the disease process and longer-term outcomes using specialist nurses and psychologists.	met = readily available at any point in pathway, partially met = available but not necessarily during critical care stav, not met = no psychological provision		3=Not applicable to Unit
3	Multimodal monitoring of patients with neurological injury should be consistent with international consensus recommendations.			3=Not applicable to Unit
4	Early and formal involvement of the neurorehabilitation team as part of the multidisciplinary team should be sought to optimise outcomes and facilitate transitions of care.	met = neurohub consult within first week after injury (may be specialist physio or practitioner or consultant), partially met = neurohub meets prior to transfer, not met = no input in acute setting		3=Not applicable to Unit
5	Specialist equipment needs to be freely available to facilitate the acute rehabilitative needs of all brain and spinal injured patients while on neurocritical care.			3=Not applicable to Unit
6	Neurocritical care units must be part of a regional network of care, with agreed rational transfer and repatriation protocols that ensure rapid acceptance of patients for specialist care, and transfer back to referring hospitals or onwards for further specialist long-term care when the need for specialist neuroscience care no longer exists.	met = meet full recommendation with audit data - partially - meet recommendation but no audit data, not met = no networks / poor network		3=Not applicable to Unit
7	Follow up and audit of outcomes from neurocritical care should include a measure of functional recovery at a minimum of six months.	met / not met		
8	Regular neurocritical care morbidity and mortality meetings should be undertaken involving all members of the multidisciplinary team, including the admitting specialties, allowing structured judgement case review.	met = quarterly or more frequent MDT involvement, partially = less frequent or less MD, not met = no MDM		3=Not applicable to Unit
9	Patients requiring intensive care for acute neurosurgical and neurological diseases in non-specialist centres should have direct communication to expertise in specialist neuroscience centres.	met/not met		3=Not applicable to Unit





3	After successful completion of clinical and academic PgDip ACCP requirements, including Non- Medical Prescribing, ACCPs should apply to the FICM for ACCP Membership.	Met = all ACCPs have FICM, partially met, = at least 50% have FICM not met = <50%	3=Not applicable to Unit	
4	It is recommended that employing units should only appoint FICM-associated ACCPs to ensure a standard knowledge base, minimum skillset and that FICM ACCP curriculum competencies have been met.	Met = all ACCPs have FICM competencies partially met = 50% have FICM competencies, not met = <50%	3=Not applicable to Unit	
5	While working autonomously, the ACCP will always work within a multi-professional team led by a consultant who is trained in ICM.		3=Not applicable to Unit	
6	It is recommended that critical care units employing ACCPs have transparent ACCP standard operating procedures and outcomes, and that any incidents are reviewed as part of the unit's governance arrangements.	Met = SOP in place, not met = no SOP	3=Not applicable to Unit	
7	It is recommended that the management of ACCPs forms a tripartite arrangement between an ICM consultant, ICU clinical supervisor and professional lead such as a senior nurse or AHP from the ACCP's base profession.	Met/not met	3=Not applicable to Unit	
8	Continuing professional development (CPD/appraisal) for ACCPs should be undertaken according to the FICM CPD/appraisal guidance on an annual basis.	Met/not met	3=Not applicable to Unit	
2.5 Pharmacists				
STANDARDS				
1	There must be a designated intensive care pharmacist for every critical care unit.	met / not met	2=Fully met	
2	There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and 2 for every Level 2 bed for a 5/7 a week service.	met = 0.1 bed, partially = 0.05-0.1 per bed, not <0.05	0=Not met	
3	Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020.	met - 7 days per week, partially met 5 days per week.	1=Partially met	
4	The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy.	met / not met	0=Not met	
5	Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so (Advanced Stage I) must have access to an Advanced Stage II (excellence level) intensive care pharmacist for advice and referral.	met / not met	0=Not met	
6	As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays). Attend = dips into ward rounds), as appropriate and discuss issues.	met = 5 days per week, partially met - 3-5 days per week, not met - less than less or not on ward round.	0=Not met	
7	There must be sufficient patient-facing pharmacy technical staff to provide supporting roles.	met / un met	0=Not met	
RECOMMENDATIONS				
1	To maintain the continuity of the service during annual leave, sick leave and training leave, additional appropriate resources will be required (20% minimum is recommended).	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no cover or on call type cover only	2=Fully met	
2	Intensive care pharmacists should undergo an independent, recognised process to verify competence level.	met / not met	0=Not met	
3	Senior specialist intensive care pharmacist support should, preferably, be provided within the organisation but may be provided from a critical care network or on a regional basis.	met / not met / not applicable	0=Not met	
4	A peer-to-peer practitioner visit should occur at least once a year to ensure training issues are identified and to help maintain the competence of small teams and sole workers. This supports General Pharmaceutical Council (GPhC) revalidation.	met - yearly, partially met 1-3 yearly, not met - not done or > 3 yearly	0=Not met	
5	Where a team of intensive care pharmacists is in place, there should be a structured range of expertise, from trainee to Fellow level.	met / not met	0=Not met	
6	Intensive care pharmacists are encouraged to become active independent prescribers.	Statement		
2.6 Physiotherapists				
STANDARDS				
1	Physiotherapists must participate in opportunities for integrated decision making and dissemination of clinical information. This may include handovers, consultant-led multidisciplinary ward rounds, MDT meetings, team briefings or operational and patient safety briefings.	met / not met	2=Fully met	
2	The critical care MDT must have an identifiable lead physiotherapist who will be accountable for clinical service delivery, provide training and mentorship to junior staff, and oversee clinical governance and quality assurance.	met / not met	1=Partially met	
3	All physiotherapy staff must receive appropriate competency-based training to ensure delivery of high-quality physiotherapy intervention within critical care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover.	met / not met	2=Fully met	
4	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care, ensuring compliance with both clinical and professional guidelines and standards.	met - fully met standard 7 days per week, partially met - meet standard 5 day per week, not met	1=Partially met	5 day rehab working only, underestabli
5	Respiratory physiotherapy must be available to critical care patients 24 hours a day and seven days a week. This includes the provision of an out of hours/on-call service which may utilise specialist and non-specialist intensive care staff.	met / not met	2=Fully met	Currently met but highly vulnerable
6	Physiotherapists, as part of the multidisciplinary team, must ensure the completion of a comprehensive clinical assessment of those at risk of or with identified physical and non-physical morbidity within four days of admission to intensive care and before discharge from intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation goals.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	0=Not met	
7	Patients receiving rehabilitation will be offered therapy by the multidisciplinary team across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	met - 7 days per week, partially met 5 days per week,	1=Partially met	Rehab is 5 days a week only and often
8	Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team(s) following discharge from intensive care. This should include the holistic individualised structured rehabilitation plan.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	
RECOMMENDATIONS				
1	The service provision should be based upon the overall patient case-mix taking into account acuity, dependency and complexity of the clinical case-mix. Staff resources and capability should be appropriately matched both in knowledge, skills, and number to deliver comprehensive respiratory care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover. Demand-capacity models to robustly determine physiotherapy staffing ratios in intensive care. The suggested ratio would be one WTE physiotherapist to four ICU Level 3 beds.	met 1 WTE to four level 3 beds ( or equivalent level 2 ), partially met 0.5-1.0 WTE per four level 3 beds, not met < 0.5 per four level 3 beds	0=Not met	currently 0.4 WTE established funding
2	Physiotherapy services should provide assessment and intervention for physical rehabilitation seven days per week.	met 7 days per week, partially met 5 days per week, not met < 5 days per week	1=Partially met	Rehab is 5 days a week only and often
3	The value and role of Therapy Support Workers or Rehabilitation Assistants should be considered as part of either the intensive care physiotherapy or multidisciplinary workforce.	Statement		
4	Competency/capability frameworks should be in place encompassing all Agendas for Change (AC) bands applicable to the local service. This should reflect relevant national competency and professional development frameworks. A local training and development programme should exist to align with these frameworks.	met / not met	0=Not met	
5	Clear role specifications should exist for intensive care physiotherapists who have reached the level of Advanced Practice according to the Health Education England Framework.	met / not met	0=Not met	
6	The intensive care physiotherapy service should have a clear local operational policy and care standards for service provision which reflects both national guidance and standards and local variations.	met / not met	0=Not met	
7	The intensive care physiotherapy service or, where appropriate, as part of the MDT, should have robust and evidence-based clinical guidelines/standard operating procedures surrounding airway clearance interventions and specialist rehabilitation interventions including early mobilisation of patients in intensive care.	met / not met	0=Not met	
8	The lead physiotherapist, or appropriate deputy, should participate in all relevant local (and where appropriate, regional) intensive care operational delivery, governance and quality improvement groups. This may include governance meetings, service improvement work-streams, morbidity and mortality review meetings, business continuity meetings, operational or clinical management meetings. This should also include active participation with their regional Critical Care Operational Delivery Network.	met / not met	3=Not applicable to Unit	
9	The physiotherapy intervention(s), as part of the patient's individualised, structured rehabilitation plan, should be matched to the acuity, dependency and complexity of the patient, considering the patient's clinical needs and tolerance to intervention. This should align with the individualised, patient-centred rehabilitation goals and a holistic rehabilitation approach should be taken across a 24-hour period.	met / not met	1=Partially met	Rehab is 5 days a week only with limits
10	Physiotherapists should play a key collaborative role in the coordination and delivery of ventilation and tracheostomy weaning plans, including post-extubation and post-decannulation care. Additionally, physiotherapists should be a core part of the multidisciplinary delivery of non-invasive ventilation in intensive care.	met / not met	0=Not met	No structured MDT approach to weani
11	Targeted airway clearance interventions should only be considered in selected patients when clinically indicated. Routine secretion clearance therapy for all invasively-ventilated patients is not recommended.	met / not met	2=Fully met	
12	Where a local intensive care follow-up clinic/service exists, a physiotherapist should contribute to this service.	met / not met	0=Not met	Limited follow up by telephone by tech
2.7 Dietetics				
STANDARDS				
1	Critical care units must have access to dietitian five days a week during working hours	met / not met	2=Fully met	
2	There must be a dietitian as part of the critical care multidisciplinary team. If the critical care dietitian is working alone, they must be at the level of advanced practice. Where a gastrostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist (SLT) level 4 to ensure an appropriate range of expertise within the team and to have overall responsibility for the service provision.	met = dedicated named dietitian(s) / not met	2=Fully met	
3	Intensive care dietitian(s) must have satisfied local or national competency requirements and be able to undertake a nutrition assessment and implement an appropriate nutrition support plan for critically ill patients. If working at advanced clinical practice level, dietitians must be able to demonstrate application of the documented capabilities outlined in the multi-professional framework for advanced clinical practice in England.	met / not met	2=Fully met	
4	Intensive care dietitian(s) must work collaboratively contributing to consultant-led ward rounds, MDT meetings, and have regular consultant communication where nutritional goals, risks and data are discussed as per the NICE CG83.	met / not met	2=Fully met	
5	Intensive care dietitian(s) must lead on the development and implementation of any local nutrition support guideline(s).	met / not met	2=Fully met	
6	Intensive care dietitian(s) must contribute to appropriate strategic meetings and clinical governance activities, including leading regular nutrition-related audits and acting on the results, plus undertaking quality improvement projects that demonstrate the impact of dietetics on service delivery, quality and effectiveness.	met / not met	1=Partially met	
7	Intensive care dietitian(s) must provide ongoing education and training for other healthcare professionals.	Met = comprehensive nutrition teaching programme for other staff, Partially = evidence of ad hoc teaching by dietitian, Not met = no dietitian led teaching	1=Partially met	
8	Intensive care dietitian(s) must provide a structured handover to a ward dietitian when patients are discharged from the critical care unit, considering nutrition-related morbidity as per the NICE Quality Standard.	Met = >75% patients, Partially 50-75%, Not <50%	1=Partially met	
RECOMMENDATIONS				
1	There is a staffing level of at least 0.05-0.1 WTE per critical care bed to provide the dietetics service is recommended.	Met = >0.05, Partially = 0.025-0.05, Not <0.025	1=Partially met	
2	Intensive care dietitian(s) provide extended scope practitioner roles such as inserting feeding tubes, using indirect calorimetry to determine energy expenditure and supplementary prescribing where appropriate.	Met = all listed, Partially = some, Not = none	0=Not met	
3	Intensive care dietitian(s) should consider undertaking and disseminating nutrition-related research to widen the evidence base.	Statement		
4	Intensive care dietitian(s) should consider joining national (Critical Care Specialist Group of the British Dietetic Association) and international intensive care and nutrition-specific societies (Intensive Care Society, European Society for Intensive Care Medicine, European Society for Parenteral and Enteral Nutrition, etc.).	met / not met	1=Partially met	
5	Intensive care dietitian(s) should represent dietetics on national and international society committees and guideline development groups.	Statement		
6	Intensive care dietitian(s) working at an advanced level should have or be working towards a master's level award.	Statement		
2.8 Speech and Language Therapists				
STANDARDS				
1	Critical care units must have access to a speech and language therapist five days a week during working hours.	met = 5 days, partially >=3 days, not <3 days	1=Partially met	There is no dedicated SLT services in
2	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	Met = >98%, partially met > 80%		
3	All critically ill patients who have communication and/or swallowing difficulties (dysphagia) must have timely access to an SLT service.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours		
4	All Speech and Language Therapists working in intensive care must be appropriately trained, competent and familiar with the use of relevant equipment.	met / not met	1=Partially met	Limited amount of SLT's with appropre
RECOMMENDATIONS				
1	The critical care SLT service is provided by a minimum of 0.1 WTE (whole time equivalent) per bed	met = 0.1, partially 0.05-0.1, not <0.05	0=Not met	



2	Patients should have access to a communication aid according to individual need in order to facilitate patient interaction and rehabilitation.	met = always available inc advanced devices, partially = available but may not have same day access or simple devices only, not met = no access (apart from simple white boards/signs)	1=Partially met	
3	Speech and Language Therapists should contribute to a suitable tracheostomy or non-invasive ventilation weaning plan for complex or long-stay patients.	met / not met	0=Not met	
4	SLT are available seven days a week.	met 7 days per week, partially met 5 days per week, not met, less than 5 days or sporadic service	0=Not met	
5	FES should be available for Speech and Language Therapists to use in assessment and management of dysphagia in intensive care patients.	met - FES available 5 days/week, partially met = adhoc availability, not met - no service	0=Not met	
6	Speech and Language Therapists should work as an integral member of the multidisciplinary team on the critical care unit, contributing to all multidisciplinary ward rounds, tracheostomy teams, clinical governance groups, audit, research, education and policy development.	met - SLT attend daily ward rounds 5 days a week, partially met - available on request, not met = no service	1=Partially met	
7	Swallowing and communication recommendations and treatment plans should be included in any medical handover when the patient is transferred from intensive care to another unit or ward.	Met (included in standardised handover process) or not met	1=Partially met	
8	Patients who are being considered for risk feeding should have access to an SLT assessment in order to clarify their level of aspiration risk and optimum oral feeding consistencies.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours	0=Not met	We have not had referrals asking for S
<b>2.9 Occupational Therapists</b>				
<b>STANDARDS</b>				
1	Critical care units must have access to occupational therapy services 5 days a week during working hours.	met = 5 day a week access, partially met = < 5 days/week, not met = no service or on call service from other depts only	0=Not met	No dedicated OT, but an OT that covers
2	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient; rehabilitation plans should be updated accordingly.	See 2.6.7	0=Not met	
3	All occupational therapy staff working in a critical care environment must adhere to the Royal College of Occupational Therapists' Code of Ethics and Professional Conduct (COT 2015) and the Professional Standards for Occupational Therapy Practice (COT 2017).	met / not met	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	There should be an identifiable lead occupational therapist with appropriate experience, who will be accountable for service provision and development.	met / not met	0=Not met	
2	The occupational therapy clinical lead should be responsible for supporting learning opportunities, training and clinical supervision for junior staff providing occupational therapy services in intensive care.	met / not met	0=Not met	
3	The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation programmes that address the complex functional, cognitive and psychosocial needs of the patient cohort.	met / not met	0=Not met	
4	Occupational therapy staff on the critical care unit should be able to assess and provide non-pharmacological treatment for those patients who present with delirium.	met (OT involved in management of delirium in ICU) partially = involved but no routine review of patients with delirium or not met	0=Not met	
5	Occupational therapists should be involved in intensive care follow-up clinics to assess and facilitate appropriate referrals rehabilitation or specialist services and to address any long-term physical and non-physical impairment affecting occupational performance.	met /not met	0=Not met	OTs followups complex patients within :
<b>2.10 Psychologists</b>				
<b>STANDARDS</b>				
1	All patients must be screened daily for delirium using a validated instrument.	met = > 95% screened, partially met > 80%, not met - < 80% or no audit data	2=Fully met	
2	Non-pharmacological strategies must be in place to prevent and reduce delirium.	met - there is a local delirium guideline detailing non pharmacological strategies. Not met	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	Psychologists should ensure that delirium is accurately assessed by nurses using a validated instrument, and that when delirium is detected, risk factors are reviewed and corrected by the MDT. They should advise on non-pharmacological strategies to prevent and reduce delirium at the ward level (by improving the environment) and patient level (to facilitate orientation and engagement).	met / not met	2=Fully met	
2	Psychologists should ensure that patients and relatives receive psychological education to explain the psychological impact of intensive care, drugs, procedures and environment. This can be delivered in person or via information leaflets.	met / not met	2=Fully met	
3	NICE CG83 and QS156 stipulate that patients should receive assessments and interventions for psychological as well as physical problems throughout the intensive care pathway. These should be delivered or supervised by qualified psychologists.	met = triggered or routine assessment available for all patients, partially = only available at certain points in pathway (ICU/ward/follow up), Not met = not available at all	2=Fully met	
4	Psychologists should organise short psychological assessments for all awake, alert patients in intensive care using a validated measure such as the Intensive Care Psychological Assessment Tool.	met = >75% suitable patients assessed, partially 50-75%,not <50% (or no audit data)	1=Partially met	
5	If a patient is screened as being at risk of future psychological morbidity, psychological support should be offered by psychologists or other appropriately trained staff (e.g. nurses or psychology trainees) to give patients the opportunity to express their needs and feelings, and to have those feelings validated and normalised.	met/not met	2=Fully met	
6	All patients bound to be at risk of psychological morbidity (following the short assessment) should receive a comprehensive assessment before discharge from critical care. Psychologists should ensure that psychological needs, support and goals are included in the individualised structured rehabilitation programme that is formally documented and handed over at the time of transfer to general wards.	met = 75% assessed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met = not assessed	1=Partially met	
7	The psychologist should advocate (in conjunction with hospital outreach and mental health teams) for a system to be in place for at-risk intensive care patients to receive psychological support on general wards.	met/not met	1=Partially met	
8	Psychologists should contribute to the information (verbal and written) patients and relatives receive to help them continue their personal rehabilitation plans and to know who to contact if they need support after leaving hospital.	met/not met	1=Partially met	
9	Psychologists should participate in the follow-up reviews that intensive care patients receive in the community or at outpatient clinics. As part of the critical care unit MDT, the psychologist should provide: a) Training for staff to increase knowledge and understanding of psychological reactions, delirium, distress, stress and psychological outcomes of critical illness, b) Consultation with the multidisciplinary team on communication, sleep, effects of sedation, anxiety, stress, mood, delirium, family issues and holistic care plans, c) Psychological support for families. Relatives may need support to cope with the shock of a family member becoming critically ill and being admitted to the critical care unit, as well as stress and exhaustion from caring for a patient during a long-term admission. They may also need bereavement support if their family member dies in the critical care unit.	met = always available at FU clinic, partially = available by referral, not met = not available	3=Not applicable to Unit	
10	During patients' rehabilitation and recovery period, the psychologist should provide: a) Consultation with outreach and general ward staff regarding psychological support for intensive care patients, b) Tailored evidence-based interventions for persisting morbidity such as anxiety, depression or PTSD; these should be offered by psychologists in a well-resourced follow-up service and should include trauma-focused cognitive behavioural therapy, c) Where funding for this is not available, referrals of patients directly to psychological therapy services, or recommendations for GPs to make referrals to these services, or advice to patients on how to access local psychosocial services, and d) Drop-in support groups for intensive care patients and their families after discharge from hospital, held in the hospital or community.	Met - all elements, partially = some, not = none (could be split)	2=Fully met	
11	Employers have a duty of care to support staff working in a stressful environment such as intensive care, where burnout is highly prevalent. Workplace stress should be addressed at organisational, team and individual levels. Psychologists should consult with intensive care leadership on systemic issues influencing staff well-being. Additionally, psychologists should run or oversee staff support programmes including one-to-one sessions, drop-in groups or reflective rounds according to staff wishes and availability, as well as reactive sessions for senior managers.	Met - all elements, partially = some, not = none (could be split)	1=Partially met	
12	To develop this coordinated service for patients, families, and staff, critical care units should employ a senior HCPC-registered practitioner psychologist. Large critical care units should have access to a WTE, and smaller units should have access to a psychologist with dedicated time for intensive care to deliver the points above.	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1=Partially met	
13		met/not met	2=Fully met	
<b>2.11 Healthcare Scientists Specialising in Critical Care</b>				
<b>STANDARDS</b>				
1	Critical Care Scientists must comply with the professional standards of behaviour and practice set out in Good Scientific Practice (GSP).	met/not met	3=Not applicable to Unit	
2	Critical Care Scientists responsible for management of medical devices and point of care diagnostic services must comply with the standards by the Medicines and Healthcare Products Regulatory Agency (MHRA) and the International Organisation for Standardisation (ISO) standard (22870:2016).	met/not met	3=Not applicable to Unit	
3	Critical Care Scientists voluntarily registered with the Health and Care Professions Council (HCPC) must meet the Standard of Proficiency and comply with the Standards of Conduct, Performance and Ethics.	met = are registered and comply / not met	3=Not applicable to Unit	
4	Critical care units receiving trainee healthcare scientists for training in intensive care must comply with the requirements for training set for them by the National School of Healthcare Scientist (NSHCS).	met / not met	3=Not applicable to Unit	
<b>RECOMMENDATIONS</b>				
1	The Critical Care Scientists should successfully complete an approved training programme, either via accredited specialist training or as part of the Scientist Training Program (STP) commissioned by the National School of Healthcare Science (NSHCS) and should be registered with the HCPC.	met/not met	3=Not applicable to Unit	
2	The Critical Care Scientists should work collaboratively to be a dynamic member of the multidisciplinary team, assisting in the provision of high quality, patient-centred care within the critical care environment.	met = embedded in dept, partially = available but not embedded, not	3=Not applicable to Unit	
3	The Critical Care Scientists should draw on specialist knowledge to provide advice to medical, nursing and wider multidisciplinary team working in a critical care setting about the safe and effective use of medical devices used within the critical care environment, including monitoring, diagnosis, and therapeutic technologies supporting critically ill patients.	met / not met	3=Not applicable to Unit	
4	The Critical Care Scientists should develop and support research activities, including facilitating evidence based practice and implementation of the latest technologies and software in the critical care environment.	met / not met	3=Not applicable to Unit	
5	The Critical Care Scientists should provide effective management and support for medical devices, including advising on optimal clinical settings and troubleshooting, resulting in focused, efficient and high-quality care.	met = evidence eg logs or equipment testing available / partially = happens but no evidence, not met	3=Not applicable to Unit	
6	The Critical Care Scientists should contribute to the educational needs of the multidisciplinary team, including delivering training, mentorship and educational support.	met = evidence of involvement in teaching and training / not met	3=Not applicable to Unit	
7	The Critical Care Scientists should demonstrate flexibility and adaptability to work across diverse pathways of patient care and clinical services that are both routine and highly specialised.	Statement		
8	The Critical Care Scientists should work safely and effectively within their scope of practice and ensure they do not practice in areas where they are not proficient.	met/not met	3=Not applicable to Unit	
9	As part of the multidisciplinary team, the Critical Care Scientists should contribute to the strategic direction, planning and delivery of critical care services.	met (ideally evidence eg attend dept meetings)/ not met	3=Not applicable to Unit	
10	The Critical Care Scientists should engage with the Society of Critical Care Technologies (SCCT) as their professional body in order to work in collaboration with the Academy for Healthcare Science and the NSHCS.	met/not met	3=Not applicable to Unit	
<b>2.12 Support Staff</b>				
<b>STANDARDS</b>				
1	All support staff must have clearly identifiable roles with specific competencies.	met / not met	1=Partially met	query competencies
2	All support staff must have a period of induction and supernumerary status.	met / not met	2=Fully met	
3	All support staff must be appropriately trained, competent and familiar with the use of equipment.	met / not met	2=Fully met	
4	All support staff must be included within the intensive care team and be updated on key unit issues and developments.	met / not met	2=Fully met	
5	Support staff roles must be clearly identifiable to colleagues, patients and visitors to the department, either by uniform and/or name badges.	met / not met	2=Fully met	
6	Intensive care areas must develop healthcare support worker roles to assist registered nurses in delivering direct patient care and in maintaining patient safety.	met / not met	2=Fully met	
7	Healthcare support workers must complete the Care Certificate and adhere to the Code of Conduct for healthcare support workers.	met / not met	0=Not met	Ask Sandra
8	Administrative roles must be developed to ensure all clinical staff are free to give direct patient care, and supported with essential data collection.	met / not met	1=Partially met	
9	Each intensive care area must have sufficient staff responsible for the cleanliness of the environment.	met / not met	2=Fully met	
10	Where direct care is augmented using support staff (including unregistered nurses), appropriate training and competence assessment of those staff are required.	met / not met	1=Partially met	Ask Sandra
<b>RECOMMENDATIONS</b>				
1	All staff should be encouraged to attend further training and/or education to support their development.	met / not met	2=Fully met	
2	Each critical care area should have healthcare support workers 24/7 to assist nursing staff in delivery of direct patient care.	met = all shifts covered, partially = 75% covered, not <75%	0=Not met	

3	Each critical care area should have ward clerk/receptionist cover seven days per week.	met = 7/7, partially 5/7, not = no receptionist	1=Partially met
4	Each critical care area should have a dedicated housekeeper/cleaner seven days per week.	met = 7/7, partially 5/7, not = no dedicated staff	2=Fully met
5	Each critical care area should have a data clerk or validation email address or a suitable alternative or train not "data clerk" or a satisfactory recognised audit programme (such as ICNARC or SIC/SAG) and responsibility for the validation of these data. The Intensive Care Unit should be responsible for the validation of these data.	met = full cover with leave cover, partially = less than recommended cover or no leave cover, not met = no dedicated cover	1=Partially met
2.13	Smaller Remote and Rural Critical Care Units	Only relevant for small number of units. An autopopulate feature of not applicable would be useful	
STANDARDS			
1	Network support must be in place to ensure smaller, remote and rural critical units meet these standards and recommendations.	met = active participation in network / not met	2=Fully met
2	The critical care service must be led by consultants trained in Intensive Care Medicine (ICM).	met / not met	2=Fully met
3	There must be access to appropriate advice from a consultant in ICM at all times.	met = 24/7 access to advice / not met	2=Fully met
4	Dedicated daytime critical care must be provided by a consultant trained in ICM with no other commitments.	met = 7/7, partially = 5/7 (or involves covering other areas at same time)	2=Fully met
5	There must be a doctor or ACCP with advanced airway skills resident within the hospital 24/7.	met / not met	2=Fully met
6	There must be a 24/7 dedicated resident on the critical care unit.	met / not met	2=Fully met
7	There must be structured handover between day-time and night-time staff supported by standardised policies for practice.	met / not met	2=Fully met
8	Appropriate CPD must be supported by the employer and undertaken by all professionals who deliver intensive care.	met / not met	2=Fully met
9	Regional transport arrangements (road and air) must be put in place to allow timely, safe transfer of patients with an appropriate level of monitoring, staffing and skills.	met / not met	2=Fully met
10	All critical care units, including Level 2 units, must enter data into national databases such as ICNARC or SIC/SAG.	met / not met	2=Fully met
RECOMMENDATIONS			
1	Network support should be explicit, resourced and supported by all the Healthcare Organisations, Boards, networks and regions involved and recognised in job planning.	met / not met	2=Fully met
2	Units should consider the development of telemedicine techniques for clinical decision making and educational support, in conjunction with their regional network.	Statement	
3	Remote critical care units should implement appropriate joint clinical governance procedures with both networked units and transfer services to include case-based review, critical incident analysis, and joint educational sessions.	met = formal arrangements with SLA in place / not met	2=Fully met
4	Where an intensive care pharmacist or healthcare professional, such as a physiotherapist or dietician, cannot be effectively delivered locally in a small unit, advice should be accessible from specialist colleagues through network support. Appropriate training bodies should devise and support remote and rural training posts in critical care.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit

Section 3		Critical Care Services: Process	Level description	Level	Comments
3.1 Admission, Discharge and Handover					
STANDARDS					
1	The decision to admit to the critical care unit and the management plan must be discussed with the duty consultant in Intensive Care Medicine.	Met = >95%, partial = >90%, not <90% or not data	2-Fully met		
2	There must be documentation in the patient record of the time and decision to admit to critical care.	< 85% met, 75-85 partially met, < 75% or no data not met	1-Partially met		
3	Unplanned admissions to the critical care unit must occur within four hours of making the decision to admit.	Met = >95%, partial = >90%, not <90% or no data	1-Partially met		
4	Patients must have a clear and documented treatment escalation plan.	Met >85%, partial 80-90%, not <80 or no audit evidence	2-Fully met		
5	Patients must be reviewed, in person, by a consultant in Intensive Care Medicine as urgently as the clinical state dictates and always within 12 hours of admission to critical care.	95% of the time - Met, <95% or no data - not met	2-Fully met		
6	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2-Fully met		
7a	Consultant in Intensive Care Medicine-led ward rounds must occur twice a day (including weekends and national holidays).	< 85% met, 75-85 partially met, < 75% or no data not met	1-Partially met		
7b	The nurse in charge should be present in person for the ward round.	< 85% met, 75-85 partially met, < 75% or no data not met	2-Fully met		
8	Patients discharged from critical care must have access to an intensive care follow-up programme.	met / not met	3-Not met		
9	Outreach from critical care to a general ward must occur within four hours of the decision and must occur between 07:30hrs and 21:00hrs.	met = >80%, partially = 60-80%, not <60%	3-Not met		
10	There must be a standardised handover procedure for medical, nursing and ANP staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation prescription.	met / not met	2-Fully met		
11	Patients undergoing specialist care must be repatriated to a healthcare organisation closer to their home when clinically appropriate to continue their rehabilitation, and this must occur within 48 hours of the decision to repatriate.	< 85% met, 75-85 partially met, < 75% or no data not met	3-Not met		
RECOMMENDATIONS					
None					
3.2 Capacity Management					
STANDARDS					
1	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care patients must be prioritised, such that patients requiring critical care support are admitted without delay (within four hours after decision to admit and completion of essential resuscitation/imaging) and patients no longer requiring critical care are discharged within four hours.	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not data	1-Partially met		
2	The final decision on utilisation of critical care beds and staff (which includes moving staff to help in other areas of the hospital at times of need) rests jointly with the duty consultant and the duty nurse in charge of the critical care unit. Under no circumstances should clinical decisions be overridden by non-clinical operational management issues.	met / not met	2-Fully met		
3	Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans.	met / not met	2-Fully met		
4	Hospital boards must demonstrate regular oversight of the use of critical care escalation and the provision of intensive care outside of the critical care unit.	met / not met	3-Not met		
5	Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit.	met / not met	2-Fully met		consultant to consultant discussion
6	Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios.	met / not met	1-Partially met		
7	Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duty intensive care consultants and duty nurses in charge to coordinate the usage of intensive care beds across the network.	met / not met / not applicable	3-Not applicable to Unit		Mutual aid document
8	Regional pandemic escalation plans must include trigger levels for agreed critical care admission criteria and thresholds for restriction of planned activity to assist neighbouring critical care units.	met / not met / not applicable	3-Not applicable to Unit		HB escalation plan
9	Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units to include escalation and, if required, prioritisation of transfers over local elective activity.	met / not met / not applicable	3-Not applicable to Unit		
10	Regional Intensive Care Networks must ensure that a system to record capacity across the network is in use, and that this is updated regularly.	met / not met / not applicable	3-Not applicable to Unit		
11	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	Met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2-Fully met		
RECOMMENDATIONS					
1	Critical care units should determine the emergency capacity they require to meet Standard 1 locally, based on their admission and occupancy data. The capacity to cope with the predicted emergency workload can then be managed by ensuring an appropriate number of beds available for emergency admissions before accepting elective admissions.	met / not met	3-Not met		
2	Acute hospitals will require at least one critical care bed per 36 acute hospital beds; hospitals undertaking a large amount of complex major surgical procedures are likely to need significantly more than this.	met = 1:35 or greater, partially 1:45-1:35	1-Partially met		medical patients only
3	Training should be provided to nursing staff in areas used for critical care escalation.	met = comprehensive documented training plan in place, partially = some training but not comprehensive	1-Partially met		
4	When using alternative areas of the hospital to provide critical care capacity, there should be adequate senior nursing and medical input such that the standards of care provided to those patients meet the standards provided to the patients within the critical care unit.	met = immediate access to ICU resident / registrar / nurse in charge for advice + twice daily consultant ward round	2-Fully met		
5	Decisions to proceed with major elective surgery should take into account current occupancy, provision of emergency capacity over the next 24 hours and, at times of regional network escalation, the emergency capacity in neighbouring units.	met / not met	1-Partially met		
6	Critical care units may find it useful to develop a statistical model locally that provides predictable data on the number of emergency admissions they should plan to accommodate in each 24-hour period, and use this model to assist decision making on when it is safe to proceed with planned elective work.	Statement			
3.3 Critical Care Outreach and Rapid Response Systems					
STANDARDS					
1	There must be a hospital wide, standardised approach to the detection of the deteriorating patient and a clearly documented escalation process.	met / not met	2-Fully met		HB policy
2	All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical deterioration in all non-pregnant adult patients over 16 years. The National Early Warning Score (NEWS-2) is the recommended for call systems as the more efficient and effective. Using a common score ensures that staff operate the same language across the patient pathway and enhances the benefits of an early warning system. As part of a multi-trigger system, other triggers such as urine output/ acute kidney injury alerts, cause for concern and patient/carer Call for Concern, should be considered as they will enhance the recognition of the deteriorating patient.	met / not met	2-Fully met		HB policy
RECOMMENDATIONS					
1	Each hospital should have a graded clinical response strategy consisting of three levels: low, medium and high. Each level of response should detail what is required from staff in terms of observational frequency, skills and competence, interventional therapies and senior clinical involvement. It should define the speed and urgency of response, including a clear escalation policy to ensure that an appropriate response always occurs and is available 24/7.	met / not met	2-Fully met		HB policy
2	Each organisation should ensure patients receive care from appropriately trained critical care outreach, rapid response or equivalent teams. The critical care outreach (CCO)/Rapid Response staff should have annual competency based assessment of core and additional specific competencies from a local or regional programme. This should relate to first line clinical assessment and intervention, be clearly outlined and closely reflect the Department of Health (DH) competencies for the recognition and response to the acutely ill patients in hospital.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	2-Fully met		HB policy
3	There should be accessible educational support for registered and non-registered ward staff in caring for the acutely ill ward patient in line with recorder and first responder level as outlined in the DH competencies for the recognition and response to the acutely ill patients in hospital. Staff looking after Level 1 and enhanced care area patients should be trained following the National Competency Framework for Level 1 and Enhanced Care Areas.	met / not met	3-Not met		xxx
5	Organisations should aim to deliver Comprehensive Critical Care Outreach as outlined by the seven core elements and have an operational policy that defines the remit of the CCO/Rapid Response or equivalent team within the organisation, in regard to these seven core elements.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	3-Not met		CCO/Hospital at night hubrid in discussion
6a	All patients should be reviewed by the CCO team (or equivalent) following discharge from the critical care unit to the ward.	Met - < 85%, partially met 85-75%, unmet = 75% or no data	3-Not applicable to Unit		
6b	All CCO teams should participate in the National Critical Care Outreach Activity Outcome Dataset.	met / not met	3-Not applicable to Unit		
6c	Each organisation should develop audit tools to assess utilisation of their track and trigger and graded response system with clear governance procedures for action of poor compliance healthcare organisation-wide. This should be undertaken in combination with an audit of compliance against the standards within NICE COSPP and must be fed back to healthcare organisation Boards and Critical Care Networks where relevant.	met / not met	1-Partially met		xxx
7a	Each hospital should be able to provide a CCO/rapid response team, or equivalent, that is available 24 hours per day, seven days a week.	met / not met	2-Fully met		
7b	There should be regular review of service provision to facilitate proactive approaches in order to match service configuration against local demands and activity. These should be reflected in the operational policy. There should be a nominated lead of service at healthcare organisation Board level with appropriate administrative cascade.	met / not met	2-Not met		CCO/Hospital at night hubrid in discussion
3.4 Infection Control					
STANDARDS					
1	Staff must follow safe insertion and maintenance procedures for intravascular and urinary catheters, and remove them when not required to minimise the risk of infection.	met = policy and training in place with daily care bundle checklist and audit data, partially = no formal daily checklist or no audit, not met = no policy	2-Fully met		
2	Infection control procedures must be documented and agreed by the multi-professional team.	met - policy in place not met - no policy	2-Fully met		
3	The WHO Five Moments of Hand Hygiene must be observed. Hand contamination is often due to contact with the environment rather than directly with the patient.	Handwashing audits: Met - < 95%, partially met 95-85%, unmet = 85%	xxx		
4	Cleaning of the environment must be undertaken by trained staff and subject to audit and quality control, with particular attention to high contact surfaces. Duties of cleaning and nursing staff in cleaning specific surfaces, should be clearly defined.	met = policy in place with regular audit data and systematic reports, partially = policies in place but only ad hoc audits, not met = anything else	2-Fully met		credits for cleaning
5	There must be surveillance systems in place for audit and feedback of nosocomial infection, reporting to the national scheme where applicable, for example, reporting central venous catheter related bloodstream infection to the Public Health England Infection in Critical Care (Public Involvement Programme) (PICKIP).	met = supply data to ICQIP (or equivalent) , partially met - locally monitored, not met - not regularly monitored	xxx		
6	The principles of antibiotic stewardship must be adhered to in consultation with the microbiology team.	met = documented early consultant microbiodiagnosis report at least 1x per 100 acute care admissions	xxx		
RECOMMENDATIONS					
1	Patients should be screened for carriage of MRSA and/or carbapenemase-producing organisms according to locally determined proportionate. Severity of risk factor algorithms is generally low and universal screening is preferable in highly endemic regions.	met - done > 95% of the time , partially met 85-90% of the time, unmet - <85% or no data or not done	2-Fully met		
2	Patients with MRSA carriage or infection should receive topical suppression to reduce shedding and, if possible, single-room isolation.	met / unmet	2-Fully met		in accordance with hb policy
3	Patients with diarrhoea and airborne infections should take precedence over others in allocation of single-room isolation. Patients with suspected or confirmed influenza should be placed in single rooms appropriate for respiratory isolation.	met / not met	2-Fully met		
4	Design of new units should include infection control specialists as part of the planning team. In particular, the bed spacing, proportion of single rooms and provision of sinks should be considered according to patient case-mix, national guidelines and prevalence of multi-resistant infections.	met / not met / not applicable	3-Not applicable to Unit		
5	The intensive care team should have access to an infection control and prevention team led by a microbiologist who can offer timely review and advice. Ideally, this should be part of timetabled microbiology rounds during the week. The microbiologist will advise on the extent and duration of antimicrobial chemotherapy in accordance with local formulary as a part of antibiotic stewardship.	met / not met	2-Fully met		
6	Infection control nursing staff or intensive care nurses with infection control training should be available to provide day-to-day advice on prevention of spread of infection, isolation priority and procedures and decontamination. Allocation of patients to single-room isolation for known or suspected infection should be reviewed on admission and frequently thereafter.	met / not met	1-Partially met		not available at weekends
7	There should be a means of continuous improvement in infection prevention and control, for example using surveillance and feedback.	met = formal audit and review process in place / unmet	2-Fully met		
3.5 Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology.					
STANDARDS					
1	There must be daily input from microbiology.	Met = 7/7 , partially, 5/7 plus on call, unmet 6 less			xxx
2	There must be local antimicrobial prescribing guidelines in accordance with the principles of antimicrobial stewardship.	met / not met	2-Fully met		hb policy
3	Clear protocols must be in place for management of massive haemorrhage including the role of laboratory services.	met / not met	2-Fully met		hb protocol

4	Acutely ill patients must have access to diagnostic radiology services at all times including timely access to a radiologist.	met / not met	2=Fully met	
5	All imaging investigations must be reported within an agreed timeframe relevant to the investigation by someone appropriately trained. All imaging investigations need to be accompanied by a formal, permanently recorded report covering the entirety of the investigation.	met / not met	2=Fully met	
6	There must be seven-day availability of radiology services, appropriate to the specialties being cared for, to allow timely investigation of critically ill patients. This would include, for example, ultrasound and CT-scanning to aid sepsis diagnosis and source control; and in neurocritical care units, access to interventional radiology.	met = full service 7/7, partially = 7/7 service but some elements not always available (eg 7/7 reporting but interventional service only daytime), unmet = <7/7 service	2=Fully met	not always available
RECOMMENDATIONS				
1	Microbiology advice should be from an adequately senior clinician, and oral, face-to-face interaction is encouraged.	Met / not met	xxx	
2	Critical or unexpected results of clinical pathology, microbiology or radiological investigations should be actively communicated to a responsible clinician according to local fail-safe policies.	policy in place = met, no policy = not met	2=Fully met	HB policy
3	Urgent clinical chemistry and haematology advice should be available within 60 minutes from an appropriate specialist and a radiologist should be immediately contactable to support the management of acutely ill patients at all times.	met / not met	1=Partially met	
4	All point of care laboratory devices used to assist clinical decision making should be subject to appropriate quality assurance mechanisms, agreed by laboratory and end-users.	met = fully centralised lab standard QA process in place with audit evidence, partially = some QA process with intermittent audit, unmet = no laboratory standard QA process	2=Fully met	
5	Clear protocols for access to radiology services that are not available on site (e.g. interventional radiology, MRI in ventilated patients) should be available.	met / not met	2=Not applicable to Unit	
6	Liaison psychiatry services should be available in all acute hospitals with a single point of referral. Emergency mental health referrals should be seen within one hour of referral and urgent mental healthcare referrals within 24 hours of referral (within the liaison team's usual operating hours).	met = available and meets time criteria, partially = available but not <1h <24h, not met = not available	1=Partially met	
7	Patients who have self-harmed, irrespective of the apparent motivation, should have a comprehensive psychosocial assessment. This should generally be the responsibility of the liaison psychiatry service and should not be delayed until after medical treatment is complete unless the patient's treatment is necessary, or the patient is unresponsive or otherwise incapable of being assessed.	met / not met	0=Not met	patients must be medically fit for crisis team assessment
8	Liaison professionals should be available to advise on issues around mental capacity and there should be working arrangements detailing who is responsible for assessing patients who may need to be detained under mental health legislation.	met / not met	2=Fully met	
3.6 Rehabilitation				
STANDARDS				
1	The rehabilitation needs of all patients must be assessed within four days of admission to intensive care (or on discharge if sooner) and a rehabilitation plan outlined by all relevant therapy professions is clinically indicated.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) unmet	1=Partially met	
2	Patients receiving rehabilitation must be offered therapy by the multi-professional team across a seven-day week and of a quantity and frequency appropriate to each therapy, in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	all rehab needs met 7 days a week = met, all rehab needs met 5 days per week = partially met, rehab needs not met consistently = unmet	1=Partially met	
3	All patients must be screened for delirium at least daily, and when changes or fluctuations in behaviour occur, in the event of a positive delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors completed.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) unmet	2=Fully met	
4	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) unmet	0=Not met	
5	Patients who stay in critical care for more than four days and are at risk of morbidity must have their ongoing rehabilitation needs addressed at post discharge follow-up, or in the community setting, at two to three months after discharge from critical care. At this point, additional referrals to any necessary services can be made.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) unmet	0=Not met	
6	Adults at risk of poor quality recovery must have an individualised rehabilitation plan documented in their formal handover of care when transferred from critical care to a general ward. All members of the care team must be aware of this. Patient involvement in setting this rehabilitation plan should occur as much as feasible and appropriate.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) unmet	0=Not met	
7	Adults who were in critical care and at risk of poor quality recovery must be given information to explain what they can do to help their recovery. This information should be provided, at the latest, before discharge from hospital.	> 85% of patients - met, 75-85% partially met, < 75% (or no data) unmet	2=Fully met	
RECOMMENDATIONS				
1	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per week, provision should be made for other therapy services to be provided as needed at weekends.	met 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet	1=Partially met	
2	Specialist interventional co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to ensure that assessments, referrals and documentation are completed and transferred to ongoing services and teams.	met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doesn't exist	0=Not met	
3	The role of therapy support workers or rehabilitation assistants should be considered as part of the rehabilitation team; these roles may be uni-professional or multi-professional in nature and recruited from nursing or allied health backgrounds. These may enable enhanced delivery and increased efficiency of rehabilitation service delivery, as well as ongoing rehabilitation to be delivered following discharge from critical care. Further work is required to determine the appropriate models of these roles.	Statement		
4	Rehabilitation outcomes should be monitored and progression made using outcome measures appropriate for the stage of recovery, individual therapy, and dependent on local resources (including personnel, equipment, and finances).	met = rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially = no, no only, unmet = no expression monitoring		
5	The rehabilitation plan that forms part of the handover of care on discharge from critical care should address all relevant domains for individual patients including, but not restricted to, physical, functional, communication, social, spiritual, nutritional and psychological.	met / not met		
6	To facilitate the rehabilitation component of the formal handover of care on discharge from critical care a general ward, weekly multidisciplinary rehabilitation ward rounds should be led by a senior member of the critical care multi-professional team and result in an update to the rehabilitation goals. These should be set in conjunction with the patient and/or care where appropriate.	met / not met	0=Not met	
7	Expectations of both patients and families should be identified regularly and addressed in a consistent manner by the most appropriate senior member of the team. All patient and family communication should be centrally documented to ensure that it can be accessed easily by all team members.	met / not met	2=Fully met	
8	For high-risk/complex patients, capturing the experience for the patient and family in a manner that they can reflect upon and engage with during the time spent in hospital should be considered. This may take the form of diaries, either paper or electronic, and may include photos, videos and written information. This material may be collected prospectively or retrospectively depending on the desire of patient and family.	met / not met		
3.7 Intensive Care Follow Up				
STANDARDS				
1	Patients with higher risk of morbidity related to critical illness must be given information about ongoing rehabilitation goals in the community.	met = all patients provided with rehab goals, partially = selected patients, unmet = none	2=Fully met	
2	Patients discharged from the critical care unit must have access to an intensive care follow-up programme, which can include review of clinical notes, patient questionnaires to assess recovery and an outpatient clinic appointment two to three months' post hospital discharge if required for specific patients.	met / not met	0=Not met	
RECOMMENDATIONS				
1	The follow-up programme should be formally and clearly communicated to the patient and their relatives on discharge from critical care, and again on discharge from hospital. Primary care should also be informed through the discharge summary.	met = all patients, partially = selected patients, unmet = none		
2	The follow-up programme should ensure the delivery of structured and supported self-directed rehabilitation to all patients at critical care discharge and at hospital discharge.	met = all patients, partially = selected patients, unmet = none		
3	A minimum 20-30 minute follow-up appointment should be offered two to three months after hospital discharge if appropriate. The follow-up team should include an intensive care consultant, intensive care nurse, clinical psychologist, physiotherapist, dietician and occupational therapist according to the individual patient's needs.	met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none		
4	Selection of patients for follow up should be based on length of stay (more than three days) or at increased risk (e.g. following anaesthesia, or post cardiac arrest/trauma). Self-selection of patients should also be facilitated.	met / not met		
5	Follow up should involve actively seeking common physical sequelae, such as weakness, weight loss and sexual dysfunction, and the consequences of critical care unit-related procedures (e.g. tracheostomy).	met / not met		
6	Review of current medication should be performed and rationalised with input from pharmacy if required.	met / not met		
7	Psychological sequelae (such as anxiety, depression, nightmares and post-traumatic stress disorder) should be sought via screening tools e.g. Hospital Anxiety Depression Scale (HADS), and UK Post Traumatic Stress Syndrome score (UK PTSS-14). This could be facilitated by review of clinical notes with patients and family or patient diary, use of screening questionnaires and review by a clinical psychologist.	Met = screening process in place for psychological seq for all patients, partially = for selected patients, unmet = no screening		
8	Following structured review, appropriate referrals to other services may be required and should be arranged where required.	met= referral from clinic / not met = referral via GP		
9	A bereavement follow-up service should be offered where explanations of diagnoses, treatments and support can be provided.	met / not met		
10	The establishment of a critical care patient and relatives support group should be encouraged.	met / not met	1=Partially met	
11	Patients and relatives should be surveyed regularly and this information should be utilised to assess rehabilitation and follow-up services.	see other standards		Established pre covid but not sustained during
3.8 The Patient and Relative Perspective				
STANDARDS				
1	All patients must be regularly assessed for the presence of pain which should be managed with a protocolised multimodal analgesic regimen.	met = all elements done, relatives provided with written info, Partially met = some elements done or not all families, not met = not done	2=Fully met	
2	The effects of delirium must be explained to patients and their families and this should be emphasised in follow-up visits post critical care. Written information about delirium must be provided.	met = Unit has guideline/protocol for delirium prevention/management that includes these measures and is included in induction training for staff / not met	1=Partially met	
3	When patients are sedated or unconscious or have delirium and require any intervention or nursing care, staff must explain to them in simple terms what they are doing.	met = guideline in place and done, partially met = some elements but not comprehensive or systematically applied, not met = not done	2=Fully met	
4	Critical care staff must offer patients ways to help improve the quality of their sleep, for example eye masks and ear plugs. Staff must try to minimise light and noise during the night.	met = written and >75% families having a formal documented communication, partially 50-75%, unmet = no written info and/or <50% having formal communication	0=Not met	
5	Patients and families must be given high quality verbal and written information while the patient is in critical care (such as information about the patient's treatment, what the patient might experience and how they might feel) and when they leave the unit (to help explain what has happened to the patient and what might help them in their recovery). Each unit must have such documents readily available and needs for patients and relatives. Young visitors and their parents will need specific support.	met = SLT involved and have full range of communication aids available / partially met = limited access to speech and language / not met	2=Fully met	fully met
6	Patients must be given help to communicate (e.g. speaking valves) (for patients with a tracheostomy, wipe boards or flash cards).	met / not met	0=Not met	
7	Critical care units must have policies about how to safeguard vulnerable adult patients.	met / not met		
8	Units must obtain regular feedback about the care that patients and relatives received during their critical care admission in order to learn from and act on the feedback received.	met / not met	0=Not met	
RECOMMENDATIONS				
1	Intensive care patients should have a patient diary.	met = >80% patients >48h stay, partial = only longer stay or <80%, unmet no diary	2=Fully met	
2	Understanding the individual who has become critically ill is important to help their treatment and recovery. A This is Mr board or document for each patient is very beneficial and should be used if possible.	met / not met	1=Partially met	
3	Intensive care and ward staff should have training in what intensive care is like for patients and relatives and what challenges patients face while in intensive care and during their rehabilitation. Asking former patients and relatives to help with this training is beneficial.	met / not met	0=Not met	
4	Intensive care staff should let relatives know how they can help the patient, for example by talking to or reading to the patient (even if the patient is unconscious or sedated), as a familiar voice can be reassuring. Relatives should also be allowed to help with simple aspects of caring for the patients, if they would like to, such as applying hand cream or brushing hair. Written information should be provided for relatives.	met / not met	2=Fully met	
5	Intensive care staff should spend time talking to the patient and relatives, seeing how they feel, asking about any worries they have and checking their understanding of any information that has been given. Clear information should be given to relatives regarding when they can visit.	met / not met	2=Fully met	
6	A room should be provided for relatives to wait in or have time away from the unit. This room should be comfortable and its facilities regularly reviewed. Feedback should be sought from families whether additional facilities and support are required.	met = relatives room, partially met, relatives room but poor facilities, not met = no dedicated relatives room	2=Fully met	
7	On discharge from the critical care unit, patients should be given the contact details of the healthcare professionals who are co-ordinating the patient's rehabilitation pathway.	met / unmet	0=Not met	
8	All patients should be visited by a critical care outreach team, who can help with the transition from Critical Care to ward this transition.	met / not met	0=Not met	
9	Intensive care patients should have access to formal support provided by the critical care service after they leave. ie critical care followup / outreach services.	met / not met	0=Not met	
10	Critical care units should provide relatives of patients who died in intensive care the opportunity of a follow-up meeting with an ICU staff member to discuss any questions they may have about their relative's time on the unit. Families may be given a leaflet after their relative dies in order that they can arrange a meeting at a later date if they wish to. It can also include other sources of support. Some units hold memorial services for relatives.	met / not met	0=Not met	Work underway to develop bereavement pathway supported by clinical psych
3.9 Staff Support				
STANDARDS				
1	All units must have policies in place to support staff engagement and retention.	met / not met	2=Fully met	
2	Induction and escalation policies must be clearly identified for all staff groups.	met / not met	2=Fully met	
3	100% of new staff must receive a job-specific induction to the unit.	met / not met	2=Fully met	
4	Workplace equity within staff groups must be transparent (e.g. rostering, annual leave policies, job plans). Staff must be aware of the policies.	met / not met	2=Fully met	

5	Staff well-being is an organisational priority. Units must monitor and regularly review metrics of staff well-being as quality indicators (e.g. sickness rates).	met - quarterly , partially met 1-2 yrs, unmet - not monitored or more than 2 yearly intervals	2+Fully met	
6	All staff must have opportunities for personal development reviews including annual appraisals.	met - > 85% of staff appraised / PDP done, Partially met 75-85% not met < 75% of staff	2+Fully met	
7	All staff working in critical care must be able to access the Freedom to Speak Up Guardian.	met / not met	1+Not applicable to Unit	Not specifically with this title but regular meetings to encourage feedback
8	Staff must be provided with adequate resources consistent with other GPCSC standards to deliver their job role, e.g. adequate staffing, access to facilities for nutrition and hydration, adequate equipment.	Statement		
9	Staff rostering must comply with Health and Safety Executive recommendations for sleep and rest.	met / not met	2+Fully met	
10	Units must provide adequate workplace facilities for staff breaks, which are separated from areas for relatives.	met / not met	2+Fully met	Source available Could be better
<b>RECOMMENDATIONS</b>				
1	All staff engaged in a managerial or leadership role should have access to appropriate mentoring and/or coaching services to support them in their role.	met / not met	2+Fully met	
2	All units should promote healthy rest and sleep policies for staff required to work overnight.	met / not met	2+Fully met	
3	All staff members should have access to an independent, professional psychological support service, which provides counselling services.	met / not met	2+Fully met	
4	All staff members should have self-referral access to an occupational health service and rapid access physiotherapy services.	met / not met	2+Fully met	
5	All units should provide frequent opportunities for shared learning, clinical communication, and reflection, to reduce professional isolation. This includes routine clinical practice (e.g. multidisciplinary rounds, mortality and morbidity meetings), as well as specific reflective events (e.g. Schwartz Centre Rounds, debriefing following medical emergencies).	met / not met	2+Fully met	
6	All staff should have ergonomic clinical work areas with appropriate access to light and control of noise.	met / not met	2+Fully met	
7	All staff should be supported to maintain a healthy lifestyle, e.g. provision of advice on diet and exercise.	met / not met	2+Fully met	
8	All units should conduct regular (at least annual) reviews of organisational policy on staff health and well-being.	met / not met	2+Fully met	HB wide policy
<b>3.10 Inter and Intra Hospital Transfer of Critically Ill Patients</b>				
<b>STANDARDS</b>				
1	Transfer to other critical care units for non-clinical reasons must be avoided where possible.		2+Fully met	
2	Appropriate equipment must be available to undertake a safe transfer and to manage complications/adverse events which may occur during a transfer. All equipment used for patient transfers must conform to the relevant safety standards, be regularly serviced, and checked immediately before use.	met / not met	2+Fully met	
3	All staff involved in a patient transfer must be trained, competent and familiar with the use of equipment.	met / not met	2+Fully met	
4	Where patient transfers result in a change of team managing the patient during or following a transfer, an appropriate and documented handover must be undertaken between the teams to ensure good continuity of care. This should include providing copies of the clinical record.	met / not met	2+Fully met	
5	A named intensive care consultant must take overall responsibility for the decision to transfer a patient and the level of support required, but does not necessarily have to undertake the transfer.	met / not met	2+Fully met	
6	Inter-hospital transfers must be undertaken in a timely fashion according to the patient's clinical condition.	met / not met	2+Fully met	
7	For inter-hospital transfers, there must always be a named consultant who will take responsibility for the patient on arrival at the receiving hospital. This must be agreed prior to the transfer being undertaken.	met / not met	2+Fully met	
8	Where patients have completed specialist care and ongoing intensive care needs can be provided in the patient's home, hospital transfer must take place within 48 hours of referral to the receiving hospital.	Percentage occurring within 48 hours of decision. Met > 85%, partially met 75-85%, not met < 75% of the time or no data collected.	1+Partially met	
<b>RECOMMENDATIONS</b>				
1	Transfers should follow the advice and protocols presented in the latest ICS transfer guidance.	met - meet standard, partially met, dont meet standard but risk assessment in place , not met - dont meet standard and no risk assessment	2+Fully met	
2	The reason for any transfer should be documented in the patient's notes. This should include an assessment of potential benefits against risks. Transfer decisions should only be made by consultant intensive care team members, and this information should also be documented.	met = documented 90%, partially met 80-90%, unmet <80% or no data or not a consultal decision	2+Fully met	
3	An adequately stocked and regularly checked, dedicated transfer bag should be available for use during all patient transfers. This bag should contain appropriate drugs and equipment for interventions that might be required in transit. The transfer bag contents should be checked routinely (ideally daily and a log of checks maintained) or, if sealed with a tag, then a daily check that the seal is unbroken. The transfer bag must be restocked between uses to avoid delays when it is needed. Staff carrying out patient transfers should be familiar with bag layout and content.	met = checked with log and tagged, partially = daily check but not tagged or logged, unmet = no checking or significant deficiencies in it available	2+Fully met	Supported by operating theatre
4	The patient's vital signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy any physiological deterioration during the transfer.	met = audit evidence of obs or transfer forms, unmet = no evidence	2+Fully met	
5	Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be scrutinised within a robust audit system, allowing eventful or substandard transfers to be investigated and lessons learnt to be shared widely, as well as numbers and reasons for transfers.	met = use of a network wide agreed form or electronic recording system, unmet = no standard system	2+Fully met	
6	Where an adverse event occurs during a transfer, this should be reported and investigated using the healthcare organisation incident reporting system at the transferring unit. All learning should be widely shared.	met / not met	2+Fully met	
7	Every acute healthcare organisation should have a designated consultant and nurse who are responsible for maintaining standards of transfer of critical care patients, guideline production, training, governance, audit and reporting.	met - both, partially met - one, not met - none	1+Partially met	
8	Training in transfer medicine should be an integral part of Intensive Care Medicine training for doctors and nurses.	Statement		
9	Where multiple teams are involved in a patient's care, appropriate handover should be undertaken between the teams prior to transfer. This should not delay the transfer.	met / not met	2+Fully met	
10	The patient, where possible, and their next-of-kin should be informed of the decision to transfer and an explanation given to them of the need for transfer. This discussion should be documented.	met = 95%, partially = 80-95%, unmet <80% documented	2+Fully met	
11	There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area. The definition of 'delay' will vary according to the reason for the transfer. For patients being transferred from a specialist critical care unit to a general critical care unit at the completion of specialist care, a delayed transfer is one that has not been undertaken 48 hours after the time of referral to the general critical care unit.	met / not met	2+Fully met	
12	Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who are at a high risk of harbouring such infections both during transfer and in the receiving hospital; their availability should be such that this does not delay a patient transfer. Similarly, isolation facilities must be available for immunocompromised patients who require them.	met / not	2+Fully met	
13	Critical care units should have an agreement with their local ambulance providers in relation to the contracted transport provision for intensive care services, and to ensure these standards are met throughout the entire patient pathway.	met / not met	2+Fully met	
14	There should be a system for monitoring the quality of inter hospital transfers and governance arrangements which includes capture of numbers, reasons for transfers, incidents, delayed transfers and outcomes, audit measures and lessons should be widely shared.	met = well established processes, data available, partially met - reviewed, limited data available, not met - death undertaken or not at all	2+Not met	
15	There should be standardised network wide transfer documentation and training programmes.	met = both / partially met = one or the other / not met = neither		
16	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and prevent the adverse impact of transfers on the transferring unit due to loss of key staff.	Statement		
<b>3.11 Care at the End of Life</b>				
<b>STANDARDS</b>				
1	Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and communicated to patients and their loved ones. The latter being of particular relevance if patients lack capacity (below).	met = 98% with clear documentation, partially = 95-98% documented but gaps found in documentation on audit, unmet = <95% or major failures in what is documented	2+Fully met	
2	Decision making surrounding end of life care (EOLC) must be performed in accordance with relevant statutory requirements and professional guidance: a) Mental Capacity Act 2005 (MCA 2005), England and Wales, b) Adults with Incapacity Act (2000), Scotland, c) Mental Capacity Act (Northern Ireland) 2016, d) Human Tissue Act, England, e) General Medical Council's Good Medical Practice: Specifically, Treatment and Care Towards the End of Life, Good Practice in Decision Making.	met / not met	2+Fully met	
3	Declaration of death by cardiorespiratory or neurological criteria must be done in accordance with professional guidance.	met / not met	2+Fully met	
4	Consideration must be made as to whether organ and tissue donation can be offered to every dying patient, and where appropriate the specialist nurse-organ donation (SNOD) should be contacted.	met = considered with audit data on referral rates reviewed quarterly, partially = considered but no audit data or <70% referral rate, unmet = not done	2+Fully met	
5	In order to identify dying patients and identify potential changes in their condition, those at high risk of dying must have their condition regularly reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.	Statement		
<b>RECOMMENDATIONS</b>				
1	Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying. Best practice dictates that those close to the patient should also be informed.	met / not met	2+Fully met	
2	Decision making related to care at the end of life should, wherever possible, involve patients and people close to them, as well as medical professionals. If the patient lacks capacity and there is no individual with Lasting Power of Attorney, responsibility for determining treatment rests with treating clinicians. Previous decisions should also be taken into account e.g. treatment escalation plans (TEP), BESTPACT (Best Practice Statement for End of Life Care) and treatment.	met / not met	2+Fully met	
3	At least two consultants, supported by senior ICU nursing agreement, should contribute to the process of recommending withdrawal or withholding treatments. Such processes are decided on a case-by-case basis and clarity of communication can be improved by outlining likely benefits and benefits of such decisions.	met - 7 days per week, partially met 5 days per week.	1+Not met	
4	Once patients are recognised as being in their final days/hours of life, therapeutic goals should be reviewed and accordingly altered to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn. The discussion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is intrinsic to palliative care in critically ill patients. This should be discussed with patients and families within that context. If initiated in emergent situations for incapacitated patients, DNACPR decisions should be discussed with patients' surrogates (as defined by the MCA or equivalent) at the earliest opportunity. The British Medical Association, Resuscitation Council UK and Royal College of Nurses have recently updated guidance on DNACPR.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	1+Partially met	
5	Dying patients should be managed by multi-professional teams that include senior medical and nursing staff from intensive care and referral teams. It may also include specialist palliative care teams.	met / not met	2+Fully met	
6	Therapeutic plans should be made and anticipatory medications prescribed for all patients in their final hours/days of life, enabling prompt symptom control. This includes therapeutic options for analgesia, dyspnoea, anxiety and agitation. Doses should be titrated for symptom relief based on explicit assessments. Where appropriate, the double effect of drugs used should be transparent to patients, staff and family.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	2+Fully met	
7	Care should address dying patients' need for spiritual and emotional support, and include that of their families and others close to them. The needs of loved ones to be with, care for and otherwise attend to dying patients should be met as far as is possible. If appropriate, religious or secular expertise should be sought (e.g. referral to chaplaincy, psychological services or patients' GPs). Staff should also have access to these support services.	met / not met	2+Fully met	
8	If death is considered to be very close, patients should not normally be transferred out of the critical care unit unless it is to facilitate (via discussion with patients and loved ones) significant improvements in care. If practical to do so, patients should be given the opportunity to die at home or in a hospice. All transfers should involve a handover of care and quality of care.	met / not met	2+Fully met	
9	Intensive care clinicians often have a responsibility for decision making and care of acutely unwell and deteriorating patients outside of the critical care unit. When reviewing such patients for potential treatment escalation, they should work with patients' clinical teams to ensure that decisions and communication regarding care at the end of life are made to the same standards as on the critical care unit.	met / not met	2+Fully met	
<b>3.12 Organ Donation</b>				
<b>STANDARDS</b>				
1	If a patient is close to death, doctors must explore with those close to them whether they had expressed any views about organ or tissue donation. Doctors must follow any national procedures for identifying potential organ donors and, in appropriate cases, for notifying the Specialist Nurse-Organ Donation (SNOD).	met = routinely done with collaborative requesting when possible, partially met = routinely done but not with collaborative requesting, unmet = poor results on referral rates	2+Fully met	
2	The National Institute for Health and Clinical Excellence guidance requires that the intensive care team caring for the patient should initiate discussions about potential organ donation with the SNOD whenever a patient meets the criteria for undertaking the tests, to confirm death using neurological criteria or when there is an intention to withdraw life-sustaining treatment in patients with a life-limiting or life-limiting condition which will, or is expected to, result in circulatory death.	met >85% of the time, partially met 75-85% of the time, unmet < 75% of the time or no data collected.	2+Fully met	
3	Critical care units must comply with the criteria for diagnosing death using neurological or circulatory criteria as set by the Academy of Medical Royal Colleges.	met / not met	2+Fully met	
4	All units must contribute data to the national potential donor audit.	met / not met	2+Fully met	
<b>RECOMMENDATIONS</b>				
1	Each acute hospital should have an Organ Donation Committee to oversee all aspects of deceased organ donation as recommended by the Department of Health's Organ Donation Taskforce. Funding for the committee's activities is provided by NHS Blood and Transplant (NHSBT).	met / not met	2+Fully met	
2	Each acute hospital should have a clinical lead for organ donation (CLiD) funded by NHSBT, with responsibility to implement organ donation policies, promote the adoption of best practice guidelines and to address any local barriers to donation.	met / not met	1+Partially met	Clinical lead is shared across two hospitals
3	Each critical care unit should have a designated SNOD employed by NHSBT to provide advice on all issues relating to donation, organise donor coordination, support the intensive care staff in donor management, complete the potential donor audit, engage in teaching and training and support donor families.	met / not met	1+Partially met	SNOD x 2 based across four hospitals
4	Guidelines on end of life care and withdrawal of life-sustaining treatments (WLST) should be compliant with the Mental Capacity Act 2005, and based on the guidance provided by the General Medical Council, and should be followed irrespective of any potential for organ donation. Determining best interests at the end of life should include an assessment of a patient's preferences and wishes regarding organ donation. Guidance on decisions regarding WLST in patients with devastating brain injury (DBI) should be based on the recommendations of FICM/AC and other professional bodies.	met / not met	2+Fully met	
5	A planned and collaborative approach to the family for organ donation between the intensive care team and the SNOD team should be routine practice as recommended by NICE in 2016.	met / not met	2+Fully met	

6	Consultants in Intensive Care Medicine should actively manage brain stem dead consented donors to optimise organ quality and increase the number of organs successfully retrieved and transplanted. Donor optimisation care bundles or protocols should be available and used.	met / not met	2=Fully met	
7	The intensive care team should manage resources flexibly to facilitate organ donation and/or end of life care for patients outside the critical care unit where appropriate.	met / not met	2=Fully met	
3.13 Legal Aspects of Capacity and Decision Making				
STANDARDS				
1	Units must have regular, minuted, multidisciplinary team meetings to review cases where dispute have or may have arisen.	met / not met	1=Partially met	
2	All patients must be presumed to have capacity to consent or withhold consent.	Statement		
3	If the patient has made a valid and applicable Advance Decision Refusing Treatment (ADRT), it must be respected (although an ADRT does not have formal legal standing in Scotland, they are likely to be highly persuasive to the court).	Statement		
4	Final determination of capacity for a specific treatment must be made by the treating clinician and documented.	Statement		
5	If a patient has capacity, their decision must be respected, even if the treating clinician considers the decision to be unwise.	Statement		
6	Patients who lack capacity must only be treated in their best interests (England & Wales) or if it is of benefit to the patient (Scotland).	Statement		
7	Determination of best interests/benefit must involve consultation between the treating consultant and individuals close to the patient (family and friends).	Statement		
8	The aim is to achieve consensus between team and family/friends as to what is in the best interests/benefit to the patient. When there is continued disagreement about best interests/benefit, the treating clinician must not act unilaterally.	Statement		
9	If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application must be made.	Statement		
RECOMMENDATIONS				
1	A written departmental protocol for resolution of disagreements should be in place. Disagreements may be within the team, between different clinical teams or between team and family/friends.	met / not met	1=Partially met	Hospital concerns policy (from family)
2	An ADRT that does not meet the criteria to be formally legally binding should nevertheless be taken into account as part of the best interests assessment as a strong indication of the patient's wishes and opinions.	Statement		
3	In situations of intractable disagreement, mediation should be considered prior to approaching the Court of Protection (England & Wales)/Court of Session (Scotland). NHS Resolution or the Civil Mediation Council provide access to individual mediators or recognised experts.	Statement		
4	Independent Mental Capacity Advocates (IMCA) should be consulted (in England and Wales) when a patient is 'unbefriended'. This only applies when there is no one who can be consulted about best interests, i.e. no family or friends. IMCAs should not be consulted because there is dispute about best interests between the medical team and family.	Statement		

Section 4	CRITICAL CARE SERVICES: CLINICAL CARE		Level description	Level	Comments
4.1 Respiratory Support					
STANDARDS					
1	Units must have access to sufficient modern invasive and non-invasive ventilators which will support pressure/volume controlled ventilation, titration of inspired oxygen concentration, support spontaneous ventilation and allow application of PEEP.	met / not met	2=Fully met		
2	Pulse oximetry, capnography, ECG, blood pressure monitoring and ventilator alarms must be used for all ventilated patients whose trachea is intubated.	met / not met	2=Fully met		
3	An accurate height must be measured on admission for every patient requiring invasive mechanical ventilation to calculate predicted body weight (PBW) and corresponding target tidal volume to allow protective ventilation (6ml/kg PBW in those with ARDS or at risk of ARDS).	met / not met	2=Fully met		
4	Units must have evidence-based, written guidelines covering the use of non-invasive ventilation, the management of ARDS, prevention of ventilator-associated pneumonia and weaning from ventilation (including the use of sedation).	met - guidelines for all and review date within last 3 years , partially met - one or more gudielines missing or not reviewed within the last 3 years, not met - limited guidlines and / or older than 3 years	1=Partially met		
5	Referral pathways for patients with severe but potentially reversible acute hypoxaemic respiratory failure must be in place with Regional Extra-corporeal Membrane Oxygenation-capable (ECMO) Centres.	met / not met	2=Fully met		
6	Units must have written guidelines on the indication, risks and practice of prone positioning in hypoxaemic respiratory failure.	met / not met	2=Fully met		
7	Units must have immediate access to point-of-care testing to enable arterial blood gas analysis.	met ABG machine on unit or within easy use, with a backup within 5 mins or unit or >1 machine, partially = single ABG machine with backup machine 5-30 minutes away or 24/7 on call repairs within 30 mins, unmet = no on-site backup and services >2	2=Fully met		
8	Standard operating procedures, including checklists, should be developed for intubation, extubation, bronchoscopy, prone positioning, tracheostomy and any high risk/invasive procedures.	met - guidelines for all and review date within last 3 years , partially met - one or more gudielines missing or not reviewed within the last 3 years, not met - limited guidlines and / or older than 3 years	2=Fully met		
9	Non-invasive ventilation must be considered and available for patients with acute hypercapnic respiratory failure.	met / not met	2=Fully met		
10	High flow nasal oxygen must be available for the management of patients with acute hypoxaemic respiratory failure.	met / not met	2=Fully met		
RECOMMENDATIONS					
1	Tidal volume (ml/kg PBW) , plateau airway pressures and cumulative fluid balance should be monitored and recorded daily in all patients requiring invasive ventilation.	met - all recorded daily , partially met - one / two not recorded daily, not met - more than two not recorded	2=Fully met		
2	Audit of compliance with ARDS, ventilator associated pneumonia and weaning guidelines should be undertaken quarterly.	met / not met	0=Not met		
3	Units should have standardised systems to monitor VAP rates and antibiotic resistance patterns.	met / not met	0=Not met		
4	There is insufficient evidence at present to inform clinicians about the role of Extracorporeal Carbon Dioxide Removal (ECCO2R) in acute hypoxaemic respiratory failure and ARDS. Patients should only receive ECCO2R within the governance framework set out in NICE Guidance.	met / not met	0=Not met		
4.2 Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services					
STANDARDS					
1	Level 3 units must have access to a regional home ventilation and weaning unit. Arrangements must be in place to collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex weaning problems to the Regional Centre.	met / not met	2=Fully met		
2	Units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.	met / not met	1=Partially met		
RECOMMENDATIONS					
1	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or neurological co-morbidities. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure.	met / not met	0=Not met		
2	Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietitian members.	met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved	0=Not met		
3	These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols.	met protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols in place/not reviewed in last 2 years	0=Not met		
4	Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and resources to provide these services as described in the section of this document on rehabilitation (Chapter 3.6).	met / not met	0=Not met		
5	The use of non-invasive ventilation (NIV) as a bridge to spontaneous breathing should be considered in selective groups. Resources and skill in NIV should be available in all units managing patients with prolonged ventilatory needs.	met / not met	2=Fully met		
6	Early discussion with regional domiciliary ventilation services should occur in any patient with chronic neuromuscular impairment, and in those requiring more than 21 days of ventilation. Regional weaning centres should offer advice to referring units to assist with weaning .	met / not met / NA if no regional weaning service	0=Not met		
7	The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation centres and protocols should be in place to aid these decisions.	met / not met / NA if no regional weaning service	2=Fully met		
4.3 Renal Support					
STANDARDS					
1	Critical care units must have the necessary facilities and expertise to provide acute RRT for patients with AKI on a 24/7 basis.	met / not met	2=Fully met		
2	Patients receiving acute RRT, where the cause of AKI is unclear or where RRT will be needed on intensive care discharge, must be discussed with the local renal team as per the NICE guideline.	met / not met	2=Fully met		



3	Patients receiving acute RRT must be cared for by a multi-professional team that is trained and experienced in delivering and monitoring RRT.	met / not met	2=Fully met	
4	Acute RRT for patients with progressive or severe AKI must be started before the onset of life-threatening complications associated with renal dysfunction.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	The decision to initiate RRT should be based on the condition and prognosis of the patient as a whole, and not on isolated urea or creatinine values as per Kidney Diseases Improving Global Outcomes (KDIGO) recommendations and the NICE guideline.	met / not met	2=Fully met	
2	Where life-threatening complications of AKI occur, such as intractable hyperkalaemia, RRT should be started emergently unless a decision has been made not to escalate therapy.	met / not met	2=Fully met	
3	Patients with end-stage renal failure who are not in a renal unit/dialysis centre and require urgent RRT may require critical care admission. In such cases, there should be close liaison with the regional renal service regarding transfer and vascular access.	met / not met	2=Fully met	
4	Continuous and intermittent RRT should be considered as complementary therapies for AKI. The choice of therapy should be based on patient status, expertise of the clinical staff and availability of machines.	met / not met	2=Fully met	
5	The dose of RRT should be prescribed at the beginning of the RRT session. It should be reviewed daily and tailored to the needs of the patient.	met = clear standardised RRT prescription with evidence of daily review and audit, partial = done but not clearly evidenced, no audit, unmet = no standardised RRT prescription	2=Fully met	
6	The decision to use anticoagulation to maintain circuit patency and the choice of anticoagulant should be based on the potential risks and benefits in an individual patient, the expertise of the clinical team and the options available. KDIGO guidelines suggest using regional citrate anticoagulation for CRRT rather than heparin in patients who do not have contraindications for citrate.	citrate anticoagulation should be available Met/unmet	2=Fully met	
7	Bicarbonate, rather than lactate should be used as a buffer in dialysate and replacement fluid for acute RRT.	met / Partially met = daily prescription chart but compliance not audited / not met		
8	Drug dosing may need adjusting whenever RRT is started or the RRT prescription is altered. Close collaboration with an intensive care pharmacist with suitable experience in AKI and the effects of RRT is essential.	met / not met	2=Fully met	
9	Patients treated with acute RRT should receive standard enteral nutrition as long as there are no significant electrolyte abnormalities or fluid overload refractory to RRT.	met / not met		
10	When discharged from critical care, the accepting team and GP should be informed that the patient had received RRT for AKI while in intensive care so that appropriate follow-up arrangements can be made.	met / not met	2=Fully met	
4.4 Gastrointestinal Support and Nutrition				
STANDARDS				
1	The type and position of nasogastric feeding tubes (NGTs) used for enteral feeding, hydration and/or drug administration, must comply with NHS Improvement guidelines.	met / not met	2=Fully met	
2	Intensive care services must have a nutrition support guideline with institutional strategies to promote nutrition delivery and to overcome EN intolerance. It is suggested that it should include: a) Measures to minimise the risk of EN aspiration, b) Criteria for the use of prokinetic medications, c) Criteria for naso-jejunal feeding, d) Criteria for use of parenteral nutrition, e) Consistent times for stopping and restarting EN around anaesthetic, surgical or bedside procedures and f) A protocol for initiation of nutrition without waiting for a dietitian's plan.	met = clear guideline in place meeting these criteria, partial = guideline in place with some omissions or >3y since review, unmet = no guideline or fails many of these criteria	1=Partially met	New guideline is underway as part of all wales systems
3	Intensive care services must have guidance in place relating to the identification of, and nutrition support for, those at risk of re-feeding syndrome.	met = clear guideline in place meeting these criteria and audit evidence, partial = guideline in place with some omissions or >3y since review or no audit evidence, unmet = no guideline or fails many of these criteria	1=Partially met	Guidance needs updating
4	Intensive care services must ensure that there is access to a range of parenteral nutrition bags which include vitamins, trace elements and minerals. A 'standard' bag of parenteral nutrition must be available within 24 hours.	met = all elements listed, partial = TPN available but limited range, unmet = not available or a single standard bag only available	1=Partially met	Limited range
5	Intensive care services must have access to a range of enteral nutrition products to include: a) Low electrolyte, b) High protein, c) Fluid restricted and d) 'Tolerance' (semi-elemental)	met / not met	2=Fully met	
RECOMMENDATIONS				
1	Nutritional status and risk should be assessed on admission, and energy, protein and micronutrient needs determined by a critical care dietitian or clinician with appropriate specialist training or experience.	met / not met	2=Fully met	
2	It is recommended that nutrition support (PN if EN is not possible) should be instigated within 48 hours in patients expected not to be on a full oral diet within three days.	met / not met	2=Fully met	
3	Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them.	met / not met	2=Fully met	
4	Efforts need not be made to cover full energy targets with EN or PN until clinical stability has been achieved. Delivering a calorie load which exceeds energy expenditure appears harmful and should be avoided, whereas hypocaloric nutrition may be safe initially.	met / not met	2=Fully met	
5	The energy content from certain drugs (e.g. Propofol, IV glucose and citrate anti-coagulation renal replacement therapy) should be accounted for to avoid overfeeding.	met / not met	2=Fully met	
6	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines.	met / not met	2=Fully met	
7	Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly infusion rate of EN to optimise delivery after interruptions.	met / not met	0=Not met	Will be part of WICIS
8	There should be access to nasal bridles to secure NGTs in agitated patients and guidelines for their use and aftercare.	met / not met	0=Not met	No bridles across the HB
9	Nutrition support targets should be included in the rehabilitation of critically ill patients.	met / not met	2=Fully met	
10	There should be bowel management guidelines which include: a) Regular monitoring and documentation of bowel habits (frequency & type), b) Minimising the use of drugs that can cause constipation or diarrhoea, c) The need for rectal examinations and treating faecal loading/impaction, d) When to use laxatives, enemas and suppositories, e) Management of ileus.	met = bowel management guideline and audited, partially met = protocol but not audited, unmet - no guideline	0=Not met	No guidelines in place for this
4.5 Liver Support				
STANDARDS				
1	Contact with regional liver and or liver transplant centre must be made early following admission to a critical care unit of a patient with ACUTE liver failure. Advice about management, prognosis and possible transfer can be discussed.	Statement		
2	Patients with ALF must be managed in a liver transplant centre if liver transplantation is clinically indicated.	Statement		



RECOMMENDATIONS				
1	Patients with liver failure plus any other organ dysfunction should be managed in a critical care environment. Attention should be made to cardiovascular support, rapid correction of actual or relative hypovolaemia, early renal and metabolic support.	met / not met	2=Fully met	
2	Sepsis is very common in patients with liver failure and intravenous antibiotics should be prescribed in any patient with a suggestion of sepsis on admission to critical care. The choice of antibiotic will be driven by knowledge of local microbiological flora and resistance patterns.	met / not met	2=Fully met	
3	The use of prophylactic blood products and other procoagulants products prior to interventions should be avoided. In general, patients with liver failure develop a balanced coagulation disorder. Both pro- and anti-coagulant protein production is reduced. Viscoelastic tests, such as thrombo-elastography or ROTEM, may help in management.	met: thromboelastogrpahy available, partially: principles followed but no TE available, unmet		
4	Patients with ALF should have access to plasma exchange therapies.	met / not met / not applicable	0=Not met	
5	Patients with ALF should have access to techniques used to assess intracranial pressure and/or cerebral perfusion, with intracranial hypertension being a recognised complication in patients with ALF. Strategies to monitor and manage ICH should be available in centres managing this group.	met / not met / not applicable	2=Fully met	
6	Advice should be sought from a specialist hepatologist for help with diagnosis, specific therapies and prognosis.	met / not met	2=Fully met	
7	Centres managing liver failure and liver trauma should have access to interventional radiologists.	met / not met / not applicable	0=Not met	
8	Links should be made with regional centre providing transjugular intrahepatic portosystemic shunt (TIPSS) for patients with bleeding varices.	met / not met	0=Not met	
9	Units that manage patients with liver failure should have 24-hour access to both diagnostic and therapeutic upper GI endoscopy service.	met = both, unmet if not available or no intervention available	1=Partially met	
10	Drug dosing may need adjusting in patients with liver failure. Close collaboration with an intensive care pharmacist with suitable experience in liver failure is essential.	met / not met	2=Fully met	
4.6 Cardiovascular Support				
STANDARDS				
1	Electrocardiography, chest X-Ray and transthoracic echocardiography (includes focused echo) although expertise may not be in unit and could be provided by other specialty such as cardiology. must be available at all times at the patient's bedside.	met = all available, partial = echo availability in hospital 24/7 but not always on unit, unmet = no echo available	1=Partially met	
2	A consultant cardiologist must be available at all times either locally or through a formal network.	met / not met	1=Partially met	
3	Adults with acute heart failure must be reviewed within 24 hours of admission by a dedicated specialist heart failure team (or equivalent), and their management should follow the guidelines detailed in the NICE Quality Standards.	met / not met	0=Not met	
4	Protocols for immediate transfer to a facility able to provide percutaneous revascularisation of patients presenting a myocardial infarction must be in place.	met / not met	2=Fully met	
5	The intensive care team must facilitate the implementation of national standards, guidelines and pathways pertaining to the patients with a cardiac disease, to be delivered in addition to the other organ support being provided.	met / not met	0=Not met	
6	The advanced management of patients with acute valvular insufficiency or acute heart failure secondary to valve disease must be guided in consultation with a local cardiologist and the specialist cardiothoracic surgical unit.	met / not met	0=Not met	
RECOMMENDATIONS				
1	A validated method for advanced haemodynamic assessment with a skilled operator in both the practical use of the device and interpreting the data it provides should be available at all times.	met / not met	2=Fully met	
2	An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.	met / not met	0=Not met	
3	Local protocols in the use of vasoactive drugs should be in place, although there is little evidence to support the use of any single agent in practice.	met / not met	2=Fully met	
4.7 Echocardiography and Ultrasound				
STANDARDS				
1	The gold standard investigation is a comprehensive study, performed and reported by a fully trained clinical specialist.	Statement		
2	A more limited study, focusing on a specific clinical question, is appropriate in many instances. This must be performed by a trained and competent practitioner.	met / not met	0=Not met	
3	Individuals who scan and report independently must be trained to a level that is appropriate for their clinical practice.	met / not met	0=Not met	
4	The service must have a nominated lead consultant with dedicated time in their job plan that is sufficient to reflect the demands of the service and associated governance processes.	met / not met	0=Not met	
5	Ultrasound equipment must be readily available, serviced regularly and up to date. There must be sufficient equipment to ensure immediate access for ultrasound guided vascular access at all times. Linear, curvilinear and phased array probes are required to provide a comprehensive ultrasound service.	met= immediate availability (ie on unit) of ultrasound machine for vascular access and rapid access of machine for focused echo/lung ultrasound / partially = not all elements eg only 1 machine on a large unit / not all probe types/ not met	2=Fully met	
6	Infection control measures must be adhered to at all times.	met / not met	2=Fully met	
7	The disinfection and storage of transoesophageal echocardiography probes must follow national guidelines. A record must be retained in order to identify and track patients after device usage in the event of future complication/infection.	met / not met / not applicable ( no TOE)	2=Fully met	
8	All images must be securely stored for quality assurance purposes with appropriate data governance. Reliance on the ultrasound machine storage capacity is not a secure method.	met = all images are stored, reviewed by trained echo specialist and uploaded to PACS, partial = uploaded but not reviewed or reviewed but non centralised storage, unmet = images not safely archived in PACS	0=Not met	
9	Whenever scans are performed to inform clinical decision making, a structured report must be generated and stored in the patient record.	met = structured report and audited, with > 90% compliance, partially met reported but not structured, not audited or < 90% compliance , not met = < 50% reported/documentd in notes	0=Not met	
10	Training scan reports must not be stored in the patient record unless someone suitably trained verifies the document first.	met / not met	0=Not met	
11	Quality improvement, audit, and peer review activity must occur regularly.	Fully met = peer review process at least monthly, partially met = peer review less frequently, not met = no regular system of peer review (excludes ad hoc peer review)	0=Not met	
12	Transoesophageal echocardiography (TOE) must be immediately available in all cardiothoracic critical care units and those units providing extra-corporeal circulatory support.	met / not met / not applicable ( no TOE)		

RECOMMENDATIONS				
1	All critical care units should be able to ensure the provision of point-of-care ultrasound.	met / not met	2=Fully met	
2	The service should be supported by a fully trained link-person within the cardiology and radiology departments, as appropriate.	met / not met	0=Not met	
3	Individuals who participate should regularly attend their institutional ultrasound meetings.	met / not met	0=Not met	
4	Individuals who scan and report independently should keep a personal logbook of their images and reports.	met / not met	0=Not met	
5	Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to more advanced accreditation.	met / not met	0=Not met	
6	Images and reports should be uploaded together to the same archive used by the host institution's cardiology or radiology department, as appropriate. Reports should identify the focused nature of the investigation and the clinical context. Scans undertaken as part of training should not be archived before they have been verified by a trainer.	met / not met	0=Not met	
7	Regional networks and electronic image transfer systems should be created to allow for prompt access to review scans by a specialist with Level 2 accreditation, or equivalent, when this is required.	met / unmet	0=Not met	
8	Consideration should be given to the development of fully qualified physiologists with dedicated intensive care commitment and experience under joint supervision to deliver echocardiography services within intensive care.	met / not met / not applicable	0=Not met	
9	Regular replacement of ultrasound equipment is required to ensure it remains up to date. Normal guidance states that electrical equipment is replaced every seven years, however ultrasound equipment may need to be updated more frequently to keep up with technological advances.	met / not met	0=Not met	
4.8 Neurological Support				
STANDARDS				
1	Adult patients with refractory convulsive status epilepticus must be admitted to critical care and have EEG monitoring established; the primary endpoint of treatment being the suppression of epileptic activity on EEG.	met - continuous EEG or processed EEG available on unit, not met, no EEG / Processed EEG available	0=Not met	
2	Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infarction must be considered for coronary angiography with follow-on primary percutaneous coronary intervention if indicated.	met / not met	2=Fully met	
3	Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the linked spinal cord injury centre consultant within four hours of diagnosis to establish a partnership of care.	met / not met	2=Fully met	
4	Previously fit adults, admitted to critical care following a primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation.	met / not met	2=Fully met	
5	Adults under the age of 60 with middle cerebral artery infarction admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre.	met / not met	2=Fully met	
6	Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice.	met / not met	2=Fully met	
7	Prognostication in hypoxic-ischaemic brain injury after resuscitation from cardiac arrest should follow the European Advisory Statement on Neurological Prognostication in comatose survivors of cardiac arrest.	met - able to fully follow partially met - able to undertake some additional testing beyond CT, unmet - unable to meet any additional investigations	2=Fully met	
RECOMMENDATIONS				
1	Protocols should be available to deliver post-resuscitation care to comatose survivors following cardiac arrest as per the Resuscitation Council (UK) guidelines.	met / not met	2=Fully met	
2	The management of traumatic brain injury should follow national and international best practice guidance.	met / not met	2=Fully met	
3	Management of patients with prolonged disorders of consciousness should follow national guidance.	met / not met	2=Fully met	
4	Patients with perceived devastating brain injury should be admitted to the critical care unit to aid prognostication as per national guidance.	met / not met	2=Fully met	
5	Intracerebral haemorrhage should be managed in accordance with international guidance with particular attention to the reversal of anticoagulation and acute control of blood pressure.	met / not met	2=Fully met	
6	The management of suspected viral encephalitis or acute meningitis in adults should follow national guidance.	met / not met	2=Fully met	
7	The management of patients with ventilatory insufficiency due to neuromuscular disease should follow BTS/ICS guidelines.	met / not met	2=Fully met	
8	The management of decompensated acute inflammatory neuropathy should follow best practice guidance.	met / not met	2=Fully met	
9	Autoimmune encephalitis should be suspected and investigated in all adults presenting with the internationally described criteria proposed to identify this disease.	met / not met	0=Not met	
10	Adults admitted with an acute neurological problem should have access to daily consultation or advice from neurology specialists, if necessary by telemedicine.	met - as per recomendation, partially met - less frequently than daily consultation, no telemedicine, unmet - difficult to access neurology advice	0=Not met	
11	Critical care units caring for patients with neurological pathology should have agreed venous thromboembolism (VTE) policies that balance the risk of recurrent haemorrhage with the need to provide prophylaxis against VTE.	met / not met	0=Not met	
12	Fever control to normothermia following traumatic brain injury, aneurysmal subarachnoid haemorrhage, ischaemic stroke, or haemorrhagic stroke may improve outcome.	a temperature controlling device with a closed feedback loop must be available met / not met	2=Fully met	
13	Appropriate patients with acute ischaemic stroke should be referred for mechanical thrombectomy in accordance with national commissioning policy.	met - referral pathway in place 24/7 partially met - referral pathway les than 24/7, unmet - no referral pathway	0=Not met	
4.9 Burns				
Burns units only				
STANDARDS				
1	Staffing models must promote joint care between burn and critical care teams as this may improve safety and confer a significant survival benefit.	met / not met	3=Not applicable to Unit	
2	A burns theatre must be located in immediate proximity (preferably within 50 metres) to any service providing critical care for burn injured patients.	met / not met	3=Not applicable to Unit	
3	Burn injured patients who require critical care must be managed by consultants in Intensive Care Medicine who have an appropriate level of training in this field and have acquired the relevant knowledge and skills needed to care for these patients.	met / not met	3=Not applicable to Unit	

4	Burn injured patients must be cared for in an appropriate service as determined by the National Burn Care Referral Guidance.	met / not met	3=Not applicable to Unit	
5	Transfer of critically ill burn patients between services must comply with Intensive Care Society guidelines.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	All burns over 20% total body surface area (TBSA) should have access to thermally controlled single-bedded cubicles.	met / not met	3=Not applicable to Unit	
2	Fibre-optic bronchoscopy should be used to assess inhalation injury.	met / not met	3=Not applicable to Unit	
3	Services providing centre level care should be co-located with a major trauma centre. Where this is not the case, mechanisms for ensuring appropriate integration with trauma centre care should be in place.	met / not met	3=Not applicable to Unit	
4	In specialist centres, clinical guidelines should include: a) Fluid resuscitation and management of associated complications, b) Assessment and management of burns to the face and airway, c) Management of smoke inhalation injury and its sequelae, including carbon monoxide and cyanide poisoning, d) Recognition and management of the acutely unwell and deteriorating burn injured patient, including burn specific criteria for the diagnosis of sepsis, e) Management of hypothermia and hyperpyrexia, f) Management of burn wound infections including antimicrobial stewardship, g) Nutritional assessment, h) Rehabilitation. These guidelines should be subject to periodic review and update.	met - all guidelines and reviewed within 3 years, partially met - one / two missing guidelines or not reviewed within 3 years, not met - more than two missing or not reviewed within 3 years	3=Not applicable to Unit	
5	The implementation of end of life care as a result of burn injury should only be made following assessment by at least two consultants, one of whom should be a specialised burn care surgeon.	met / not met	3=Not applicable to Unit	
6	There should be a nominated lead consultant for burns, who participates in network and national morbidity and mortality audit meetings.	met / not met	3=Not applicable to Unit	
4.10 Care of the Critically Ill Pregnant (or Recently Pregnant) Woman				
STANDARDS				
1	Any critical care unit that admits antenatal women over 20 weeks' gestation must have rapid access to obstetric and paediatric services able to attend in an emergency. There must be a clear plan and equipment immediately available for performing a per-mortem caesarean section in the event of maternal cardiac arrest, with appropriate neonatal resuscitation equipment.	met / not met	3=Not applicable to Unit	
2	An obstetric team (normally a consultant obstetrician, a consultant obstetric anaesthetist and a midwife) must review all pregnant women admitted to critical care at least once in every twenty-four hour period.	met - as per standard, partially met - less frequent, unmet - difficult to achieve	3=Not applicable to Unit	
3	In antenatal ICU admissions, when fetal viability is a possibility, a health care professional trained in neonatal resuscitation must be available within 10 minutes and a senior neonatologist or paediatrician must be able to attend within 30 minutes.	met / not met	3=Not applicable to Unit	
4	All critical care units that admit pregnant or recently pregnant women must have a named lead clinician for maternal critical care (MCC). The main function of this role is to be the point of liaison between critical care and obstetric services (including obstetric anaesthesia).	met / not met	3=Not applicable to Unit	
5	Breast feeding (including the use of breast pumps) must be encouraged and supported in all post-natal women admitted to critical care.	met / not met	3=Not applicable to Unit	
6	Women who require care that falls outside Enhanced Maternal Care (EMC) must be referred as soon as possible to the general critical care service. The route of escalation to critical care services must be clearly defined.	met / not met	3=Not applicable to Unit	
7	Critical care outreach or equivalent must be available and provide clinical support and education into EMC.	met / not met	3=Not applicable to Unit	
8	Critically ill pregnant or recently pregnant women who undergo intra- or inter-facility transfer must be transferred in accordance with standards equivalent to the Intensive Care Society's Guidelines for the transport of the critically ill adult	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	Level 3 antenatal ICU admissions and post-natal admissions that are anticipated to last more than 48 hours should be considered for transfer to a regional or supra-regional critical care unit with experience in MCC.	met / not met	3=Not applicable to Unit	
2	Physical contact between a mother and her baby should be maintained during post-natal critical illness, even if the mother is unconscious. This contact and other events of the admission should be recorded in a critical care diary which can be used in psychological rehabilitation after critical care or in bereavement counseling.	met / not met	3=Not applicable to Unit	
3	All women admitted to critical care should be offered an appointment in a critical care follow-up clinic or a post-natal review, which includes input from a clinician with experience in critical care follow-up.	met / not met	3=Not applicable to Unit	
4	Recognition of EMC should be incorporated into midwifery pre & post registration curricula and feature in obstetric, anaesthetic and critical care training programmes.	Statement		
5	Healthcare professionals looking after critically ill women should undergo regular, cross-specialty, multidisciplinary team training, to encourage sharing of knowledge and skills and to promote teamwork and effective communication.	met / not met	3=Not applicable to Unit	
6	Simulation-based learning should be considered to assist healthcare professionals to develop the technical and non-technical skills for EMC.	met / not met	3=Not applicable to Unit	
7	Critical care networks should consider nominating specific units as the nominated regional or supra-regional unit for MCC.	met / not met	3=Not applicable to Unit	
8	Obstetric units delivering EMC or level 2 critical care should be members of a regional MCC network which itself should have a formal relationship with the local Critical Care Operational Delivery Network and Strategic Clinical Networks.	met / not met	3=Not applicable to Unit	
9	MCC quality indicators should be monitored, using data reported through the ICNARC Case Mix Programme and the Scottish Intensive Care Society Audit Group and used to improve local performance.	met / not met	3=Not applicable to Unit	
4.11 Care of the Critically Ill Child in an Adult Critical Care Unit				
STANDARDS				
1	Critically ill children under 16 years old must only be admitted to and stay on an adult critical care unit if a PICU bed is unavailable, or when there is an expected short duration of critical care e.g. an older child with overdose or alcohol excess.	met / not met	3=Not applicable to Unit	
2	Admission must be discussed and agreed by the local consultant in Intensive Care Medicine, local consultant paediatrician and the consultant in paediatric Intensive Care Medicine (this may be the regional paediatric transport team consultant).	met / not met	3=Not applicable to Unit	
3	A nominated lead intensive care consultant and lead nurse in the adult critical care unit must be responsible for intensive care policies, procedures and training related to the care of children.	met / not met	3=Not applicable to Unit	
4	An adult critical care unit that may provide care for critically ill children must have an appropriately equipped area for providing paediatric critical care.	met / not met	3=Not applicable to Unit	
5	Medical staff with responsibility for the resuscitation and airway management of the critically ill child on an adult unit must have up-to-date competencies in advanced paediatric life support and advanced airway management. This medical cover may be provided by anaesthetists or consultants in Intensive Care Medicine according to local arrangements.	met / not met	3=Not applicable to Unit	

6	Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer of critically ill children and the provision of paediatric critical care must be available.	met / not met	3=Not applicable to Unit	
7	Escalation, end of life and organ donation decisions must be discussed in collaboration with the regional consultant in paediatric intensive care (this may be the regional paediatric transport team consultant), under a shared care and shared responsibility model.	met / not met	3=Not applicable to Unit	
8	There must be collaborative working between the adult critical care unit and the regional PICU to ensure that staff are supported to work outside their normal core competencies. There must be 24/7 access to paediatric medical and paediatric nursing advice.	met - as per standard, partially met - no formal arrangement, unmet - not anticipated to happen	3=Not applicable to Unit	
9	A local consultant paediatrician and consultant in paediatric Intensive Care Medicine must be available for advice at all times.	met / not met	3=Not applicable to Unit	
10	There must be 24-hour access for parents/carers to visit their child.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	A registered paediatric nurse should be available at all times to support the care of the child.	met / not met	3=Not applicable to Unit	
2	The child should be reviewed by a consultant paediatrician twice a day during their stay on the adult unit.	met - as per standard, partially met - visited as requested / required , unmet unlikely to acheive standard	3=Not applicable to Unit	
3	There should be access to specialist paediatric healthcare professional and pharmacy advice at all times.	met - as per standard, partially met - visited as requested / required , unmet unlikely to acheive standard	3=Not applicable to Unit	
4.12	Standardised Care of the Critically Ill Patient			
STANDARDS				
1	Patients must be assessed daily for risk of thromboembolic disease and receive appropriate prophylaxis.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
2	Patients undergoing controlled mechanical ventilation must receive tidal volumes based on predicted body weight (PBW). Patients with ARDS must receive a tidal volume of less than or equal to 6 ml/kg PBW.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	0=Not met	
3	Ventilated patients must have respiratory function evaluated daily and undergo spontaneous breathing trials where appropriate.	met / not met - no SBTs	2=Fully met	
4	Sedation must be individualised to patient needs and the appropriateness of a sedation hold considered daily.	met / not met	2=Fully met	
5	All patients must be assessed regularly for evidence of pain, with analgesia optimised to minimise sedation requirements.	met / not met	2=Fully met	
6	All patients must be screened daily for evidence of delirium using a validated method such as the Confusion Assessment Method for the ICU (CAM-ICU) or the Intensive Care Delirium Screening Checklist (ICDSC).	met / not met	2=Fully met	
7	Indwelling intravascular catheters must be inspected daily for evidence of infection using a suitable scoring system e.g. Visual Infusion Phlebitis Score (Jackson 1998) to guide necessity for removal.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
8	The continued need for indwelling catheters (intravascular or urinary) must be considered daily.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
9	Monitoring of invasively ventilated patients must include continuous waveform capnography.	met / not met	2=Fully met	
10	Care bundles must be in place for Intubation Associated Pneumonia (IAP) prevention, Central Venous Catheter (CVC) insertion and maintenance, and Peripheral Venous Cannula (PVC) insertion and maintenance.	met / not met	2=Fully met	
RECOMMENDATIONS				
1	For patients without ARDS, a tidal volume of 4-8 mls/kg PBW and a peak/plateau pressure (depending on mode) of below 30 cmH2O should be targeted.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
2	A ventilated patient care bundle should be in place with appropriate mechanisms for ensuring adherence.	met / not met	2=Fully met	
3	Ventilated patients should receive H2 receptor blockade (e.g. ranitidine) or a proton pump inhibitor for gastric protection until established on full enteral nutrition.	met / not met	2=Fully met	
4	Unless clinically contra-indicated, ventilated patients should be nursed in a semi-recumbent position at 30 to 45 degrees.	met / not met	2=Fully met	
5	Where there is no contraindication, enteral nutrition (EN) should be initiated within 48 hours after admission to the ICU.	met / not met	2=Fully met	
6	When EN is not feasible or insufficient, parenteral nutrition should be started as soon as possible in patients with (or at high risk of) malnutrition, (which maybe a combination of cachexia (disease related) and malnutrition (inadequate consumption of nutrients)).	met / not met	2=Fully met	
7	All sedated patients should have sedation levels monitored hourly using a scoring system such as the Riker Sedation–Agitation Scale or the Richmond Agitation–Sedation Scale to ensure sedation is minimised.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
8	Noise levels and patient interventions should be minimised overnight to facilitate natural sleep.	met / not met	2=Fully met	
9	A transfusion threshold of 70g/L should be used in general intensive care patients. A higher target Hb may be beneficial in patients with sepsis (in the first six hours), ischaemic stroke, traumatic brain injury with cerebral ischaemia, or acute coronary syndromes.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met	
10	Critical care units should consider standardisation of drug concentrations in line with FICM/ICS guidance.	met / not met	0=Not met	

Section 5		CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS		Level description	Level	Comments
5.1		Research and Development				
STANDARDS						
1	All individuals participating in R&D activity must have completed Good Clinical Practice (GCP) training for research and keep this up to date.	met / not met				
RECOMMENDATIONS						
1	Critical care units should nominate a lead for R&D activities who should coordinate activity and ensure it is carried out to UK Policy Framework for Research and Development	met / not met or not applicable		2-Fully met		
2	Critical care units should participate in research networks, which are organised at Local Critical Care Network (LCCN) level through the regional National Institute of Healthcare Research (NIHR) Critical Care research network lead	met / not met or not applicable		2-Fully met		
3	All research studies should be registered on the UK Critical Care Research Portfolio whenever they fulfil eligibility criteria.	met / not met or not applicable		2-Fully met		
4	Critical care units participating in research should provide information to patients, relatives, and surrogate decision-makers (SDMs) about research, research, for example through auditors, leaflets, or written consent, intensive care information resources.	met / not met or not applicable		2-Fully met		
5	Critical care units participating in research should have clear procedures for approaching patients, families and SDMs in a manner that minimises stress, but provides adequate information in a timely manner	met / not met or not applicable		2-Fully met		
6	Critical care units participating in multiple research studies should have clear co-enrolment policies based on the UK co-enrolment guideline	met / not met or not applicable		2-Fully met		
5.2		Audit and Quality Improvement				
STANDARDS						
1	Critical care units must have a structured and planned clinical audit programme to compare practice to published standards. There must be an identified lead for the audit programme.	met / not met		1-Partially met		
2	Critical care units must participate in a National Audit Programme for Adult Critical Care, such as the Scottish Intensive Care Society Audit Group (SICISAG) or Intensive Care National Audit and Research Centre (ICNARC) programmes.	met / not met		2-Fully met		
3	Critical care units must have a surveillance system in place for audit and feedback of nosocomial infection, for example, catheter-related bacteraemia and other blood stream infections, reported to the national scheme where applicable. Critical care units should also report the incidence of intubation-associated pneumonia. All units must participate in national audit programmes for nosocomial infections in intensive care, for example, Public Health England Infections in Critical Care Programme (ICCOIP) and Scottish nosocomial infections in ICU audit programme.	met / not met		2-Not met		
4	Critical care units must measure night-time discharges in order to encourage and support local improvement to reduce night-time intensive care discharges.	Discharges after 21:59 as percentage of all eligible admissions - met <2% partially met, 2-4% not met-2%		2-Not met		Data not reviewed
5	Critical care units must obtain regular feedback about the care that patients and relatives receive during their critical care admission in order to learn from and act on the feedback received.	met - annual process, partially met, undertaken every 1-2 years, unmet, never done or less than 2 yearly		2-Not met		
RECOMMENDATIONS						
1	Units should have nominated medical and nursing leads for quality improvement and audit. Appropriate time should be made available in job plans for these duties. Time to participate in audit and quality improvement programmes should also form part of the job plans of all intensive care staff (medical, nursing, pharmacists, healthcare professionals and ancillary staff).	met/ unmet		2-Not met		
2	Hospitals should have a quality improvement (QI) programme in place for each critical care unit in their organisation. The programme should aim to deliver safe, efficient, effective, patient-centred, timely and equitable patient care, which is evidence based, and should follow recognised quality improvement methodology.	met / unmet		1-Partially met		
3	Staff should be encouraged and supported to train in quality improvement methodology and all projects should be multidisciplinary, recognising the necessity for a team approach and the contribution of all staff groups.	met / unmet		1-Partially met		EQUIP Programme available
4	Audit should be linked to QI programmes. Units should have robust data-collection systems in place that support the collection of activity and quality data for local and national audit programmes.	Met - robust data collection and feedback for both local and national audit, partially met - robust data collection and feedback for national audit only, not met - no robust systems for data collection or		2-Not met		
5	Critical Care Networks should have a formal, multi-professional, peer-review programme in place for the units in their jurisdiction. Their reviews should be based on published national standards, but are likely to include other areas that are agreed locally.	met / not met - not applicable		2-Fully met		
6	All critical care units must measure and report their delayed discharges, out of hours discharges, non-critical transfers and readmissions within 48 hours of discharge, a potential indicator of resource pressures. It is recommended that units should also measure early discharges as they may be a marker of insufficient resources.	Met - submit all data to ICNARC / SICISAG data tools, partially met - one or more data submissions missing, not met - poor data compliance with ICNARC / SICISAG		1-Partially met		OTOC figures captured by RIS, NI to other measure
5.3		Clinical Governance				
STANDARDS						
1	There must be an appropriately trained consultant and senior nurse identified as leads for clinical governance. The consultant must not be the clinical lead or clinical director for critical care.	met / not met		1-Partially met		Medical support under discussion
2	There must be a robust system in place for reporting, investigating, and learning from all patient safety incidents. Appropriate action plans must be formulated in response to incidents. Units should also learn from things that go well, a process described in excellence reporting.	met / not met		2-Fully met		
3	Units must hold regular structured multidisciplinary clinical governance meetings, where they discuss unit morbidity and mortality, including all deaths, critical incidents and near misses. A written record of actions taken and lessons learnt should be kept and a timely and reliable method for dissemination of shared learning should be in place. There should be clear structures in place for dissemination findings to staff, and delegates it care should lead to measurable change.	met - meets full standard with minimum of quarterly meetings, partially met - meets standard but less than quarterly, unmet - doesn't meet the standards		2-Not met		
4	Regular feedback must be obtained from service users and staff about the quality of care delivered, for example by the use of safety surveys and relatives' questionnaires.	met - undertake critical care led staff safety and relative surveys at least once a year, partially met is less frequently or only one group surveyed, Not met - no patient or staff survey		2-Not met		
5	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care. Appropriate actions must be taken whenever preventable factors are found.	met - mortality review process that includes all deaths in ICU / not met				
6	All units must maintain a risk register that is regularly reviewed and updated by both senior managerial and clinical staff.	met - in place, quarterly review, partially met, in place less than quarterly review, unmet - not in place		1-Partially met		
7	The unit must have processes to ensure clinical staff are aware, in a timely fashion, of key learning points from national safety alerts and local learning (for example from patient safety incidents, excellence reports, patient concerns and compliments). Staff must also be able to easily access important information to inform patient care (for example information about medications and unit policies) whenever needed.	met / not met		2-Fully met		
8	Staff who have to conduct reviews of patient safety incidents, root cause analysis and appreciative enquiry must be trained in the management of these processes so the reviews are conducted safely and constructively. Similarly, effective quality improvement requires staff that are trained in quality improvement methodologies.	met / not met		2-Fully met		
9	Each unit must have local safety standards for invasive procedures (including tracheostomy, bronchoscopy, central line and chest drain insertion and lumbar puncture). They must also have safe standards for the handover of information for patients going to have invasive procedures in other departments. These standards should include documentation of invasive procedures, handovers and information transfer, procedural verification, a safety briefing and time out, and a sign out and debriefing. An example of this process is the NHS England Safety standards for invasive procedures.	met / not met		2-Fully met		Critical care LocSSIP in place
10	Critical care units must comply with reviews and visits by national organisations, (for example the CQC in England).	met / not met		2-Fully met		
RECOMMENDATIONS						
1	Intensive care staff should work with other clinical teams in the hospital with respect to joint learning from morbidity and mortality review and ensuring best practice around handovers of care.	met - done quarterly, partially met, done annually, not met, not done - use comments box		2-Not met		
2	Units should regularly review guidelines from professional organisations and other sources of evidence to ensure that the unit complies with best practice. These evidence sources should be translated into comprehensive locally agreed guidelines or Standard Operating Procedures.	met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed		1-Partially met		
3	The unit should identify key performance indicators (KPIs) that describe outcomes of their service. Such KPIs may be generic and common to most units, such as complication rates, e.g. delirium rates, pain scores or pressure sores. Alternatively, these may be unit specific, for example rates of emergency intubations on cardiac critical care units.	met / not met		2-Not met		
4	Staff should be recognised as the key resource in intensive care. A fully engaged, well-motivated well-trained and well-led workforce is essential to allow excellence in clinical care to flourish. Staff sickness rates, turnover rates and information from appraisal, staff feedback and exit interviews should all be monitored to ensure staff wellbeing.	Met - all staff wellbeing criteria stated are monitored, partially met - some criteria are monitored, not met - none of criteria are monitored.		1-Partially met		
5	Units should work with other units within their network, and nationally, to share learning, disseminate best practice, quality improvement and best benchmarking and peer review purposes. The governance of critical care units is tightly audited by outside agencies, including intensive care networks. The external responsibility for the oversight of governance arrangements varies between the different networks.	met - Units participate in Network led program to share best practice and QI / not met		2-Not met		
6	The unit should be able to demonstrate that it is continuously working to improve patient care using recognised quality improvement techniques delivered by appropriately trained staff.	met- Unit have undertaken at least one local patient centric QI program in previous 12 months / unmet		1-Partially met		
5.4		Critical Care Networks				
		*These may not be applicable for countries which do not have networks				
STANDARDS						
1	Critical care ODNs must support the activity of provider healthcare organisations in service redesign and delivery of the commissioned pathway, quality improvements, innovation and standardisation of clinical practice. They provide a mechanism for peer review and benchmarking self-assessment in the network.	met / not met / not applicable		2-Fully met		
2	Critical care ODNs must support commissioners in the delivery of their commissioning functions, through creating and delivering innovation, quality improvements and efficiency across the pathway, and developing, devising and supporting local strategies for adult critical care services across the geographical footprint, including advice on procurement.	met / not met / not applicable		2-Not applicable to Unit		
3	Critical care ODNs must support delivery of a resilient critical care service within a geographical area to meet emergency requirements.	met / not met / not applicable		2-Fully met		
4	Each provider of adult critical care must engage, contribute and participate in activities of their local critical care ODN and will contribute to the funding of their local ODN through a nationally agreed mechanism; this is currently a 10% CQUIN top slice, but may be supplemented by local agreements made in conjunction with key stakeholders through the ODN Executive Oversight Governance Board.	met / not met / not applicable		2-Fully met		Unsure of funding
5	The intensive care team in provider organisations must engage, contribute and participate in a critical care ODN, including audit activity, peer review and quality improvement processes.	met / not met / not applicable		2-Fully met		
RECOMMENDATIONS						
1	ODNs should take a whole-system, collaborative-provision approach to facilitate the delivery of safe and effective services across the patient pathway, with an emphasis on the quality and equity of access to service provision.	met / not met / not applicable				
2	ODNs should identify and implement improvements to enhance patient care, enabling the design of effective clinical flows and pathways of care for networked provision of services. This will allow for more local determination, innovation and efficiency across the pathway.	met / not met / not applicable				
3	ODNs should focus on quality and effectiveness through facilitation of comparative benchmarking and auditing of services, with implementation of required improvements. This should span the wider hospital system, to include dedicated critical care units, as well as resources to support acutely unwell patients on general wards. This includes rehabilitation of patients recovering from critical care in hospital and in the community.	met / not met / not applicable				
4	ODNs should create an operational model that allows effective work programmes for the delivery of local and regional priorities, review specification standards, national programme of care outcomes and outcome framework targets.	met / not met / not applicable				
5	ODNs should have robust governance arrangements that ensure functionality, working with both providers and commissioners, to enable the development of improved service standards to continually enhance the patient, family and care experience.	met / not met / not applicable				
6	ODNs should have a core management team capable of delivering the work of the network according to local requirements. They should provide clinical and executive management leadership to support the delivery of established network plans, enabling action in response to adverse situations or outlying practices. As a minimum, this would include senior management, lead medical and nursing roles and administrative support. These roles are independent of both the host organisation and the substantive employer where this is not the host.	met / not met / not applicable				
7	Each participating member organisation should ensure appropriate representation at critical care ODN meetings, task groups and other forums in accordance with the ODN's terms of reference. Through the baseline contract agreement (local or national), member organisations should comply with ODN standards, policies and guidelines.	met / not met / not applicable		2-Fully met		
8	Each adult critical care provider should adhere to requirements to measure and evaluate quality indicators and service delivery, in line with the national Adult Critical Care Service Specification (2009). This specification may be supplemented by additional requirements by the local ODN (for example GPCIS V2 standards and recommendations). Such supplemental standards should be agreed by the ODN through their local governance structure.	met / not met / not applicable				
9	ODNs should provide leadership support in network-wide emergency preparedness, have a role in clinical contingency planning and respond to increased demand through national, regional and local determination. ODNs should act on identified challenges as they arise, e.g. a local critical care bed crisis or large-scale major incidents.	met / not met / not applicable				
10	ODNs should encourage the positive engagement of adult critical care providers in their networks and support critical care units in developing their service to its maximum potential by implementing the recommendations outlined above.	met / not met / not applicable				
5.5		Critical Care Commissioning				
STANDARDS						
1	All units must comply with national commissioning arrangements in place in England, Wales, Scotland and Northern Ireland.	met / not met		2-Not applicable to Unit		
2	COMDS must be collected and reported in all designated Adult Critical Care locations in England.	met / not met / NA		2-Not applicable to Unit		
3	Data collection must commence from the date and time that the patient first occupies a designated critical care bed or, if in a non-designated critical care unit, the date and time that the patient first occupies a designated critical care area / not met - data is collected on critical care episodes delivered outside of designated critical care area / not met	Met - data is collected on critical care episodes delivered outside of designated critical care area / not met		2-Fully met		
4	Adult critical care reference cost submissions must assign costs to individual HRGs.	Statement				
5	All providers in England, Wales and Northern Ireland with adult critical care services must be members of a Critical Care Operations Delivery Network.	met / not met		2-Fully met		

RECOMMENDATIONS				
These recommendations may not be applicable to these units outside of England and Wales				
1	Collection of all 34 fields in CCMS is recommended. This should be done by dedicated trained personnel.	met / not met	Is/Not applicable to Unit	
2	There should be clinical oversight of the CCMS data entry/data submission to ensure accuracy of data.	met / not met	Is/Not applicable to Unit	
3	Preparation of reference costs should include experienced clinician involvement.	met / not met	Is/Not applicable to Unit	
4	Agreement should be in place to support early notification to a patient's CCG for longer-stay patients who are likely to have complex home needs, such as home ventilation to aid discharge planning including the identification of a funding package.	met / not met	Is/Not applicable to Unit	
5	A lead commissioner should be identified with a commissioning forum for each critical care service.	met / not met	Is/Not applicable to Unit	



Section 6		CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS	Level description	Level	Comments
6.1	Fire				
STANDARDS					
1	All units must have well marked fire call points, fire extinguishers and oxygen shut-off valves.	Met or unmet	2=Fully met		
2	Each unit must have a specific fire evacuation policy in place, which takes account of: a) the layout of the building, including any need to negotiate stairs during an evacuation, b) the provision of ventilatory support, intravenous therapies and invasive monitoring for patients during such an evacuation, c) the fact that critical care staff may themselves be affected by a fire and therefore be unfit to continue working. Action cards summarising the evacuation procedure should be displayed within the unit, ideally next to fire call points, so that they can be referred to in an emergency.	Met or unmet	1=Partially met	Departmental fire plans currently being updated to include guidance from the Association of A	
3	Recommendations for the safe use of oxygen cylinders must be adhered to at all times and include: the safe use of oxygen cylinder bed brackets, b) the safe storage of oxygen cylinders and c) following the recommended sequence of events when turning on an oxygen cylinder.	Met / unmet	2=Fully met		
4	Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring and curtains.	Met / unmet	2=Fully met		
5	New units must be designed using Department of Health guidance and in conjunction with the Trust fire safety officer, with consideration given to the provision of: a)multiple exit routes, b) ski pad, ski sheets or other evacuation aids for all bed spaces which are readily available, c) adopting small bays rather than open areas and d) splitting ICU departments into separate clinical and non-clinical areas.	met / not met / not applicable	3=Not applicable to Unit		
6	Units must have a major incident plan in place which allows for the transfer in of multiple critical care patients from a neighbouring hospital's critical care unit should it need to carry out an emergency evacuation.	Met / unmet	2=Fully met	Major Incident plans in place, along with Business Continuity plans. Activity 18 relates to the i	
7	Any problem with oxygen cylinders and associated equipment must be reported immediately to both the medical gas supplier and the Medicines and Healthcare products Regulatory Authority (MHRA).	Met / unmet	2=Fully met		
8	All staff must undergo regular training in fire prevention and fire procedures, to include training in-situ in the specific clinical areas in which they work. All staff must know: a) the location of fire call points within their own unit and how to operate them, b) the location of fire extinguishers within their unit and which type to use in the event of a fire. Medical and senior nursing staff must also know the location of the medical gas pipeline shut-off valves in their unit, how to operate them and the implications of doing so.	met = > 90% of staff compliant , partially met > 75%., not met < 75%	1=Partially met	Fire training is mandatory. Arranging unit specific training	
9	All intensive care staff must be given basic training regarding the safe use of oxygen cylinders.	met = > 90% of staff compliant , partially met > 75%., not met < 75%	1=Partially met	Sandra confirm details please	
10	Local unit evacuation policies must be drawn up, with consideration for: a) other locations within the hospital where critical care might be provided on a temporary basis; b) provision of equipment and drugs; c) evacuation cases at each bed space; d) triage of patients (the least unwell patients being evacuated first and the most unwell patients last); e) possible co-existing power and/or equipment battery failure; f) use of transport ventilators and hand ventilation if needed; g) temporary discontinuation of renal replacement therapy; and h) transfer of hospital notes especially if electronic patient monitoring is in use. In a major fire, it is possible that serial evacuations will be required with a staged move to the outside, and that the whole hospital may need to be evacuated.	Met / unmet	0=Not met	Departmental fire plans currently being updated to include guidance from the Association of A	
RECOMMENDATIONS					
1	Evacuation policies should include liaison with the Bronze (Operational), Silver (Tactical) and Gold (Strategic) commanders in conjunction with the senior fire officer on scene. Timing of evacuation is crucial: if evacuation occurs too early, then patients may be harmed by a transfer, if evacuation occurs too late, then patients and staff may be harmed by fire and smoke.		1=Partially met	Fire evacuation plan discusses Liaison with hospital fire response team.Patients evacuated or	
2	Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be practised.	Met - tested annually , partially met tested daytime only and / or less than annually, unmet, not tested in the last 2 years	0=Not met	Fire evacuation exercises have been requested from the fire team. Current Covid situation m	
3	Units should have a system whereby staff involved in a traumatic incident, such as a fire in the critical care unit, receive debriefing and are followed up for signs of a trauma stress reaction or Post Traumatic Stress Disorder (PTSD). The Trauma Resilience Management (TRiM) system is a screening tool used in the military and more recently used successfully in healthcare which could be considered.	Met - system available / unmet - no system in place to do this	1=Partially met	Included in Fire Plan	
4	Critical care networks should develop systems to support planning for, and management of, a major incident in one critical care unit within the network, so that other units can cooperate to accommodate all critically ill patients in this type of situation. A retrieval team approach, with staff from neighbouring units travelling to the affected unit to transfer patients, should be planned. Liaison with neighbouring units and local ambulance services at an early stage is advised.	met / not met / not applicable	3=Not applicable to Unit	Local BCP and Major Incident plans apply	
6.2	Major Incidents				
STANDARDS					
1	All hospitals designated receiving hospitals with Level 3 critical care capability must be prepared to double their normal Level 3 ventilated capacity and to maintain this for up to 96 hours.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard	0=Not met	innadequate logistics to double capacity	
2	All nominated supporting hospitals with Level 3 critical care capability must be prepared to double their normal capacity for Level 3 beds for general use and to support the decant of patients from other receiving hospitals.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard	0=Not met	Inadequate logistics to double capacity	
3	All hospitals with intensive care capacity must have in place plans to support the retrieval or transfer of patients; supporting hospitals must have to support patient transfers by providing suitably skilled transfer teams for each patient needing to be moved within Critical Care Operational Delivery Network areas and beyond.	Met / unmet	1=Partially met		
4	All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but not exclusively intensive care patients, should the intensive care areas become unusable for any reason.	Met / unmet	2=Fully met	Patients will be taken to Theatres/Recovery or the day surgery unit depending upon the locali	
5	All hospitals must have a lock down plan that includes all intensive care areas, preventing unauthorised access.	met / unmet	1=Partially met	Yes to Critical Care	
6	All hospitals must have a recovery plan to ensure a rapid return to normality once the incident is closed. This must include adequate rest and psychological support for staff.	met / unmet	2=Fully met	Business Continuity plans in place.Dedicated Psychologist working in Critical Care Team	
7	Action cards must be available for use on activation of plan and must include information and communication routes that are to be used.	met / unmet	1=Partially met	Action Cards included in major incident and fire plans	
RECOMMENDATIONS					
1	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response (EPRR) leads and clinical colleagues to create the intensive care response to a major incident, hospital evacuation or mass casualty plans.	met / unmet			
2	Intensive care should have access to emergency planning and response training including strategic/crisis leadership.	met / unmet			
3	Intensive care service staff should participate in the local and regional multidisciplinary exercises including 'table top' and 'live' exercises to further refine local and regional plans and communication routes between organisations and networks.	met / unmet - within the last 2 years	0=Not met		
4	Intensive care leads should work with their EPRR teams to facilitate exercises in the evacuation of very dependent patients from any part of their hospital. This should include practical use of ski sheets, and other patient handling aids, as well as rehearsing the decision making and forward planning required by shift leads to support a controlled, staged evacuation.	met / unmet - within the last 2 years	0=Not met		
5	Intensive care staff should be prepared to take a central leadership role in any major incident and should be prepared to send teams 'forward' to the Emergency Department, as well as any preoperative hold areas and recovery.	met - plans in place to enable to do so, unmet - no plans	0=Not met	Would participate as designated in local major incident response	
6	The plan to double the number of intensive care beds should include an inventory of where equipment is to come from, where the beds should be located and who should staff them. This should be near the permanent critical care unit, where possible allowing the normal functioning of the hospital around it.	met / unmet	0=Not met	Inadequate logistics to double capacity	
7	Advance consideration of staff workforce requirements, including mutual aid from colleagues in neighbouring hospitals should form part of the intensive care service planning.	met / unmet	2=Fully met		
8	Staff welfare should be actively supported during an incident and critical care staff access to informal, immediate debrief or later formal counselling.	met - plan in place , unmet - no plan in place	2=Fully met		
9	Clinical standards should be maintained as long as possible, critical incident reporting encouraged and contemporaneous note kept to enable quality post-incident lessons to be investigated, communicated and learnt.	met - within plan , unmet - not in plan	0=Not met		
6.3	High Consequences Infectious Diseases: Initial Isolation and Management				
STANDARDS					
1	Each critical care unit must ensure there are local contingency plans for the initial isolation and management of critically ill patients with suspected HCIDs. These plans must be regularly practiced and reviewed, including the use of table-top exercises and simulations.	Met - plan in place and tested within 2 years, partially met - plan in place but not tested within 2 yrs, unmet - no plan	2=Fully met		
2	Units must liaise with local Directors of Infection Prevention and Control to ensure the correct personal protective equipment (PPE) is procured and sufficient stocks are readily available for use by appropriately trained intensive care staff in the event it is required.	met / unmet	2=Fully met		
RECOMMENDATIONS					
1	A consultant in Intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience preparations, incorporating plans for the appropriate isolation and management of suspected patients with HCID.	met / unmet	0=Not met		
2	A clinical area where critically ill patients with suspected high consequence infectious diseases may be isolated, either within the unit or elsewhere, should be prospectively identified. Ideally plan to utilise negative pressure rooms with anterooms where available.	met / unmet	1=Partially met	Limited side rooms	
3	All clinical equipment used in the management of a patient with a HCID should be dedicated to that patient alone. Equipment should be single use where possible.	met - within a plan to do so, unmet - no plan	2=Fully met		
4	Training should be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provided. This should incorporate annual fit testing of respiratory protective equipment (e.g. FFP3 masks).	met - annual fit testing done unmet - not annual fit testing	2=Fully met		
5	Critical care staff providing care for a patient with a suspected or confirmed HCID should be dedicated to the care of that patient on a clinical shift and should not provide concurrent care for other patients, thus limiting the risk of cross-infection.	met - within plan to do so, unmet - no plan	2=Fully met		
6	Contingency planning should incorporate plans for holding securely the large volume of clinical waste resulting from clinical care including discarded contaminated PPE. Once a HCID is confirmed, further advice on correct disposal of the waste will be provided.	met - within plan to do so, unmet - no plan	2=Fully met	Hospital plan	
7	Patients with a suspected viral haemorrhagic fever should be risk assessed in accordance with the Advisory Committee on Dangerous Pathogens Viral Haemorrhagic Fever (ACDP VHF) Risk Assessment algorithm and investigations to exclude malaria promptly undertaken, in keeping with local procedures.	met - local procedure in place, unmet - no local procedure			
8	Patients with suspected airborne HCIDs should be risk assessed according to national guidelines where they exist (disease-specific e.g. MERS guidance collections3.4 or generic airborne HCID guidelines, as appropriate).	met - local procedure in place, unmet - no local procedure	2=Fully met		
9	Following recognition of a patient with a suspected HCID: a) local infectious disease and/or microbiology and virology services should be notified and advice sought, including guidance on obtaining appropriate diagnostic clinical specimens, b) Local clinicians should liaise with the Imported Fever Service (note this service is available to clinicians across the UK) for further clinical advice and to facilitate access to specialist diagnostics as required, and c) all suspected cases should be reported immediately to local health protection authorities (e.g. the local Health Protection Team).	met - local procedure in place, unmet - no local procedure	2=Fully met		
10	Critical care units accepting international medical transfers should perform a risk assessment prior to transfer if a patient is being transferred from a country with known HCID outbreaks or countries where there is a significant risk of specific HCIDs; refer to national guidance (disease-specific or generic HCID guidance).	met - local procedure in place, unmet - no local procedure	2=Fully met		
6.4	Surge and Business Continuity Planning				
STANDARDS					
1	Adult critical care units (in England) must submit twice-daily information on their bed capacity through NHS Pathways Directory of Services (DoS).	met / unmet / NA ( if non English units)	0=Not met		
2	Each organisation with an adult critical care unit must have their own escalation plan and business continuity plan.	met / unmet	2=Fully met		
RECOMMENDATIONS					
1	Unit managers and senior clinical staff should develop plans and checklists for scenarios such as: a) supply chain disruption (road/fuel crisis, extreme weather, industrial action or civil disturbance), b) Infrastructure failures (intermittent power cuts or 'brownouts', failure of water or heating), c) interruption of normal staffing patterns (e.g. transport disruption, school closures). Checklists should include, for example, which drugs and consumables would run out first if supplies are disrupted.	met / unmet	2=Fully met		
2	Plans should also include options for: a) Unit evacuation, both internally and externally to other sites in the event of major infrastructure failure, or other events (e.g. fire) which threaten the ongoing operation of intensive care facilities, b) Capability for accommodating intensive care patients evacuated from another site.	met / unmet ( repetition )	1=Partially met	Limited options	
3	As lack of critical care capacity is frequently the bottleneck in other surge-events, managers and clinicians should have identified areas within their acute hospital sites to allow for expansion of critical care capacity. This may include use of operating theatres, recovery and augmented higher care areas, or upgrading Level 2 critical care areas to permit mechanical ventilation and Level 3 care.	met / unmet	2=Fully met		
4	If increased activity is anticipated, the increase in requirement for consumables should be quantified using the concept of 'days of supply' (i.e. what is needed to run one intensive care bed for a 24-hour period). This should include consideration of oxygen and air supplies.	met - within plan , unmet - not in plan	2=Fully met	Hospital plan	
5	Expansion may also require consideration of essential equipment and possible alternatives.	met - within plan , unmet - not in plan	2=Fully met		

## An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



### Introduction

In June 2019, the Intensive Care Society (ICS) and Faculty of Intensive Care Medicine (FICM) released the second edition of Guidelines for the Provision of Intensive Care Services (GPICS). The first edition of GPICS (2015) built on the earlier Core Standards for Intensive Care Units (2013) and has become the definitive reference source for the planning, commissioning and delivery of Adult Critical Care Services in the UK. Many units have found the GPICS standards and recommendations to be invaluable in developing successful business cases to enhance their local services and improve patient care. GPICS has also been used as the benchmark by which local services are peer reviewed and assessed by healthcare regulators, such as the Care Quality Commission (CQC). The ICS and FICM have worked in collaboration to develop this tool kit to help individual units to compare their services to the latest version of GPICS. The standards and recommendations are presented in Excel format with a drop down option of 'met', 'partially met', 'unmet' or 'not applicable to this service' next to each guideline. The tool kit also allows units to produce a PDF summary page which provides a useful overview of their responses.

This tool kit is not stand-alone and should be used alongside the full GPICS document which is available via the link below. We recommend that the toolkit is completed in collaboration with members of the multi-disciplinary team, so that each section is completed by individuals who are best placed to make an accurate assessment. We are aware that defining compliance with standards and recommendations is difficult and have deliberately left this to the judgment of local clinicians and managers.

We see the further development of this tool kit as an iterative process, working with individuals and networks to improve and refine its functionality. If you have any suggestions or comments please contact us at [info@ics.ac.uk](mailto:info@ics.ac.uk). We hope you find this tool kit useful.

[Click here to go to the full GPICS document online](#)

or double-click on the embedded PDF ( you may need to switch to Windows to view after opening)>>

[Click here to view the Instructions sheet](#)



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# An Excel tool kit for the Guidelines for the Provision of Intensive Care Services V2, 2019.



## Instructions

### 1. To add your unit name to the summary page please enter it here:

Critical care unit name:  
Operational Delivery Network (ODN) /Region  
Date (dd/mm/yyyy)

Withybush General Hospital  
Wales  
30/06/2023

### 2. Filling in the sheet

Do not fill anything in on summary of scores sheet. On every other sheet, every box that is blue requires a number to be inputted as follows:

0 = Not met 1 = Partially met 2 = Fully met

3 = Not Applicable to your ICU

### 3. Navigating the sheets

To get to a sheet either click on the sheet name tab at the bottom of the screen, or from the Summary of scores, click on the text that you want to go to.

### 4. Creating a PDF

To create a PDF summary of the gap analysis of your ICU click on the button below (macros must be enabled for it to work).

Summary of the gap analysis of your ICU compared to the GPICS v2 Report date:

Section	Description	STANDARDS			RECOMMENDATIONS		
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Fully Met
1	CRITICAL CARE SERVICES: STRUCTURE						
1.1	Levels of Critical Care	0%	0%	100%	0%	0%	0%
1.2	Outcomes	0%	25%	75%	0%	67%	33%
1.3	Level 2 and 3 Physical Facilities	0%	0%	50%	0%	13%	50%
1.4	Clinical Information Systems	0%	0%	100%	90%	10%	0%
1.5	Clinical Equipment	19%	6%	75%	0%	0%	100%
1.6	Cardiothoracic Critical Care				0%	0%	0%
1.7	Neurocritical Care	0%	0%	0%	0%	0%	0%
2	CRITICAL CARE SERVICE: WORKFORCE						
2.1	Medical Staffing	0%	20%	80%	0%	0%	100%
2.2	Registered Nursing Staff	0%	10%	90%	0%	40%	60%
2.3	Workforce, Induction & Training of Medical and Nursing Staff	0%	18%	82%	10%	70%	20%
2.4	Advanced Critical Care Practitioners						
2.5	Pharmacists	50%	25%	13%	60%	20%	20%
2.6	Physiotherapists	0%	13%	88%	36%	18%	45%
2.7	Dieticians	0%	38%	63%	67%	33%	0%
2.8	Speech and Language Therapists	0%	50%	0%	75%	25%	0%
2.9	Occupational Therapists	67%	0%	33%	100%	0%	0%
2.10	Psychologists	0%	0%	100%	8%	58%	33%
2.11	Healthcare Scientists Specialising in Critical Care						
2.12	Support Staff	10%	10%	80%	20%	20%	60%
2.13	Smaller Remote and Rural Critical Care Units						
3	CRITICAL CARE SERVICES: PROCESS						
3.1	Admissions, Discharge and Handover	9%	27%	64%	0%	0%	0%
3.2	Capacity Management	14%	29%	57%	0%	60%	40%
3.3	Critical Care Outreach and Rapid Response Systems	0%	0%	100%	0%	29%	57%
3.4	Infection Control	0%	17%	83%	0%	0%	100%
3.5	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology	17%	17%	67%	38%	0%	63%
3.6	Rehabilitation	0%	57%	43%	14%	29%	57%
3.7	Intensive Care Follow Up	50%	50%	0%	91%	9%	0%
3.8	The Patient and Relative Perspective	14%	14%	71%	30%	0%	70%
3.9	Staff Support	11%	0%	89%	13%	13%	75%
3.10	Inter and Intra Hospital Transfer of Critically Ill Patients	13%	25%	63%	8%	8%	85%
3.11	Care at the End of Life	0%	0%	100%	11%	0%	89%
3.12	Organ Donation	0%	0%	100%	0%	0%	100%
3.13	Legal Aspects of Capacity and Decision Making	0%	100%	0%	0%	100%	0%
4	CRITICAL CARE SERVICES: CLINICAL CARE						
4.1	Respiratory Support	0%	10%	90%	50%	25%	25%
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	100%	0%	29%	29%	43%
4.3	Renal Support	0%	0%	100%	0%	0%	80%
4.4	Gastrointestinal Support and Nutrition	0%	20%	80%	30%	0%	70%
4.5	Liver Support				22%	11%	67%
4.6	Cardiovascular Support	17%	83%	0%	33%	0%	67%
4.7	Echocardiography and Ultrasound	70%	0%	30%	33%	33%	33%
4.8	Neurological Support	14%	0%	86%	8%	8%	85%
4.9	Burns						
4.10	Care of the Critically Ill Pregnant (or Recently Pregnant) Woman	0%	0%	100%			
4.11	Care of the Critically Ill Child in an Adult Critical Care Unit						
4.12	Standardised Care of the Critically Ill Patient	0%	0%	100%	10%	10%	80%
5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS						
5.1	Research and Development	0%	0%	100%	0%	0%	100%
5.2	Audit and Quality Improvement	20%	20%	60%	33%	33%	33%
5.3	Clinical Governance	30%	0%	70%	50%	33%	17%
5.4	Critical Care Networks	0%	0%	100%	0%	0%	10%
5.5	Critical Care Commissioning	0%	0%	50%			
6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS						
6.1	Fire	10%	10%	70%	33%	33%	33%
6.2	Major Incidents	29%	14%	57%	78%	0%	22%
6.3	High Consequence Infectious Diseases: Initial Isolation and Management	0%	0%	100%	10%	0%	90%
6.4	Surge and Business Continuity Planning	0%	0%	100%	0%	0%	100%

Section 1		Critical Care Services: Structure	Level description	Choose level	Comments
1.1 Levels of Critical Care					
STANDARDS					
1	All patients admitted to a critical care unit must be included in a national clinical audit programme in which Levels of Care data are collected.		met / not met	2=Fully met	
2	Level of Care classification must not be used in isolation to decide upon a patient's requirements.		met/ not met	2=Fully met	
RECOMMENDATIONS					
	None.			3=Not applicable to Unit	
1.2 Outcomes					
STANDARDS					
1	Critical care units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.	met - comprehensive programme with multi-professional involvement, partially - programme but limited multi-professional involvement, not met - no review		2=Fully met	
2	The unit must participate in a National Audit Programme for Adult Critical Care.	See section 1.1		2=Fully met	
3	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care.	met / not met		2=Fully met	
4	Critical care units should participate in a programme of hospital acquired infection surveillance to monitor and benchmark rates of catheter related bloodstream infections, antimicrobial use and frequency of multi-resistant infections eg Infection in Critical Care Quality Improvement Programme (ICQ-IP)	Met / unmet		1=Partially met	
RECOMMENDATIONS					
1	The UK intensive care community should encourage and develop a validated methodology to review referrals to intensive care and evaluate decision making and subsequent outcomes relative to intensive care admission and refusal.	National measure			
2	Units should develop a consistent approach to patient-centred decision-making, evaluating burdens and benefits of admission to intensive care, and be able to demonstrate this through the audit of pre-admission consultation, agreed criteria of referral, and time limited treatment trials.	met - all admissions audited and reviewed, partially met, some audit evidence of this process, not met - no audit information / no review of admissions		2=Fully met	
3	Longer-term mortality should be collected on all patients admitted to critical care.	met - collected on all patients, partially met - intermittent audit / review, not met - not reviewed		1=Partially met	
4	The UK intensive care community should encourage and develop validated measures of longer-term patient- and family-centred outcomes beyond mortality, including measures of functional ability, socioeconomic consequences, and carer burden.	National measure			
5	The UK intensive care community should encourage and develop validated measures of quality of care relating to end of life and bereavement.	National measure			
6	Critical care units should consider systematic assessment of patient and family experiences and demonstrate how these are used to guide improvement.	met - quarterly assessment, partially met - 1-2 yearly, not met - not done		1=Partially met	
1.3 Level 2 and 3 Physical Facilities					
STANDARDS					
1	Critical care facilities must comply with national standards.	met / not met		2=Fully met	
2	All new build units must comply with HBN 04-02.	met / not met / not applicable		3=Not applicable to Unit	
3	Medicines and fluid storage must comply with HBN 00-03.	met / not met			Pharmacy to confirm
RECOMMENDATIONS					
1	Existing units that do not comply should have a timeline to establish when national standards will be met.	met - time line and evidence to suggest progress, partially met - timeline but no evidence of progress, not met - no timeline / not applicable if standards met		2=Fully met	
2	Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.	met/not met		3=Not applicable to Unit	
3	The unit should have enough beds and resources to obviate the need to transfer patients to other critical care units for non-clinical reasons.	met - non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions		2=Fully met	
4	When planning or redesigning a critical care area, Document HBN 04-02 should be considered.	met, partially met, not met, not applicable		2=Not applicable to Unit	
5	Critical care units should incorporate sufficient storage for medicines (including refrigerated and controlled drugs), IV fluids (including renal replacement) and enteral feeds. Storage areas/shelves should be secure and appropriately temperature controlled for all medicines. ICU designs also, need to account for how selected medicines, including patients' own drugs, will be securely stored and readily accessible near the patient's bedside.	met, partially met, not met, not applicable		2=Fully met	
6	It is recommended that critical care areas that have undergone recent new unit planning and building are contacted by those embarking on a new build to share experiences and lessons.	met, partially met, not met, not applicable		3=Not applicable to Unit	
7	Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and dignity needs, and staff and visitor areas. Consideration should also be given to the patient's recovery and rehabilitation needs, including the potential for long-stay patients to spend periods outside.	met, partially met, not met, not applicable		1=Partially met	
8	Critical care units should be inspected as part of the peer-review process, including the review of the building and facilities. Feedback should include any concerns or highlights any disposal to improvement.	met - peer reviewed, feedback included, partially met - peer review, no feedback, not met - no peer review		2=Fully met	
9	Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners.	National/regional measure			
1.4 Clinical Information Systems*					
*If no CIS then Not applicable					
STANDARDS					
1	The CIS must comply with the set of common specifications, frameworks and implementation guides that support interoperability as specified with the NHS Interoperability Framework ( <a href="https://open.digital.nhs.uk/services/interoperability-standards">https://open.digital.nhs.uk/services/interoperability-standards</a> )			3=Not applicable to Unit	
2	CIS procurement and customisation must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system. This must include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineers, the COO (Chief Clinical Information Officer) and ICT specialists.	met, partially met, not met, not applicable		2=Fully met	
3	The CIS must have a rigorous business continuity access (BCA) plan and resilience system so that critical patient information remains available and system downtime must not compromise patient safety in any way. There must be a process to ensure that sufficient staff trained in BCA contingency measures are available 24/7.	Met = full BCP present and tested, partially = some aspects not expected to continue as usual or BCP untested, Not met = no documented BCP		3=Not applicable to Unit	
4	Where patient data management systems (PDMS) or electronic patient record (EPR) systems are used, there must be access to a dedicated workstation computer at each bed space. An appropriate number of both mobile and fixed workstations must be available to facilitate timely patient care by medical, nursing and allied staff on ward rounds and on an ad hoc basis.	Met = workstation for every bedspace plus additional workstations for mobile staff, partially met = insufficient mobile workstations, not met = absence of workstation at every bedspace (even if mobile stations available) or absence of any mobile workstations.		3=Not applicable to Unit	
5	The CIS must have robust implementation and ongoing training programmes to support all staff in its clinical and management use. These should be provided by the NHS organisation in partnership with the vendor company. Due consideration should be given to how the training will be provided to new starters and bursar staff. There should be a mechanism by which any specialty involved in the critical care unit has access to all pertinent information and is able to document in such a way as to facilitate care. This is particularly important when patient care and hospital documentation systems are distinct.	Met = training provided to all staff requiring it including new starters, >90% on first day of clinical duty or before, partially met >80% but <90% trained on first day of starting, not met = <80% trained on day 1		3=Not applicable to Unit	
RECOMMENDATIONS					
1	Critical care units should consider using a CIS.	met / not met		1=Partially met	
2	CISs should be part of an electronic health record. The specification should include high-resolution data capture from patient monitoring, infusion devices, ventilators, cardiac output measurement, temperature management devices, intra-aortic balloon pumps, extra-corporeal life support (ECLS) devices, blood gas analysers and renal replacement therapies (RRT) devices. A CIS should be capable of customizable display of the information above with clinical notes.	Met = >90% of device types ever used linked to system, partially met = 80-90% of all devices linked, not met = <80% of devices linked (ie we wouldn't expect a unit using 2 IABPs a year to link them, but would expect a unit using them monthly to link from)		3=Not met	
3	The CIS should be connected to the hospital's patient information system for demographic and admission/discharge data, to laboratories for results, to radiology for reports and to other key software, e.g. National Critical Care Audit Systems and Hospital Electronic Prescribing and Medication Administration (HEPMA) for electronic data sharing. The CIS should be able to collect and share electronically Critical Care Minimum Data Sets (CCMDS) and national audit data to facilitate electronic generation of reports and audit. In the event of replacing existing CIS, it must be possible to access archived patient records in a user-friendly format.	Met = clinical staff do not need to manually log in to another system to obtain results required to care for patients, partially met = clinical staff have to log into 1 additional system regularly, not met = staff have to access >1 additional system to obtain routine information required for patient assessment		1=Partially met	
4	Investigation order should be fully integrated and recorded, and include electronic prescribing of drugs and fluids and ordering of laboratory and radiology services.	partially met = clinical staff have to log into 1 additional system regularly, not met = staff have to access >1 additional system to obtain routine information required for patient assessment		3=Not met	
5	Daily summary plans should capture electronically activity data from the rest of the CIS, with the addition of free-hand text for healthcare professionals treating and visiting the patients.	Met = captures all required data, Unmet = unable to capture any information regarded as essential to review patient		3=Not met	
6	The CIS should be capable of forming worklists for individual members of the critical care team to allow patient- and staff-based lists of tasks to be completed. The CIS should include the ability to alert when tasks are near due, due and overdue, and record and audit performance.	Met = provides care-specific worklists and alerts, partially met = either alerts or worklists not provided comprehensively, unmet = unable to provide worklists or does not provide alerts (could probably do with scripting)		3=Not met	
7	There should be a functionality within the database to alert, within a short timeframe, lack of compliance with care bundles and specifically for physiological abnormalities that are undesirable or life threatening. These alerts should be via dashboards displayed clearly within the unit and also via text or email to smartphones or notebook-type devices carried by healthcare staff.	Met = alerts provided in real time in format required by unit, partially met = some alerts but not all those required or can only be provided in a suboptimal medium, not met = no dashboard facility		3=Not met	
8	The CIS should include customizable transfer/discharge summary, pulling key information from diagnoses, intensive care management, clinical notes, labs and medication.	Met = can be accessed remotely from any device, partially met = can only be accessed from specific pre-configured devices, not met = cannot be accessed or can be accessed but concerns over data security		3=Not met	
9	Flexibility through assessing care records online or through mobile devices should be possible.	single log in provided computer operating system already logged in, not met = user has to enter ID more than once to access		3=Not met	
10	The CIS should handle authentication and authorization through Single Sign-On, including the use of RFID/Smart card/biometrics.	Met = versatile system where users have been able to create decision support algorithms as required, partially met = some pre-specified decision support provided but limited additional configuration by end user, Not met = no decision support available		3=Not met	
11	The system should provide capacity to evolve sophisticated electronic decision support systems, to facilitate patient safety and quality. The CIS should be capable of feeding data to other tele-health solutions for remote monitoring and advice on patient management.				
1.5 Clinical Equipment					
STANDARDS					
1	All equipment must conform to the relevant safety standards and must be regularly serviced and maintained in accordance with the manufacturer's guidance.	met / not met		2=Fully met	
2	Uninterruptable power supply adequate to provide at least one hour of continuity of any critical equipment without battery back-up must be provided.	met / not met		2=Fully met	
3	There must be a programme in place for the routine replacement of capital equipment.	met / not met		3=Not met	
4	All staff must be appropriately trained and competent and familiar with the use of equipment. Up-to-date training records must be maintained to demonstrate that all staff have received the appropriate training and are competent to use the equipment. Care workers responsible for review the assessment, procurement, use and replacement of equipment on the critical care unit in collaboration with the electro-technical engineering (ETBE) provider and the organisation's overarching equipment governance.	Met = >85% trained staff for all equipment, partially 75-85% trained staff all equipment, not met < 75% or no clear record		2=Fully met	
5	ETBE support must be available either in-house or on a contracted basis to ensure equipment is appropriately serviced. Regardless of the model of support, ETBE personnel must have the appropriate skills and equipment to service the equipment used.	Met / not met		3=Not met	
6	Equipment must be uniquely identified and listed on an appropriate asset register along with details of its life cycle and service history/requirements to facilitate planned maintenance and replacement.	Met = >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record		2=Fully met	
7	There must be documented procedures for decontamination (cleaning, disinfection and sterilisation) as appropriate, depending on equipment risk category and sensitivity of devices. Appropriate sterile services must be provisioned so that national standards are followed for the re-sterilisation of endoscopes and reusable.	Met = >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record		2=Fully met	
8	Critical care units must be able to provide appropriate systems in place to ensure an adequate supply of consumables.	Met = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents		2=Fully met	
9	There must be robust mechanism for reporting adverse incidents resulting from the use of clinical equipment. Serious incidents involving clinical equipment may also need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).	Met - policy in place, partially met, no policy but can evidence, not met, no policy and / or no evidence		2=Fully met	
10	The MHRA may issue safety alerts pertaining to medical devices, as may device manufacturers from time to time. There must be designated role and robust mechanism for ensuring that such alerts are cascaded to staff and acted upon as appropriate.	Met - 100 % alerts received and acted upon, partially met 85-100% received, not met - no robust mechanisms or not able to evidence		1=Partially met	
11	Sufficient equipment must be available to meet the service demand to enable treatment provision (basic and specialist) monitoring, ventilation, renal replacement therapy, information technology facilities etc.) in an appropriate timescale to meet patient need. Consideration must be given to the need to provide additional capacity in times of surge demand.	Met = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents		2=Fully met	
12	Magnetic resonance imaging (MRI) compatible equipment must be provided for use where mechanically ventilated patients are to undergo MRI investigation. These must be clearly labelled and staff must be adequately trained.	met / not met / not applicable		3=Not met	Capital bid
13	Where advanced monitoring techniques are used (e.g. diagnostic electroencephalography, cardiac output monitors, intracranial pressure/other invasive neuromonitoring), there must be provision of appropriately trained staff to adequately interpret the results in a timely manner and to deal with likely complications of their use where appropriate.	Met = all advanced techniques reported within 6 hours of event (no verbal and provisional reports). Partially 6-24h, Not met = greater than 24h delay		2=Fully met	
14	Immediate access to point of care blood gas analysis and glucose/lactate analysis on a 24/7 basis must be provided.	Met / not met		2=Fully met	
15	Where equipment to be trialled on a loan basis for evaluation purposes, it is essential that adequate indemnity and governance arrangements are in place in case of injury to other patients or staff from potentially unfamiliar equipment, and the supplier should provide adequate training to ensure correct use. The EBME provider should facilitate this process by testing the equipment for safety as well as evaluation servicing and maintenance implications.	met / not met		2=Fully met	
RECOMMENDATIONS					
1	Standardisation of equipment should be encouraged both within the critical care unit and in other areas where intensive care may need to be delivered.	Met = all L3 areas of the hospital use same monitoring / ventilators / portable ventilators / RRT / monitoring sets. Partially met = 1 item different, Not met = >1 item different (specialist equipment used in only 1 area not included)		2=Fully met	
2	The provision of diagnostic ultrasound equipment should be guided by the likely patient population and staff expertise. At very least, there must be immediate access to sufficient ultrasound equipment to ensure that emergency activities can be carried safely and in a timely manner, even in sub-optimal circumstances.	met / not met		2=Fully met	
1.6 Cardiothoracic Critical Care					
*Not applicable to non Cardiothoracic Critical Care					

STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of GPCB.	met / not met	3=Not applicable to Unit	
2	Each cardiothoracic critical care unit must have designated lead consultant with training in cardiothoracic intensive care. This should be recognised in their job plan and they should be involved in multidisciplinary service planning and governance within the unit.	met / not met	3=Not applicable to Unit	
3	Each cardiothoracic critical care unit must have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service.	met / not met	3=Not applicable to Unit	
4	There must be a resident doctor or ACCP and a resident cardiac surgeon. There must be on-site 24/7 access to a doctor or ACCP with advanced airway skills. The resident team must be trained in Cardiac Surgery Advanced Life Support (ICALS) and be capable of emergency chest re-openings 24/7.	met / not met	3=Not applicable to Unit	
5	Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complies with national standards. There should be a clear escalation pathway from non-operative care to intensive care.	met / not met	3=Not applicable to Unit	
6	The care of patients falling outside the protocolised care pathways must be reviewed by a multidisciplinary team led by a consultant trained in cardiac Intensive Care Medicine.	met / not met	3=Not applicable to Unit	
7	Ventilated patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	met / not met	3=Not applicable to Unit	
8	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care.		3=Not applicable to Unit	
9	There must be a critical care pharmacist for every cardiothoracic critical care unit, supported by sufficient pharmacy technical staff.	met / not met		
10	All cardiothoracic critical care units must participate in local and national audits. For example, for units in England, Wales and Northern Ireland, this is participation in the ICNARC ABCSC (Assessment of Risk in Cardiothoracic Intensive Care) programme – the national clinical audit for cardiothoracic critical care units.	met / not met	3=Not applicable to Unit	
11	Trans-thoracic and transoesophageal echocardiography must be immediately available.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	The patient monitoring and physical support requirements in a cardiothoracic critical care unit should be no less than the requirements of patients cared for in a general (Level 2) critical care unit.	met / not met	3=Not applicable to Unit	
2	Cardiac and thoracic surgery post-operative care is carried out in a dedicated environment with each component located in close proximity.		3=Not applicable to Unit	
3	The cardiothoracic critical care unit should have in place agreed clinical criteria for the appropriate case mix and arrangements for escalation to a general critical care facility as required.	met = clear written protocol, partially met = occurs in practice but referee/accepter dependent, not met = escalation does not/cannot occur	3=Not applicable to Unit	
4	ACCPs, with adequate training and appropriate support, can provide a safe, sustainable alternative to medical staff in the cardiothoracic critical care unit.	Statement		
5	Each day, a consultant in charge of the cardiothoracic critical care unit should coordinate input from members of the various teams in the immediate post-operative period.	met / not met	3=Not applicable to Unit	
6	Perfusion services should be readily available.	met / not met	3=Not applicable to Unit	
7	Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an active part in shaping services and analysing quality. Patient mortality is currently in the public domain for each unit and each member of the MDT should have an understanding of how their own role contributes to patient outcomes.	met / not met	3=Not applicable to Unit	
1.7 Neurocritical Care*				
*NOT Applicable if non-neurocritical care				
STANDARDS				
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in the relevant chapters of GPCB.	Met / not met	3=Not applicable to Unit	
2	Neurocritical care units should have access to investigation facilities and appropriate clinical expertise for the following: a) diagnostic radiology (24-hour access to CT; access to MRI for ventilated subjects, and diagnostic angiography); b) access to biochemistry and microbiology services to analyse cerebrospinal fluid (CSF); c) neurophysiology (including electroencephalography (EEG) and evoked-response diagnosis and monitoring). Access to continuous 24-hour EEG monitoring is highly desirable.	met - all available, partially - some available	3=Not applicable to Unit	
3	All cases requiring immediately lifesaving neurosurgery must be admitted to the local neurosurgical centre irrespective of the initial availability of neurocritical care beds.	fully met - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met -	3=Not applicable to Unit	
4	Patients with a Glasgow Coma Scale (GCS) score of 8 following a head injury at any time must have access to specialist treatment from neuroscience unit.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)	3=Not applicable to Unit	
5	As per NICE Q574, eligible patients must have assessment for in-patient rehabilitation if new cognitive, emotional, behavioural or physical difficulties persist for more than 72 hours.	met / not met	3=Not applicable to Unit	
6	In addition to general rehabilitation, neurologically impaired patients must have access to specialist neuro-rehabilitation services.	met = have access immediately once ready for discharge from acute centre, partially met = have access but discharge delays >48h for >20% patients, not met = no access or delays > 4 weeks to access neuro rehab.	3=Not applicable to Unit	
7	Neurocritical care must have resources to support mechanical ventilation in line with NICE IPD 548.	met - 24/7, partially - 5/7 per week, not met - available less than 50%	3=Not applicable to Unit	
8	Neurocritical care must have resources to support regional networks for the safe and timely management of patients with subarachnoid haemorrhage.	met = all patients appropriate for escalation discussed, not met (must allow local clinicians professional latitude to NOT refer those clearly too frail for intervention)	3=Not applicable to Unit	
9	Patients must be cared for by a multi-professional intensive care team with specialist expertise and experience in managing critically ill neurological patients using agreed protocols based on the best evidence available.		3=Not applicable to Unit	
10	Care of critically ill neurological patients must fully integrate involvement of admitting specialties (neurology, neurosurgery, spinal surgery), and diagnostic/interventional specialties (neurophysiology and neurophysiology).		3=Not applicable to Unit	
11	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.			
RECOMMENDATIONS				
1	Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care.	met / not met	3=Not applicable to Unit	
2	Both the patient and family of the patient on neurocritical care should be offered support and guidance in the disease process and longer-term outcomes using specialist nurses and psychoeducators.	met = readily available at any point in pathway, partially met = available but not necessarily during critical care stay, not met = no psychoeducator provision	3=Not applicable to Unit	
3	Multimodal monitoring of patients with neurological injury should be consistent with international consensus recommendations.		3=Not applicable to Unit	
4	Early and formal involvement of the neurorehabilitation team as part of the multidisciplinary team should be sought to optimise outcomes and facilitate transitions of care.	met = neurohab consult within first week after injury (may be specialist physio or practitioner or consultant), partially met = neurohab review prior to transfer, not met = no review in acute setting	3=Not applicable to Unit	
5	Specialist equipment needs to be freely available to facilitate the acute rehabilitative needs of all brain and spinal injured patients while on neurocritical care.		3=Not applicable to Unit	
6	Neurocritical care units must be part of a regional network of care, with agreed national transfer and repatriation protocols that ensure rapid acceptance of patients for specialist care, and transfer back to referring hospitals or onwards for further specialist long-term care when the need for specialist neuroscience care no longer exists.	met - meet full recommendation with audit data, partially - meet recommendation but no audit data, not met - no networks / poor network	3=Not applicable to Unit	
7	Follow-up and audit of outcomes from neurocritical care should include a measure of functional recovery at a minimum of six months.	met / not met	3=Not applicable to Unit	
8	Regular neurocritical care morbidity and mortality meetings should be undertaken involving all members of the multidisciplinary team, including the admitting specialties, allowing structured judgement case review.	met = quarterly or more frequent MDT involvement, partially = less frequent or less MDT, not met = no MMM	3=Not applicable to Unit	
9	Patients requiring intensive care for acute neurosurgical and neurological diseases in non-specialist centres should have direct communication to expertise in specialist neuroscience centres.	met/not met	3=Not applicable to Unit	

Section 2	CRITICAL CARE SERVICES: WORKFORCE	Level description	Level	Comments
2.1				
Medical Staffing				
STANDARDS				
1	Patients' care must be led by a consultant in Intensive Care Medicine, who is defined as "... a consultant who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine. A consultant in Intensive Care Medicine will have daytime Direct Clinical Care Programmed Activities in Intensive Care Medicine identified in their job plan. These programmed activities will be exclusively in ICM and the Consultant will not be responsible for a second speciality at the same time."	Met = 24/7 cover by consultant in ICM, partially met = all daytimes covered by ICM consultant but 1-2 nights per week covered by an anaesthetist with direct telephone access to a named "second on call" ICM consultant, not met = anything else	2+Fully met	
2	Consultant work patterns must deliver continuity of care.	Met = daytime consultants work blocks of 3 or more days, with job planned handover time, partially met = blocks of <3 days or days themselves divided but with clear handover, not met = anything else	2+Fully met	
3	The daytime consultant to patient ratio must not normally exceed a range between 1.8 and 1:1.2.	Fully met = 7 days a week, partially met = 5 days per week	2+Fully met	
4	The daytime intensive care resident to patient ratio should not normally exceed 1:8.	Fully met = 7 days a week, partially met = 5 days per week	2+Fully met	
5	All staff that contribute to the resident rota must have basic airway skills. All critical care units must have immediate 24/7 on-site access to a doctor or ACCP with advanced airway skills.	Met / not met	2+Fully met	
6	There must be a designated Clinical Director and/or Lead Consultant for Intensive Care Medicine.	Met / not met	1+Partially met	No Lead Consultant
7	A consultant in Intensive Care Medicine must be immediately available 24/7. The consultant responsible for intensive care out of hours must be able to attend within 30 minutes.	Met / not met	2+Fully met	
8	In small hospitals or units that cannot attract overnight or an anaesthetist, consultant without daytime K&A sessions, or a necessary decision by the unit's size and remoteness, must also have a consultant in Intensive Care Medicine available for advice 24/7, either by local	Met / not met	3+Not applicable to Unit	
9	A consultant in Intensive Care Medicine must undertake ward rounds twice a day, seven days a week.	Met = >95% of days 2 ward rounds occur, partially met = 90-95%, not met = <90%	2+Fully met	
10	The ward rounds must have early input from nursing, microbiology, pharmacy and physiotherapy and regular input from statistics, speech and language therapy, occupational therapy and clinical psychology to assist decision making. The nurse in charge should be present in	Met - all met 7 days per week, partially met - (define missing groups) or only 5 days per week, not met - not achieved	1+Partially met	
11	Rotas for consultants and resident staff must be cognisant of fatigue and the risk of burnout.	Met = staff confirm rota is resilient, partially met = staff believe rota has features that are unsustainable in the long term, not met = failed rota requiring regular locum cover	2+Fully met	
RECOMMENDATIONS				
1	The consultant rota should seek to avoid excessive periods (> 24 hours) of direct patient consultant responsibility.	met / not met	2+Fully met	
2	The resident rota should be compliant with working time directives (i.e. Working Time Directive 2003)	met / not met	2+Fully met	
2.2				
Registered Nursing Staff				
STANDARDS				
1	Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	met 98% of the time or not met	2+Fully met	
2	Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.	met 98% of the time or not met	2+Fully met	
3	Each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service e.g. a Band 6a Nurse.	met / not met	2+Fully met	
4	There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7 in critical care units. Units with fewer than six beds may consider having a supernumerary clinical coordinator to provide the supervisory role during peak activity periods, e.g. early shifts.	Met = supernumerary nurse does not have their own patient >99% of time, partially met = supernumerary nurse is occasionally used in emergency to care for patient on <5% shifts, not met = supernumerary nurse is required to care for their own patient >5% shifts	2+Fully met	
5	Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to enable the delivery of safe care (i.e. 11-20 beds +1, 21-30 beds +2, etc.). The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g. multiple pods/bays, single rooms). Consideration for the need of additional staff also needs to be taken during events such as infection outbreaks.	Met = unit >11 beds always has second supernumerary nurse available. Partially = available >60% shifts, not met = unit has >11 beds and no additional nurse	3+Not applicable to Unit	
6	Each critical care unit must have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD framework for intensive care nursing staff and pre-registration student allocation. This should equate to a minimum of 1.0 WTE per 75 nursing staff.	Met - 1.0 per 75, partially met 1.0 per 100, unmet - no educator or less than 1.0 per 100	2+Fully met	
7	All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to enable achievement of basic specialist competence.	Met = always provided until competence achieved, partially = provided but may have own patient before full competencies completed, Not met = anything else	2+Fully met	
8	A minimum of 50% of registered nursing staff must be in possession of a post-registration award in Critical Care Nursing.	met or not met	2+Fully met	
9	Units must not utilise greater than 20% of registered nurse from bank/agency on any one shift when they are NOT their own staff.	Met = >95% of shifts, partially <90-95% shifts, not <90%	1+Partially met	
10	Where direct care is augmented using support staff (including unregistered nursing roles), appropriate training and competence assessment	met or not met	2+Fully met	
11	In addition to leadership competencies the lead nurse/matron (terms are synonymous for this purpose) for the critical care unit must meet, as a minimum, the same specialist critical care nurse educational standards as the staff caring for Level 3 patients.	met or not met	2+Fully met	
RECOMMENDATIONS				
1	Step 1 of National Competencies for Adult Critical Care Nurses should commence when a nurse with no previous experience of the specialty begins working in Intensive Care Medicine.	met / not met	2+Fully met	
2	Steps 2 and 3 of National Competencies for Adult Critical Care Nurses should be incorporated into academic intensive care programmes.	met / not met	2+Fully met	
3	Post-registration adult intensive care nursing courses should be awarded a minimum of 60 credits at Level 6. To meet the requisite standard, courses must adopt the core curriculum described in the National Standards for Critical Care Nurse Education (2016).	National measure		Fully met with 2 post reg courses
4	Additional Clinical Nurse Educators will be required for larger units, i.e. 1.0 WTE for approximately 75 staff. Clinical Nurse Educators should be senior intensive care nurses who have attained Step 3 competence, have completed a post-registration intensive care award and be in possession of a post-registration teaching qualification.	See above	3+Not applicable to Unit	
5	Registered nurses supplied through an agency to work in intensive care should provide evidence of appropriate experience and competence to care for critically ill patients.	met / not met	1+Partially met	
6	The Best Practice Principles to Apply When Considering Moving Critical Care Nursing Staff to a Different and Unfamiliar Clinical Care Area should be followed at all times to enable staff to achieve and maintain competence in intensive care nursing. The potential adverse effects on staff morale, recruitment and retention should be considered, particularly when this is recurrent. Executive Directors of Nursing should take requisite steps to minimise this.	Met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2+Fully met	
7	Supernumerary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive care nursing.	met / not met	1+Partially met	Working towards
2.3				
Workforce, Induction & Training of Medical and Nursing Staff				
STANDARDS				
1	Each critical care unit must have a dedicated supernumerary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for coordinating the education and training and CPD framework for intensive care nursing staff and pre-registration students.	See above 2.2.6	2+Fully met	
2	All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to allow adequate time for registered nurses to develop basic skills and competencies assessed to ensure they can safely care for a critically ill patient.	See above 2.2.7	2+Fully met	
3	All registered nurses commencing in intensive care must be working towards Step 1 of the National Competency Framework for Adult Nurses in Critical Care.	See above 2.2.1- recommendation	2+Fully met	
4	A minimum of 50% of registered nursing staff must be in possession of a post-registration award in intensive care nursing.	See above 2.2.8	2+Fully met	
5	Where direct care is augmented using non-registered support staff, appropriate training and competence assessment must be provided.	See above 2.2.11	2+Fully met	
6	All non-consultant medical staff commencing a post in the critical care unit must have a consultant-led departmental induction to the unit with a formal published programme. This must take place prior to commencing any clinical duties, and must include, but is not limited to: a) Instructions on how to raise patient safety concerns, b) Instructions on how to raise issues of bullying and undermining, c) Introduction to key members of medical, nursing, allied professional and operational support staff, d) Highlighting key departmental guidelines and how to access all departmental guidelines, e) Explanation and distribution of the doctor's rostered work pattern, and their roles and responsibilities when rostered to work both during the daytime and out of hours, f) Arrangements for access to all IT systems, including passwords, provision of identification badges and tutorials on the use of any clinical IT systems on the day of induction, and g) Assigning each doctor an Educational Supervisor.	met - includes all elements, partially met - some elements, not met - no identifiable written programme.	2+Fully met	
7	There must be a regular (e.g. weekly), consultant-led teaching programme relevant to all non-consultant grade doctors. Time to attend this must be protected, with attendance mandatory for all non-consultant grade doctors rostered to be on duty. These sessions should be open to all members of the MDT.	met - meets all elements, partially met - some elements met, not met - no regular teaching	1+Partially met	
8	There must be regular clinical governance, morbidity and mortality, and literature review meetings open to all members of the MDT. These meetings must be attended by both consultants and non-consultant grade doctors and non-consultant grade doctors must have the opportunity to lead the presentations at these sessions.	met - meets all elements, partially met - some elements met, not met - no meetings as described	2+Fully met	
9	All consultants responsible for the educational supervision of trainees must be recognised by the GMC for this role and there must be a sufficient time allocated in the Educational Supervisor's job plan to allow 0.25 SPA per trainee.	met - 0.25 PA per trainee, partially met less than 0.25 per trainee, not met, no time allocated.	2+Fully met	
10	All non-consultant grade doctors must have a bespoke personal development plan relevant to their developmental needs, and the doctor must be given the time and opportunity to achieve the objectives within the personal development plan as agreed with their Educational Supervisor.	met / not met	1+Partially met	
11	All staff supplied through an agency to work in intensive care must provide evidence of appropriate experience and competence to care for critically ill patients.	met / not met / not applicable (if never using agency)	2+Fully met	via agency screening
RECOMMENDATIONS				
1	Clinical Nurse Educators should be in possession of a post-registration award in intensive care and an appropriate postgraduate certificate in education or equivalent.	met / not met	1+Partially met	No post grad cert in Ed
2	Nurse education programmes should follow the National Standards for Critical Care Education (2016) and include both clinical competence and assessment.	met / not met	2+Fully met	
3	Study leave should be provided for all members of the MDT for intensive care-related courses and conferences.	Met = funded/partially funded (may be from charitable sources) study leave up to 10 days per year available to all staff, Partially = study leave available but unfunded or <4 days per year, Not met = anything else	1+Partially met	
4	A creative learning environment should be provided for all staff offering a range of learning experiences to meet the defined learning outcomes for their continuing professional development.	Met = monthly forum for full MDT, partially met = some provision but not monthly or not formalised, Not met = no mechanism	1+Partially met	no designated training room
5	There should be a regular monthly forum chaired by a senior member of the department, where all members of the MDT can feed back any patient safety, educational or operational issues to the senior medical, nursing and management team.	Met = trust provides electronic access to appropriate ICM journals and resources, partially met = some access but clinicians believe notable omissions, Not met = no access	1+Partially met	recently restarted
6	The hospital and/or departmental library should provide access to relevant and up-to-date Intensive Care Medicine journals and books relevant to nursing, medical and A&P staff.	Met = trust provides electronic access to appropriate ICM journals and resources, partially met = some access but clinicians believe notable omissions, Not met = no access	2+Fully met	online version
7	The critical care unit should provide access to online clinical resources from within the clinical area for all clinical staff.	Met = trust provides electronic access to appropriate ICM journals and resources, partially met = some access but clinicians believe notable omissions, Not met = no access	1+Partially met	access to on-site library available
8	All consultants should provide regular teaching and feedback to non-consultant grade doctors, nursing staff and allied health professionals.	Met = fully evidence simulation and MDT education programme, Partial = some MDT teaching provided but not comprehensive	1+Partially met	
9	There should be a regular multidisciplinary educational programme, including simulation involving medical, nursing and allied health professionals.	Met = fully evidence simulation and MDT education programme, Partial = some MDT teaching provided but not comprehensive	1+Partially met	
10	Step 4 leadership competencies (or equivalent) (CCN, 2018) should be completed by all senior nurses who undertake the role of shift leader (including those who lead patient teams in larger units) and those aspiring to such a role.	See above 2.2.5 recommendation	0+Not met	Discuss with Sandra
11	Specialist step competencies (CCN, 2018) should be completed whenever relevant to the case-mix of the unit. For example, nurses working in critical care units in major trauma centres should complete the major trauma step competencies.	met = >50% staff complete, partially 25-50%, not <50%	3+Not applicable to Unit	
2.4				
Advanced Critical Care Practitioners				
STANDARDS				
1	ACCPs must act within the formal code of conduct of their present statutory regulator. Trainee ACCPs are required to practice within the structure of the FICM curriculum, with the appropriate level of supervision.	Met/ not met	3+Not applicable to Unit	
2	All ACCPs / ACPs working on Critical Care should have completed non medical prescribing	Met = >95%, Partially = 75-95%, Not = <75%	3+Not applicable to Unit	
3	ACCPs must acknowledge any limitations in their knowledge and skills and should not perform clinical activities they do not feel skilled or competent to perform. As part of their training and ongoing professional development, they must develop (and continue to develop) a high level of clinical judgement and decision making.		3+Not applicable to Unit	
RECOMMENDATIONS				
1	A FICM-associated ACCP with supervision from an ICM consultant falls within the definition of an intensive care resident and may provide the on-site 24/7 immediate clinical/medical cover for patients.	Statement		

2	An ACCP who entered a training post after 5 November 2017 should successfully complete an ACCP specific two-year Postgraduate Diploma (PgDip) which meticulously follows the FICM ACCP curriculum, and register with FICM as a trainee ACCP. ACCPs who entered training on the above date should ensure their training programme adheres to the requirements of the FICM ACCP Membership criteria.	Met / not met / not applicable (if no ACCP)	3=Not applicable to Unit	
3	After successful completion of clinical and academic PgDip ACCP requirements, including Non-Medical Prescribing, ACCPs should apply to the FICM for ACCP Membership. It is recommended that employing units should only appoint FICM-associated ACCPs to ensure a standard knowledge base, minimum skillset and that FICM ACCP curriculum competencies have been met.	Met = all ACCPs have FICM, partially met, = at least 50% have FICM not met = <50% Met = all ACCPs have FICM competencies partially met > 50% have FICM competencies, not met = <50%	3=Not applicable to Unit 3=Not applicable to Unit	
5	While working autonomously, the ACCP will always work within a multi-professional team led by a consultant who is trained in ICM.		3=Not applicable to Unit	
6	It is recommended that critical care units employing ACCPs have transparent ACCP standard operating procedures and outcomes, and that any incidents are reviewed as part of the unit's governance arrangements.	Met = SOP in place, not met = no SOP	3=Not applicable to Unit	
7	It is recommended that line management of ACCPs forms a tripartite arrangement between an ICM consultant, ICU clinical supervisor and professional level such as a senior nurse or ANP from the ACCPs base profession.	Met/not met	3=Not applicable to Unit	
8	Continuing professional development (CPD/appraisal) for ACCPs should be undertaken according to the FICM CPD/appraisal guidance on an annual basis.	met/not met	3=Not applicable to Unit	
<b>2.5 Pharmacists</b>				
<b>STANDARDS</b>				
1	There must be a designated intensive care pharmacist for every critical care unit.	met / not met	2=Fully met	
2	There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and 2 for every Level 2 bed for a 5/7 a week service.	met = 0.1/bed, partially = 0.05-0.1 per bed, not <0.05	0=Not met	
3	Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days before 2020.	met - 7 days per week, partially met 5 days per week.	1=Partially met	
4	The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least <b>Advanced Stage II</b> (excellence level) in adult critical care pharmacy.	met / not met	0=Not met	
5	Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so <b>Advanced Stage III</b> must have access to an <b>Advanced Stage II</b> (excellence level) intensive care pharmacist for advice and referrals.	met / not met	0=Not met	
6	As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays). Attend = dips into ward round(s), as appropriate and discussion issues.	met - 5 days per week, partially met - 3-5 days per week, not met - less than less or not on ward round.	1=Partially met	
7	There must be sufficient patient-facing pharmacy technical staff to provide supporting roles.	met / un met	0=Not met	
<b>RECOMMENDATIONS</b>				
1	To maintain the continuity of the service during annual leave, sick leave and training leave, additional appropriate resources will be required (20% minimum is recommended).	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no cover or on call type cover only	2=Fully met	
2	Intensive care pharmacists should undergo an independent, recognised process to verify competence level.	met / not met	0=Not met	
3	Senior specialist intensive care pharmacist support should, preferably, be provided within the organisation but may be provided from a critical care network or on a regional basis.	met - 7 days per week, partially met 5 days per week.	1=Partially met	
4	A peer-to-peer practitioner visit should occur at least once a year to ensure training issues are identified and to help maintain the competence of small teams and sole workers. This supports General Pharmaceutical Council (GPhC) revalidation.	met - yearly, partially met 1-3 yearly, not met - not done or > 3 yearly	0=Not met	
5	Where a team of intensive care pharmacists is in place, there should be a structured range of expertise, from trainee to Fellow level.	met / not met	0=Not met	
6	Intensive care pharmacists are encouraged to become active independent prescribers.	Statement		
<b>2.6 Physiotherapists</b>				
<b>STANDARDS</b>				
1	Physiotherapists must participate in opportunities for integrated decision making and dissemination of clinical information. This may include handovers, consultant-led multidisciplinary ward rounds, MDT meetings, team briefings or operational and patient safety briefings.	met / not met	2=Fully met	
2	The critical care MDT must have an identifiable lead physiotherapist who will be accountable for clinical service delivery, provide training and mentorship to junior staff, and oversee clinical governance and quality assurance.	met / not met	2=Fully met	
3	All physiotherapy staff must receive appropriate competency-based training to ensure delivery of high-quality physiotherapy intervention within critical care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover.	met / not met	2=Fully met	
4	Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care, ensuring compliance with both clinical and professional guidelines and standards.	met - fully meet standard 7 days per week - partially met - meet standard 5 day per week, not met	2=Fully met	
5	Respiratory physiotherapy must be available to critical care patients 24 hours a day and seven days a week. This includes the provision of an out of hours/on-call service which may utilise specialist and non-specialist intensive care staff.	met / not met	2=Fully met	
6	Physiotherapists, as part of the multidisciplinary team, must ensure the completion of a comprehensive clinical assessment of those at risk of or with identified physical and non-physical morbidity within four days of admission to intensive care and before discharge from intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation goals.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	100% of patients assessed on same/d	
7	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	met - 7 days per week, partially met 5 days per week,	1=Partially met	No regular OT input into ITU patients. I
8	Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team(s) following discharge from intensive care. This should include the holistic individualised structured rehabilitation plan.	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	Due to no dedicated ITU Physiotherap
<b>RECOMMENDATIONS</b>				
1	The service provision should be based upon the overall patient case-mix taking into account acuity, dependency and complexity of the clinical case-mix. Staff resources and capability should be appropriately matched both in knowledge, skills, and number to deliver comprehensive respiratory care and holistic rehabilitation. However, further work is recommended of paramount importance exploring different models to not only determine physiotherapy staffing ratios in intensive care. The suggested ratio would be one WTE physiotherapist to four ICU Level 3 beds	met 1 WTE to four level 3 beds ( or equivalent level 2 ), partially met 0.5-1.0 WTE per four level 3 beds, not met < 0.5 per four level 3 beds	0=Not met	WGH has up to 6 ITU patients for the 7
2	Physiotherapy services should provide assessment and intervention for physical rehabilitation seven days per week.	met 7 days per week, partially met 5 days per week, not met < 5 days per week	2=Fully met	
3	The value and role of Therapy Support Workers or Rehabilitation Assistants should be considered as part of either the intensive care physiotherapy or multidisciplinary workforce.	Statement		White Band 4 Tec staff exist in other st
4	Competency/capability frameworks should be in place encompassing all Agenda for Change (AFC) bands applicable to the local service. This should reflect relevant national competency and professional development frameworks. A local training and development programme should exist to align with these frameworks.	met / not met	2=Fully met	
5	Clear role specifications should exist for intensive care physiotherapists who have reached the level of Advanced Practice according to the Health Education England Framework.	met / not met	2=Fully met	Specifications exist, but staff do not ou
6	The intensive care physiotherapy service should have a clear local operational policy and core standards for service provision which reflects both national guidance and standards and local variations.	met / not met	0=Not met	No local policy as no dedicated ITU Ph
7	The intensive care physiotherapy service or, where appropriate, as part of the MDT, should have robust and evidence-based clinical guidelines/standard operating procedures surrounding airway clearance interventions and specialist rehabilitation interventions including early mobilisation of patients in intensive care.	met / not met	0=Not met	No local policy as no dedicated ITU Ph
8	The lead physiotherapist, or appropriate deputy, should participate in all relevant local (and where appropriate, regional) intensive care operational delivery, governance and quality improvement groups. This may include governance meetings, service improvement work-streams, morbidity and mortality review meetings, business continuity meetings, operational or clinical management meetings. This should also include active participation/collaboration with their regional Critical Care Operational Delivery Network.	met / not met	1=Partially met	Attend as able, many of these meeting
9	The physiotherapy intervention(s), as part of the patient's individualised, structured rehabilitation plan, should be matched to the acuity, dependency and complexity of the patient, considering the patient's clinical needs and tolerance to intervention. This should align with the individualised, patient-centred rehabilitation goals and a holistic rehabilitation approach should be taken across a 24-hour period.	met / not met	2=Fully met	
10	Physiotherapists should play a key collaborative role in the coordination and delivery of ventilation and tracheostomy weaning plans, including post-extubation and sedation management. Additionally, physiotherapists should be a core part of the multidisciplinary delivery of non-invasive ventilation in intensive care.	met / not met	1=Partially met	Physiotherapy service heavily involved
11	Targeted airway clearance interventions should only be considered in selected patients when clinically indicated. Routine secretion clearance therapy for all invasively-ventilated patients is not recommended.	met / not met	2=Fully met	
12	Where a local intensive care follow-up clinic/services exists, a physiotherapist should contribute to this service.	met / not met	0=Not met	Physiotherapy service not included in t
<b>2.7 Dietetics</b>				
<b>STANDARDS</b>				
1	Critical care units must have access to dietitian five days a week during working hours	met / not met	2=Fully met	
2	There must be a dietitian as part of the critical care multidisciplinary team. If the critical care dietitian is working alone, they must be at the level of advanced practice. Where more than one dietitian is required, there must be an identifiable lead dietitian of advanced clinical practice level 4 to ensure an appropriate range of expertise within the team and to have overall responsibility for the service provision.	met = dedicated named dietician(s) / not met	2=Fully met	
3	Intensive care dietitian(s) must have satisfied local or national competency requirements and be able to undertake a nutrition assessment and implement an appropriate nutrition support plan for critically ill patients. If working at advanced clinical practice level, dietitians must be able to demonstrate application of the documented capabilities outlined in the multi-professional framework for advanced clinical practice in England.	met / not met	2=Fully met	
4	Intensive care dietitian(s) must work collaboratively contributing to consultant-led ward rounds, MDT meetings, and have regular consultant communication where nutritional goals, risks and plans are discussed as per the NICE CG83.	met / not met	2=Fully met	
5	Intensive care dietitian(s) must lead on the development and implementation of any local nutrition support guideline(s).	met / not met	2=Fully met	
6	Intensive care dietitian(s) must contribute to appropriate strategic meetings and clinical governance activities, including leading regular nutrition-related audits and acting on the results, plus undertaking quality improvement projects that demonstrate the impact of dietetics on service delivery, quality and effectiveness.	met / not met	1=Partially met	
7	Intensive care dietitian(s) must provide ongoing education and training for other healthcare professionals.	Met = comprehensive nutrition teaching programme for other staff, Partially = evidence of ad hoc teaching by dietitian, Not met = no dietitian led teaching	1=Partially met	
8	Intensive care dietitian(s) must provide a structured handover to a ward dietitian when patients are discharged from the critical care unit, considering nutrition-related morbidity as per the NICE Quality Standard.	Met = >75% patients, Partially 50-75%, Not <50%	1=Partially met	
<b>RECOMMENDATIONS</b>				
1	There is a staffing level of at least 0.05-0.1 WTE per critical care bed to provide the dietetics service is recommended.	Met = >0.05, Partially = 0.025-0.05, Not <0.025	1=Partially met	
2	Intensive care dietitian(s) provide extended scope practitioner roles such as inserting feeding tubes, using indirect calorimetry to determine energy expenditure and supplementary prescribing where appropriate.	Met = all listed, Partially = some, Not = none	0=Not met	
3	Intensive care dietitian(s) should consider undertaking and disseminating nutrition-related research to widen the evidence base.	Statement		
4	Intensive care dietitian(s) should consider joining national (Critical Care Specialist Group of the British Dietetic Association) and international intensive care and nutrition-specific societies (Intensive Care Society, European Society for Intensive Care Medicine, European Society for Parenteral and Enteral Nutrition, etc.).	met / not met	0=Not met	
5	Intensive care dietitian(s) should represent dietetics on national and international society committees and guideline development groups.	Statement		
6	Intensive care dietitian(s) working at an advanced level should have or be working towards a master's level award.	Statement		
<b>2.8 Speech and Language Therapists</b>				
<b>STANDARDS</b>				
1	Critical care units must have access to a speech and language therapist five days a week during working hours.	met = 5 days, partially >=3 days, not <3 days	1=Partially met	There is no dedicated SLT services in
2	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	Met = >98%, partially met > 80%		
3	All critically ill patients who have communication and/or swallowing difficulties (dysphagia) must have timely access to an SLT service.	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours		
4	All Speech and Language Therapists working in intensive care must be appropriately trained, competent and familiar with the use of relevant equipment.	met / not met	1=Partially met	Limited amount of SLT's with appropri



RECOMMENDATIONS				
1	The critical care SLT service is provided by a minimum of 0.1 WTE (whole time equivalent) per bed	met = 0.1, partially 0.05-0.1, not <0.05	3a/Not met	
2	Patients should have access to a communication aid according to individual need in order to facilitate patient interaction and rehabilitation	met = always available inc advanced devices, partially = available but may not have same day access or simple devices only, not met = no access (apart from simple white boards/paper)	1a/Partially met	
3	Speech and Language Therapists should contribute to a suitable tracheostomy or non-invasive ventilation weaning plan for complex or long stay patients	met / not met	3a/Not met	
4	SLT are available seven days a week	met 7 days per week, partially met 5 days per week, not met, less than 5 days or sporadic service	3a/Not met	
5	FEES should be available for Speech and Language Therapists to use in assessment and management of dysphagia in intensive care patients	met - FEES available 5 days/week, partially met - adhoc availability, not met - no service	3a/Not met	
6	Speech and Language Therapists should work as an integral member of the multidisciplinary team on the critical care unit, contributing to all multidisciplinary ward rounds, tracheostomy teams, clinical governance groups, audit, research, education and policy development.	met - SLT attend daily ward rounds 5 days a week, partially met - available on request, not met = no service	1a/Partially met	
7	Swallowing and communication recommendations and treatment plans should be included in any medical handover when the patient is transferred from intensive care to another unit or ward	met (included in standardised handover process) or not met	3a/Not met	
8	Patients who are being considered for 'risk feeding' should have access to an SLT assessment in order to clarify their level of aspiration risk and optimum oral feeding consistencies	met > 90% of referrals seen within 24 hours (excluding weekend), partially met 75-90% seen within 24 hours, not met < 75% seen within 24 hours	3a/Not met	We have not had referrals asking for S
2.9	Occupational Therapists			
STANDARDS				
1	Critical care units must have access to occupational therapy services 5 days a week during working hours.	met = 5 day a week access, partially met = < 5 days/week, not met = no service or on call service from other depts only	3a/Not met	
2	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient; rehabilitation plans should be updated accordingly.	See 2.6.7	3a/Not met	
3	All occupational therapy staff working in a critical care environment must adhere to the Royal College of Occupational Therapists' Code of Ethics and Professional Conduct (COT 2015) and the Professional Standards for Occupational Therapy Practice (COT 2017).	met / not met	2a/Fully met	On times when have inreached to critic
RECOMMENDATIONS				
1	There should be an identifiable lead occupational therapist with appropriate experience, who will be accountable for service provision and development.	met / not met	3a/Not met	
2	The occupational therapy clinical lead should be responsible for supporting learning opportunities, training and clinical supervision for junior staff providing occupational therapy services in intensive care.	met / not met	3a/Not met	
3	The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation programmes that address the complex functional, cognitive and psychosocial needs of the patient cohort.	met / not met	3a/Not met	
4	Occupational therapy staff on the critical care unit should be able to assess and provide non-pharmacological treatment for those patients who present with delirium.	met (OT involved in management of delirium in ICU) partially = involved but no routine review of patients with delirium or not met	3a/Not met	
5	Occupational therapists should be involved in intensive care follow-up clinics to assess and facilitate appropriate referrals rehabilitation or specialist services and to address any long-term physical and non-physical impairment affecting occupational performance.	met /not met	3a/Not met	
2.10	Psychologists			
STANDARDS				
1	All patients must be screened daily for delirium using a validated instrument.	met = > 95% screened, partially met = 80%, not met - < 80% or no audit data	2a/Fully met	
2	Non-pharmacological strategies must be in place to prevent and reduce delirium.	met - there is a local delirium guideline detailing non pharmacological strategies. Not met	2a/Fully met	
RECOMMENDATIONS				
1	Psychologists should ensure that delirium is accurately assessed by nurses using a validated instrument, and that when delirium is detected, risk factors are reviewed and corrected by the MDT. They should advise on non-pharmacological strategies to prevent and reduce delirium at the ward level (by improving the environment and patient level (to facilitate orientation and engagement).	met / not met	2a/Fully met	
2	Psychologists should ensure that patients and relatives receive psychological education to explain the psychological impact of intensive care days, procedures and environment. This can be delivered in person or via information leaflet.	met / not met	1a/Partially met	
3	NICE CG33 and QS158 stipulate that patients should receive assessments and interventions for psychological as well as physical problems throughout the intensive care pathway. These should be delivered or supervised by qualified psychologists.	met = triggered or routine assessment available for all patients, partially = only available at certain points in pathway (ICU/wards/follow up), Not met = not available at all	2a/Fully met	
4	Psychologists should organise short psychological assessments for all awake, alert patients in intensive care using a validated measure such as the Intensive Care Psychological Assessment Tool.	met = >75% suitable patients assessed, partially 50-75%, not <50% (or no audit data)	3a/Not met	
5	If a patient is screened as being at risk of future psychological morbidity, psychological support should be offered by psychologists or other appropriately trained staff (e.g. nurses or psychology trainees) to give patients the opportunity to express their needs and feelings, and to have those beliefs validated and normalised.	met/not met	1a/Partially met	
6	All patients found to be at risk of psychological morbidity (following the short assessment) should receive a comprehensive assessment before discharge from critical care. Psychologists should ensure that psychological needs, support and goals are included in the individualised structured rehabilitation programme that is formally documented and handed over at the time of transfer to general wards.	met = 75% assessed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met = not assessed	1a/Partially met	
7	The psychologist should advocate (in conjunction with hospital outreach and mental health teams) for a system to be in place for at-risk intensive care patients to receive psychological support on general wards.	met/not met	1a/Partially met	
8	Psychologists should contribute to the information (verbal and written) patients and relatives receive to help them continue their personal rehabilitation plans and to know who to contact if they need support after leaving hospital.	met/not met	1a/Partially met	
9	Psychologists should participate in the follow-up reviews that intensive care patients receive in the community or at outpatient clinics.	met = always available at FU clinic, partially = available by referral, not met = not available	3a/Not applicable to Unit	
10	As part of the critical care unit MDT, the psychologist should provide: a) Training for staff to increase knowledge and understanding of psychological reactions, delirium, environmental stressors and psychological outcomes of critical illness, b) Consultation with the multidisciplinary team on communication, sleep, effects of sedation, anxiety, stress, mood, delirium, family issues and holistic care plans, c) Psychological support for families. Relatives may need support to cope with the shock of a family member becoming critically ill and being admitted to the critical care unit, as well as stress and exhaustion from caring for a patient during a long-term admission. They may also need bereavement support if the family member dies in the critical care unit.	Met = all elements, partially = some, not = none (could be split)	2a/Fully met	
11	During patients' rehabilitation and recovery period, the psychologist should provide: a) Consultation with outreach and general ward staff regarding psychological support for intensive care patients, b) Tailored evidence-based interventions for persisting morbidity such as anxiety, depression or PTSD; these should be offered by psychologists in a well-resourced follow-up service and should include trauma-focused cognitive behavioural therapy, c) Where funding for this is not available, referrals of patients directly to psychological therapy services, or recommendations for GP to make referrals to these services, or advice to patients on how to access local psychological services, and d) Drop-in support groups for intensive care patients and their families after discharge from hospital, held in the hospital or community.	Met = all elements, partially = some, not = none (could be split)	2a/Fully met	
12	Employers have a duty of care to support staff working in a stressful environment such as intensive care, where burnout is highly prevalent. Workplace stress should be addressed at organisational, team and individual levels. Psychologists should consult with intensive care leadership on systemic issues influencing staff well-being. Additionally, psychologists should run or oversee staff support programmes including one-to-one sessions, drop-in groups or reflective rounds according to staff wishes and availability, as well as coaching sessions for senior managers.	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1a/Partially met	
13	To develop this coordinated service for patients, families, and staff, critical care units should employ a senior HCPC-registered practitioner psychologist. Large critical care units should have access to a WTE, and smaller units should have access to a psychologist with dedicated time for intensive care to deliver the points above.	met/not met	1a/Partially met	
2.11	Healthcare Scientists Specialising in Critical Care			
STANDARDS				
1	Critical Care Scientists must comply with the professional standards of behaviour and practice set out in Good Scientific Practice (GSP).	met/not met	3a/Not applicable to Unit	
2	Critical Care Scientists responsible for management of medical devices and point of care diagnostic services must comply with the standards set by the Medicines and Healthcare Products Regulatory Agency (MHRA) and the International Organisation for Standardisation (ISO) standard (22070:2016).	met/not met	3a/Not applicable to Unit	
3	Critical Care Scientists voluntarily registered with the Health and Care Professions Council (HCPC) must meet the Standard of Proficiency and comply with the Standards of Conduct, Performance and Ethics.	met = are registered and comply / not met	3a/Not applicable to Unit	
4	Critical care units receiving trainee healthcare scientists for training in intensive care must comply with the requirements for training set for them by the National School of Healthcare Scientist (NSHCS).	met / not met	3a/Not applicable to Unit	
RECOMMENDATIONS				
1	The Critical Care Scientists should successfully complete an approved training programme, either via accredited specialist training or as part of the Scientist Training Program (STP) commissioned by the National School of Healthcare Science (NSHCS) and should be registered with the HCPC.	met/not met	3a/Not applicable to Unit	
2	The Critical Care Scientists should work collaboratively to be a dynamic member of the multidisciplinary team, assisting in the provision of high quality, patient-centred care within the critical care environment.	met = embedded in dept, partially = available but not embedded, not	3a/Not applicable to Unit	
3	The Critical Care Scientists should draw on specialist knowledge to provide advice to medical, nursing and wider multidisciplinary team working in a critical care setting about the safe and effective use of medical devices used within the critical care environment, including monitoring, diagnosis and therapeutic technologies supporting critically ill patients.	met / not met	3a/Not applicable to Unit	
4	The Critical Care Scientists should develop and support research activities, including facilitating evidence based practice and implementation of the latest technologies and software to the critical care environment.	met / not met	3a/Not applicable to Unit	
5	The Critical Care Scientists should provide effective management and support for medical devices, including advising on optimal clinical settings and troubleshooting, resulting in focused, efficient and high-quality care.	met = evidence of logs or equipment testing available / partially = happens but no evidence, not met	3a/Not applicable to Unit	
6	The Critical Care Scientists should contribute to the educational needs of the multidisciplinary team, including delivering training, mentorship and educational support.	met = evidence of involvement in teaching and training / not met	3a/Not applicable to Unit	

RECOMMENDATIONS				
1	All staff should be encouraged to attend further training and/or education to support their development.	met / not met	2=Fully met	
2	Each critical care area should have healthcare support workers 24/7 to assist nursing staff in delivery of direct patient care.	met = all shifts covered, partially = 75% covered, not <75%	0=Not met	
3	Each critical care area should have ward clerk/receptionist cover seven days per week.	met = 7/7, partially 5/7, not = no receptionist	1=Partially met	
4	Each critical care area should have a dedicated housekeeper/cleaner seven days per week.	met = 7/7, partially 5/7, not = no dedicated staff	2=Fully met	
5	Each critical care area should have a data clerk or allocate time to a data clerk or train for data entry to a nationally recognised audit programme (such as ICNARC or SICSAG) and responsibility for the validation of these data. The Intensive Care Audit Group (ICAG) also provides a template for data collection.	met = full cover with leave cover, partially = less than recommended cover or no leave cover, not met = no dedicated cover	2=Fully met	
2.13	Smaller Remote and Rural Critical Care Units	Only relevant for small number of units. An autopopulate feature of not applicable would be useful		
STANDARDS				
1	Network support must be in place to ensure smaller, remote and rural critical units meet these standards and recommendations.	met = active participation in network / not met	3=Not applicable to Unit	
2	The critical care service must be led by consultants trained in Intensive Care Medicine (ICM).	met / not met	3=Not applicable to Unit	
3	There must be access to appropriate advice from a consultant in ICM at all times.	met = 24/7 access to advice / not met	3=Not applicable to Unit	
4	Dedicated daytime critical care must be provided by a consultant trained in ICM with no other commitments.	met = 7/7, partially = 5/7 (or involves covering other areas at same time)	3=Not applicable to Unit	
5	There must be a doctor or ACCP with advanced airway skills resident within the hospital 24/7.	met / not met	3=Not applicable to Unit	
6	There must be a 24/7 dedicated resident on the critical care unit.	met / not met	3=Not applicable to Unit	
7	There must be structured handover between day-time and night-time staff supported by standardised policies for practice.	met / not met	3=Not applicable to Unit	
8	Appropriate CPD must be supported by the employer and undertaken by all professionals who deliver intensive care.	met / not met	3=Not applicable to Unit	
9	Regional transport arrangements (road and air) must be put in place to allow timely, safe transfer of patients with an appropriate level of monitoring, staffing and skills.	met / not met	3=Not applicable to Unit	
10	All critical care units, including Level 2 units, must enter data into national databases such as ICNARC or SICSAG.	met / not met	3=Not applicable to Unit	
RECOMMENDATIONS				
1	Network support should be explicit, resourced and supported by all the Healthcare Organisations, Boards, networks and regions involved, and recognised in job planning.	met / not met	3=Not applicable to Unit	
2	Units should consider the development of telemedicine techniques for clinical decision making and educational support, in conjunction with their regional network.	Statement		
3	Remote critical care units should implement appropriate joint clinical governance procedures with both networked units and transfer services to include case-based review, critical incident analysis, and joint educational sessions.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit	
4	Where an intensive care pharmacist or healthcare professional, such as a physiotherapist or dietitian, cannot be effectively delivered locally in a small unit, advice should be accessible from specialist colleagues through network support. Appropriate training bodies should devise and support remote and rural training posts in critical care.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit	



Section 3		CRITICAL CARE SERVICES: PROCESS	Level description	Level	Comments
3.1 Admission, Discharge and Handover					
STANDARDS					
1	The decision to admit to the critical care unit and the management plan must be discussed with the duty consultant in Intensive Care Medicine.	Met = >95%, partial = >90%, not <90% or not data		2-Fully met	
2	There must be documentation in the patient record of the time and decision to admit to critical care.	< 85% met, 75-85 partially met, < 75% or no data not met		2-Fully met	
3	Unplanned admissions to the critical care unit must occur within four hours of making the decision to admit.	Met = >95%, partial = >90%, not <90% or no data		2-Fully met	
4	Patients must have a clear and documented treatment escalation plan.	Met >85%, partial 80-95%, not <80 or no audit evidence		2-Fully met	
5	Patients must be reviewed, in person, by a consultant in Intensive Care Medicine as urgently as the clinical state dictates and always within 12 hours of admission to critical care.	95% of the time - Met, <95% or no data - not met		2-Fully met	
6	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions		2-Fully met	
7a	Consultant in Intensive Care Medicine-led ward rounds must occur twice a day (including weekends and national holidays).	< 85% met, 75-85 partially met, < 75% or no data not met		1-Partially met	
7b	The nurse in charge should be present in person for the ward round.	< 80% met, 75-85 partially met, < 75% or no data not met		2-Fully met	
8	Patients discharged from critical care must have access to an intensive care follow-up programme.	met / not met		2-Fully met	
9	Discharge from critical care to a general ward must occur within four hours of the decision and must occur between 07:30hrs and 21:00hrs.	met = >80%, partially = 60-80%, not <60%		1-Partially met	
10	There must be a standardised handover procedure for medical, nursing and ANP staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation prescription	met / not met		1-Not met	
11	Patients undergoing specialist care must be repatriated to a healthcare organisation closer to their home when clinically appropriate to continue their rehabilitation, and this must occur within 48 hours of the decision to repatriate.	< 80% met, 75-85 partially met, < 75% or no data not met		1-Partially met	
RECOMMENDATIONS					
None					
3.2 Capacity Management					
STANDARDS					
1	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care patients must be prioritised, such that support is essential until admission and patients no longer requiring critical care are discharged within four hours.	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not data		1-Partially met	
2	The final decision on utilisation of critical care beds and staff (which includes moving staff to help in other areas of the hospital at times of need) rests jointly with the duty consultant and the duty nurse in charge of the critical care unit. Under no circumstances should clinical decisions be overridden by non-clinical operational management teams.	met / not met		2-Fully met	
3	Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans.	met / not met		2-Fully met	
4	Hospital boards must demonstrate regular oversight of the use of critical care escalation and the provision of intensive care outside of the critical care unit.	met / not met		2-Not met	
5	Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit.	met / not met		2-Fully met	consultant to consultant discussion
6	Escalation plans must differentiate between 'normal' operation and escalation during major incidents or pandemic scenarios.	met / not met		1-Partially met	
7	Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duty intensive care consultants and duty nurses in charge to coordinate the usage of intensive care beds across the network.	met / not met / not applicable		3-Not applicable to Unit	Mutual aid document
8	Regional pandemic escalation plans must include trigger levels for agreed critical care admission criteria and thresholds for restriction of planned activity to assist neighbouring critical care units	met / not met / not applicable		3-Not applicable to Unit	HB escalation plan
9	Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units to include escalation and, if required, prioritisation of transfers over local elective activity.	met / not met / not applicable		3-Not applicable to Unit	
10	Regional Intensive Care Networks must ensure that a system to record capacity across the network is in use, and that this is updated regularly.	met / not met / not applicable		3-Not applicable to Unit	
11	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	Met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions		2-Fully met	
RECOMMENDATIONS					
1	Critical care units should determine the emergency capacity they require to meet Standard 1 locally, based on their admission and occupancy data. The capacity to cope with the predicted emergency workload can then be managed by ensuring an appropriate number of beds available for emergency admissions before acceptance elective admissions.	met / not met		1-Partially met	
2	Acute hospitals will require at least one critical care bed per 30 acute hospital beds; hospitals undertaking a large amount of complex major surgical procedures are likely to need significantly more than this.	met = 1.35 or greater, partially 1.45-1.35		2-Fully met	medical patients only
3	Training should be provided to nursing staff in areas used for critical care escalation.	met = comprehensive documented training plan in place, partially = some training but not comprehensive		1-Partially met	
4	When using alternative areas of the hospital to provide critical care capacity, there should be adequate senior nursing and medical input such that the standards of care provided to those transferred to the patients within the critical care unit.	met = immediate access to ICU resident / registrar / nurse in charge for advice + twice daily consultant ward round		2-Fully met	Significant pressure on staffing
5	Decisions to proceed with major elective surgery should take into account current occupancy, provision of emergency capacity over the next 24 hours and, at times of national network escalation, the emergency capacity in neighbouring units.	met / not met		1-Partially met	
6	Critical care units may find it useful to develop a statistical model locally that provides predictable data on the number of emergency admissions they should plan to accommodate in each 24-hour period, and use this model to assist decision making on when it is safe to proceed with planned elective work.	Statement			
3.3 Critical Care Outreach and Rapid Response Systems					
STANDARDS					
1	There must be a hospital wide, standardised approach to the detection of the deteriorating patient and a clearly documented escalation process.	met / not met		2-Fully met	HB policy
2	All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical deterioration in all non-pregnant adult patients over 16 years. The National Early Warning Score (NEWS-2) is the recommended for call systems as the more efficient and effective. Using a common score ensures that staff operate the same language across the patient pathway and enhances the benefits of an early warning system. As part of a multi-trigger system, other triggers such as urine output/ acute kidney injury alerts, cause for concern and patient/care Call for Concern, should be considered as they will enhance the recognition of the deteriorating patient.	met / not met		2-Fully met	HB policy
RECOMMENDATIONS					
1	Each hospital should have a graded clinical response strategy consisting of three levels: low, medium and high. Each level of response should detail what is required from staff in terms of observational frequency, skills and competence, interventional therapies and senior clinical involvement. It should define the speed and urgency of response, including a clear escalation policy to ensure that an appropriate response always occurs and is available 24/7.	met / not met		2-Fully met	Health Board policy and Critical Care Outreach
2	Each organisation should ensure that all critical care teams receive care from appropriately trained critical care outreach, rapid response or equivalent teams. The critical care outreach (CCO)/Rapid Response staff should have annual competency-based assessment of core and additional specific competencies from a local or regional programme. This should relate to first line clinical assessment and intervention, be clearly outlined and closely reflect the Department of Health (DH) competencies for the recognition and response to the acutely ill patients in hospital.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency		2-Fully met	Health Board policy and Critical Care Outreach
3	There should be accessible educational support for registered and non-registered ward staff in caring for the acutely ill ward patient in line with recorder and first responder level as outlined in the DH competencies for the recognition and response to the acutely ill patients in hospital. Staff looking after Level 1 and enhanced care area patients should be trained following the National Competency Framework for Level 1 and Enhanced Care Areas.	met / not met			RESUS TEAM
4	Organisations should aim to deliver Comprehensive Critical Care Outreach as outlined by the seven core elements and have an operational policy that defines the remit of the CCO/Rapid Response or equivalent team within the organisation, in regard to these seven core elements.	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency		1-Partially met	Amber /Green status
5	All patients should be reviewed by the CCO team (or equivalent) following discharge from the critical care unit to the ward.	Met = < 85%, partially met 85-75%, unmet = 75% or no data		2-Fully met	
6a	All CCO teams should participate in the National Critical Care Outreach Activity Outcome Dataset.	met / not met		1-Partially met	Data recorded but not reported nationally at present as not a oversight probability
6b	Each organisation should develop audit tools to assess utilisation of their track and trigger and graded response system with clear governance procedures for action of poor compliance healthcare organisation-wide. This should be undertaken in combination with an audit of compliance against the standards within NICE CG502 and must be fed back to healthcare organisation Boards and Critical Care Networks where relevant.	met / not met		1-Partially met	RESUS /RRALS TEAM
7a	Each hospital should be able to provide a CCO/rapid response team, or equivalent, that is available 24 hours per day, seven days a week.	met / not met		2-Fully met	
7b	There should be regular review of service provision to facilitate proactive approaches in order to match service configuration against local demands and activity. These should be reflected in the operational policy. There should be a nominated lead of service at healthcare organisation Board level with appropriate communication cascade.	met / not met		1-Partially met	National standard used to assess service. OP in place. Leads in place
3.4 Infection Control					
STANDARDS					
1	Staff must follow safe insertion and maintenance procedures for intravascular and urinary catheters, and remove them when not required to minimise the risk of infection.	met = policy and training in place with daily care bundle checklist and audit data, partially = no formal daily checklist or no audit, not met = no policy		2-Fully met	
2	Infection control procedures must be documented and agreed by the multi-professional team.	met / unmet		2-Fully met	
3	The WHO Five Moments of Hand Hygiene must be observed. Hand contamination is often due to contact with the environment rather than directly with the patient.	Handwashing audit - Met = < 95%, partially met 95-85%, unmet = 85%		2-Fully met	
4	Cleaning of the environment must be undertaken by trained staff and subject to audit and quality control, with particular attention to high contact surfaces. Duties of cleaning and nursing staff, in cleaning specific surfaces, should be clearly defined.	met = policy in place with regular audit data and systematic reports, partially = policies in place but only ad hoc audits, not met = anything else		2-Fully met	credits for cleaning
5	There must be surveillance systems in place for audit and feedback of nosocomial infection, reporting to the national scheme where applicable, for example, reporting central venous catheter-related bloodstream infection to the Public Health England Infection in Critical Care Quality Improvement Programme (ICQIP).	met = supply data to ICQIP (or equivalent), partially met - locally monitored, not met - not regularly monitored		2-Fully met	
6	The principles of antibiotic stewardship must be adhered to in consultation with the microbiology team.	met = documented easy accessible micro-managing report or system or low level ward agent stewardship programme >85% compliance, partially = <85% (some units exempt from audits because of)		1-Partially met	
RECOMMENDATIONS					
1	Patients should be screened for carriage of MRSA and/or carbapenemase-producing organisms according to locally determined prioritisation. Sensitivity of risk factor algorithms is generally low and universal screening is preferable in highly endemic regions.	met = done > 95% of the time, partially met 85-95% of the time, unmet = <85% or no data or not done		2-Fully met	
2	Patients with MRSA carriage or infection should receive topical suppression to reduce shedding and, if possible, single-room isolation.	met / not met		2-Fully met	In accordance with hb policy
3	Patients with diarrhoea and airborne infections should take precedence over others in allocation of single-room isolation. Patients with suspected or confirmed influenza should be placed in single rooms appropriate for respiratory isolation.	met / not met		2-Fully met	
4	Design of new units should include infection control specialists as part of the planning team. In particular, the bed spacing, proportion of single rooms and provision of sinks should be considered according to patient case-mix, national guidelines and prevalence of multi-resistant infections.	met / not met / not applicable		3-Not applicable to Unit	
5	The intensive care team should have access to an infection control and prevention team led by a microbiologist who can offer timely review and advice. Ideally, this should be part of timetabled microbiology rounds during the week. The microbiologist will advise on the choice and duration of antimicrobial chemotherapy in accordance with local formulary as a part of antibiotic stewardship.	met / not met		2-Fully met	
6	Infection control nursing staff or intensive care nurses with infection control training should be available to provide day-to-day advice on prevention of spread of infection, isolation priority and procedures and decontamination. Allocation of patients to single-room isolation for proven or suspected infection should be reviewed on admission and throughout their stay.	met / not met		2-Fully met	not available at weekends
7	There should be a means of continuous improvement in infection prevention and control, for example using surveillance and feedback.	met = formal audit and review process in place / unmet		2-Fully met	
3.5 Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology.					
STANDARDS					
1	There must be daily input from microbiology.	Met = 7/7, partially, 5/7 plus on call, unmet if less		1-Not met	288
2	There must be local antimicrobial prescribing guidelines in accordance with the principles of antimicrobial stewardship.	met / not met		2-Fully met	hb policy
3	Clear protocols must be in place for management of massive haemorrhage including the role of laboratory services.	met / not met		2-Fully met	hb protocol
4	Acutely ill patients must have access to diagnostic radiology services at all times including timely access to a radiologist.	met / not met		2-Fully met	

5	All imaging investigations must be reported within an agreed timeframe relevant to the investigation by someone appropriately trained. All scans investigated must be reported in relation to the appropriate period of the investigation.	met / not met	2xFully met	
6	There must be seven-day availability of radiology services, appropriate to the specialties being cared for, to allow timely investigation of critically ill patients. This would include, for example, ultrasound and CT-scanning to aid sepsis diagnosis and source control, and in neurological care units, access to interventional radiology.	met = full service 7/7, partially = 7/7 service but some elements not always available (eg 7/7 reporting but interventional service only daytime), unmet = <7/7 service	1xPartially met	not always available
<b>RECOMMENDATIONS</b>				
1	Microbiology advice should be from an adequately senior clinician, and on-site, face-to-face interaction is encouraged	met / not met	2xFully met	
2	Critical or unexpected results of clinical pathology, microbiology or radiological investigations should be actively communicated to a responsible clinician according to local fail-safe policies.	policy in place = met, no policy = not met	2xFully met	1B policy
3	Urgent clinical chemistry and haematology advice should be available within 60 minutes from an appropriate specialist and a radiologist should be immediately contactable to support the management of acute patients at all times.	met / not met	2xFully met	
4	All point of care laboratory devices used to assist clinical decision making should be subject to appropriate quality assurance programmes, tested by laboratory and end users.	met = fully centralised lab standard QA process in place with audit evidence, partially = some QA processes with intermittent audit, unmet = no laboratory standard QA process	2xFully met	
5	Clear protocols for access to radiology services that are not available on site (e.g. interventional radiology, MRI in ventilated patients) should be available.	met / not met	2xNot met	
6	Liaison psychiatry services should be available in all acute hospitals with a single point of referral. Emergency mental health referrals should be seen within one hour of referral and urgent mental healthcare referrals within 24 hours of referral (within the liaison team's usual operating hours).	met = available and meets time criteria, partially = available but <1h <24h, not met = not available	2xNot met	
7	Patients who have self-harmed, irrespective of the apparent motivation, should have a comprehensive psychosocial assessment. This should generally be the responsibility of the liaison psychiatry service and should not be delayed until after medical treatment is complete unless life-saving treatment is necessary, or the patient is unconscious or otherwise incapable of being assessed.	met / not met	2xNot met	patients must be medically fit for crisis team assessment
8	Liaison professionals should be available to advise on issues around mental capacity and there should be working arrangements detailing who is responsible for assessing patients who may need to be detained under mental health legislation.	met / not met	2xFully met	
<b>3.6 Rehabilitation</b>				
<b>STANDARDS</b>				
1	The rehabilitation needs of all patients must be assessed within four days of admission to intensive care (or on discharge if sooner) and a rehabilitation plan outlined by all relevant therapy professions as clinically indicated.	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	1xPartially met	
2	Patients receiving rehabilitation must be offered therapy by the multi-professional team across a seven-day week and of a quantity and frequency appropriate to each therapy, in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly.	all rehab needs met 7 days a week = met, all rehab needs met 5 days per week = partially met, rehab needs not met consistently = unmet	1xPartially met	
3	All patients must be screened for delirium at least daily, and when changes or fluctuations in behaviour occur; in the event of a positive delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors completed.	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	2xFully met	
4	All patients with a tracheostomy must have communication and swallowing impairment assessed by a Speech and Language Therapist.	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	2xFully met	
5	Patients who stay in critical care for more than four days and are at risk of morbidity must have their ongoing rehabilitation needs addressed at post discharge follow-up, or in the community setting, at two to three months after discharge from critical care. At this point, additional referrals to any services needed can be made.	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	1xPartially met	
6	Adults at risk of poor quality recovery must have an individualised rehabilitation plan documented in their formal handover of care when transferred from critical care to a general ward. All members of the care team must be aware of this. Patient involvement in setting this rehabilitation plan should occur as soon as feasible and appropriate.	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	1xPartially met	
7	Adults who were in critical care and at risk of poor quality recovery must be given information to explain what they can do to help their recovery. This information should be provided, at the latest, before discharge from hospital.	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	2xFully met	
<b>RECOMMENDATIONS</b>				
1	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per week; provision should be made for other therapy services to be provided as needed at weekends.	met 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet	1xPartially met	
2	Specialist rehabilitation co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to ensure that assessments, referrals and documentation are completed and transferred to ongoing services and teams.	met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doesn't exist	2xNot met	
3	The role of therapy support workers or rehabilitation assistants should be considered as part of the rehabilitation team, these roles may be uni-professional or multi-professional in nature and recruited from nursing or allied health backgrounds. These may enable enhanced delivery and increased efficiency of rehabilitation service delivery, as well as ongoing rehabilitation to be delivered following discharge from critical care. Further work is required to determine the appropriate scope of these roles.	Statement		
4	Rehabilitation outcomes should be monitored and progression made using outcome measures appropriate for the stage of recovery, individual strategy, and dependent on local resources (includes personnel, equipment, and finance).	met = rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially = set up only, unmet = no progression monitoring	1xPartially met	
5	The rehabilitation plan that forms part of the handover of care on discharge from critical care should address all relevant domains for individual patients including, but not restricted to, physical, functional, communication, social, spiritual, nutritional and psychological.	met / not met	2xFully met	
6	To facilitate the rehabilitation component of the formal handover of care on discharge from critical care to a general ward, weekly multidisciplinary rehabilitation ward rounds should be led by a senior member of the critical care multi-professional team and result in an update to the rehabilitation goals. These should be set in consultation with the patient and/or carer where appropriate.	met / not met	2xFully met	
7	Expectations of both patients and families should be identified regularly and addressed in a consistent manner by the most appropriate senior member of the team; all patient and family communication should be centrally documented to ensure that it can be accessed easily by all team members.	met / not met	2xFully met	
8	For high-risk/complex patients, capturing the experience for the patient and family in a manner that they can reflect upon and engage with during the time spent in hospital should be considered. This may take the form of diaries, either paper or electronic, and may include photos, videos and written information. This material may be collected prospectively or retrospectively depending on the desire of patient and family.	met / not met	2xFully met	
<b>3.7 Intensive Care Follow Up</b>				
<b>STANDARDS</b>				
1	Patients with higher risk of morbidity related to critical illness must be given information about ongoing rehabilitation goals in the community.	met = all patients provided with rehab goals, partially = selected patients, unmet = none	1xPartially met	
2	Patients discharged from the critical care unit must have access to an intensive care follow-up programme, which can include review of clinical notes, patient questionnaires to assess recovery and an outpatient clinic appointment two to three months' post hospital discharge if required for specific patients.	met / not met	2xNot met	
<b>RECOMMENDATIONS</b>				
1	The follow-up programme should be formally and clearly communicated to the patient and their relatives on discharge from critical care, and again on discharge from hospital. Primary care should also be informed through the discharge summary.	met = all patients, partially = selected patients, unmet = none	2xNot met	
2	The follow-up programme should ensure the delivery of structured and supported self-directed rehabilitation to all patients at critical care discharge and at hospital discharge.	met = all patients, partially = selected patients, unmet = none	2xNot met	
3	A minimum 20-30 minute follow-up appointment should be offered two to three months after hospital discharge if appropriate. The follow-up team should include an intensive care consultant, intensive care nurse, clinical psychologist, physiotherapist, dietitian and occupational therapist according to the individual patient's needs.	met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none	2xNot met	
4	Selection of patients for follow up should be based on length of stay (more than three days) or at increased risk (e.g. following anaesthesia, or post-partum intensive care). Self-selection of patients should also be facilitated.	met / not met	2xNot met	
5	Follow up should involve actively seeking common physical sequelae, such as weakness, weight loss and sexual dysfunction, and the consequences of critical care unit-related procedures (e.g. tracheostomy).	met / not met	2xNot met	
6	Review of current medication should be performed and rationalised with input from pharmacy if required.	met / not met	2xNot met	
7	Psychological sequelae (such as anxiety, depression, nightmares and post-traumatic stress disorder) should be sought via screening tools e.g. Hospital Anxiety Depression Scale (HADS), and UK Post Traumatic Stress Syndrome score (UK PTSD-14). This could be facilitated by review of clinical notes with patients and family or patient diary, use of screening questionnaires and review by a clinical psychologist.	met = screening process in place for psychological seq for all patients, partially = for selected patients, unmet = no screening	2xNot met	
8	Following structured review, appropriate referrals to other services may be required and should be arranged where required.	met= referral from clinic / not met - referral via GP	2xNot met	
9	A bereavement follow-up service should be offered where explanations of diagnoses, treatments and support can be provided.	met / not met	2xNot met	
10	The establishment of a critical care patient and relatives support group should be encouraged.	met / not met	1xPartially met	Established pre covid but not sustained during
11	Patients and relatives should be surveyed regularly and this information should be utilised to assess rehabilitation and follow-up services.	see other standards	2xNot met	
<b>3.8 The Patient and Relative Perspective</b>				
<b>STANDARDS</b>				
1	All patients must be regularly assessed for the presence of pain which should be managed with a protocolised multimodal analgesic regimen.	met - all elements done, relatives provided with written info, Partially met - some elements done or not all families, not met = not done	2xFully met	
2	The effects of delirium must be explained to patients and their families and this should be emphasised in follow-up visits post critical care. Written information about delirium must be provided.	met = Unit has guideline/protocol for delirium prevention/management that includes these measures and is included in induction training for staff / not met	2xFully met	
3	When patients are sedated or unconscious or have delirium and require any intervention or nursing care, staff must explain to them in simple terms what they are doing.	met = guideline in place and done, partially met - some elements but not comprehensive or systematically applied, not met - not done	2xFully met	
4	Critical care staff must offer patients ways to help improve the quality of their sleep, for example eye masks and ear plugs. Staff must try to minimise light and noise during the night.	met = written and >75% families having a formal documented communication, partially 50-75%, unmet = no written info and/or <50% having formal communication	2xNot met	
5	Patients and families must be given high quality verbal and written information while the patient is in critical care (such as information about the patient's treatment, what the patient might experience and how they might feel) and when they leave the unit (to help explain what has happened to the patient and what might help them in their recovery). Each unit must have such documents readily available and needs for patients and relatives. Visual aids and other aids must meet specific needs.	met = SLT involved and have full range of communication aids available / partially met = limited access to speech and language / not met	2xFully met	
6	Patients must be given help to communicate (e.g. speaking valves (for patients with a tracheostomy, wipe boards or flash cards).	met / not met	2xFully met	
7	Critical care units must have policies about how to safeguard vulnerable adult patients.	met / not met	2xFully met	
8	Units must obtain regular feedback about the care that patients and relatives received during their critical care admission in order to learn from and act on the feedback received.	met / not met	2xFully met	
<b>RECOMMENDATIONS</b>				
1	Intensive care patients should have a patient diary.	met = >90% patients >48h stay, partial = only longer stay or <90%, unmet no diary	2xFully met	
2	Understanding the individual who has become critically ill is important to help their treatment and recovery. A 'This is Mr' board or document for each patient is very beneficial and should be used if possible.	met / not met	2xFully met	
3	Intensive care and ward staff should have training in what intensive care is like for patients and relatives and what challenges patients face while in intensive care and during their rehabilitation. Asking former patients and relatives to help with this training is beneficial.	met / not met	2xNot met	
4	Intensive care staff should let relatives know how they can help the patient, for example by talking to or reading to the patient (even if the patient is unconscious or sedated), as a familiar voice can be reassuring. Relatives should also be allowed to help with simple aspects of caring for the patients, if they would like to, such as applying hand cream or brushing hair. Written information should be provided for relatives.	met / not met	2xFully met	
5	Intensive care staff should spend time talking to the patient and relatives, seeing how they feel, asking about any worries they have and checking their understanding of any information that has been given. Clear information should be given to relatives regarding when they can visit.	met - relatives room, partially met, relatives room but poor facilities, not met - no dedicated relatives room	2xFully met	
6	A room should be provided for relatives to wait in or have time away from the unit. This room should be comfortable and its facilities regularly reviewed. Feedback should be sought from families whether additional facilities and support are required.	met / unmet	2xNot met	
7	On discharge from the critical care unit, patients should be given the contact details of the healthcare professionals who are co-ordinating the patient's rehabilitation pathway.	met / not met	2xFully met	
8	All patients should be visited by a critical care outreach team, who can help with the transition from Critical Care to ward this transition.	met / not met	2xFully met	
9	Intensive care patients should have access to formal support provided by the critical care service after they leave, ie critical care follow-up/outreach services	met / not met	2xFully met	
10	Critical care units should provide relatives of patients who died in intensive care the opportunity of a follow-up meeting with an ICU staff member to discuss any questions they may have about their relative's time on the unit. Families may be given a leaflet after their relative dies in order that they can arrange a meeting at a later date if they wish to. It can also include other sources of support. Some units hold memorial services for relatives.	met / not met	2xNot met	Work underway to develop bereavement pathway supported by clinical psych
<b>3.9 Staff Support</b>				
<b>STANDARDS</b>				
1	All units must have policies in place to support staff engagement and retention.	met / not met	2xFully met	
2	Induction and escalation policies must be clearly identified for all staff groups.	met / not met	2xFully met	
3	100% of new staff must receive a job-specific induction to the unit.	met / not met	2xFully met	
4	Workplace equity within staff groups must be transparent (e.g. rostering, annual leave policies, job plans). Staff must be aware of the policies.	met / not met	2xFully met	
5	Staff well-being is an organisational priority. Units must monitor and regularly review metrics of staff well-being as quality indicators (e.g. sickness rates).	met = quarterly, partially met 1-2 yrs, unmet = not monitored or more than 2 yearly intervals	2xFully met	

6	All staff must have opportunities for personal development reviews including annual appraisals.	met - > 85% of staff appraised / PDP done, Partially met 75-85%, not met < 75% of staff	2=Fully met	
7	All staff working in critical care must be able to access the Freedom to Speak Up Guardian.	met / not met	2=Not met	Not specifically with this title but regular meetings to encourage feedback
8	Staff must be provided with adequate resources consistent with other GPICS standards to deliver their job role, e.g. adequate staffing ratios, access to facilities for nutrition and hydration, adequate equipment.	Statement		
9	Staff rosters must comply with Health and Safety Executive recommendations for sleep and rest.	met / not met	2=Fully met	
10	Units must provide adequate workplace facilities for staff breaks, which are separated from areas for relatives.	met / not met	2=Fully met	Space available Could be larger
<b>RECOMMENDATIONS</b>				
1	All staff engaged in a managerial or leadership role should have access to appropriate mentoring and/or coaching services to support them in their role.	met / not met	2=Not met	
2	All units should promote healthy rest and sleep policies for staff required to work overnight.	met / not met	2=Fully met	
3	All staff members should have access to an independent, professional psychological support service, which provides counselling services.	met / not met	2=Fully met	
4	All staff members should have self-referral access to an occupational health service and rapid access physiotherapy services.	met / not met	2=Fully met	
5	All units should provide frequent opportunities for shared learning, clinical communication, and reflection, to reduce professional isolation. This includes routine clinical practice (e.g. multidisciplinary rounds, mortality and morbidity meetings), as well as specific reflective events (e.g. Schwartz's Patient Briefcase, debriefing following medical emergencies).	met / not met	1=Partially met	Reinforce processes already set up
6	All staff should have ergonomic clinical work areas with appropriate access to light and control of noise.	met / not met	2=Fully met	
7	All staff should be supported to maintain a healthy lifestyle, e.g. provision of advice on diet and exercise.	met / not met	2=Fully met	
8	All units should conduct regular (at least annual) reviews of organisational policy on staff health and well-being.	met / not met	2=Fully met	HR wide policy
<b>3.10 Inter and Intra and Hospital Transfer of Critically Ill Patients</b>				
<b>STANDARDS</b>				
1	Transfer to other critical care units for non-clinical reasons must be avoided where possible.		2=Not met	
2	Appropriate equipment must be available to undertake a safe transfer and to manage complications/adverse events which may occur during a transfer. All equipment used for patient transfers must conform to the relevant safety standards, be regularly serviced, and checked immediately before use.	met / not met	2=Fully met	
3	All staff involved in a patient transfer must be trained, competent and familiar with the use of equipment.	met / not met	1=Partially met	Not all staff have undergone transfer training
4	Where patient transfers result in a change of team managing the patient during or following a transfer, an appropriate and documented handover must be undertaken between the teams to ensure good continuity of care. This should include providing copies of the clinical record.	met / not met	2=Fully met	
5	A named intensive care consultant must take overall responsibility for the decision to transfer a patient and the level of support required, but does not necessarily have to undertake the transfer.	met / not met	2=Fully met	
6	Inter-hospital transfers must be undertaken in a timely fashion according to the patient's clinical condition.	met / not met	2=Fully met	
7	For inter-hospital transfers, there must always be a named consultant who will take responsibility for the patient on arrival at the receiving hospital. This must be agreed prior to the transfer being undertaken.	met / not met	2=Fully met	
8	Where patients have completed specialist care and ongoing intensive care needs can be provided in the patient's home, hospital transfer must take place within 48 hours of referral to the receiving hospital.	Percentage occurring within 48 hours of decision. Met > 85%, partially met 75-85%, not met < 75% of the time or no data collected.	1=Partially met	
<b>RECOMMENDATIONS</b>				
1	Transfers should follow the advice and protocols presented in the latest ICS transfer guidance.	met - meet standard, partially met, don't meet standard but risk assessment in place, / not met, don't meet standard and no risk assessment	2=Fully met	
2	The reason for any transfer should be documented in the patient's notes. This should include an assessment of potential benefits against risks. Transfer decisions should only be made by consultant intensive care team members, and this information should also be documented.	met = documented 95%, partially met 80-95%, unmet <80% or no data or not a consultant decision	2=Fully met	
3	An adequately stocked and regularly checked, dedicated transfer bag should be available for use during all patient transfers. This bag should contain appropriate drugs and equipment for interventions that might be required in transit. The transfer bag contents should be checked routinely (ideally daily) and a log of checks maintained, or, if sealed with a tag, then a daily check that the seal is unbroken. The transfer bag must be restocked between uses to avoid delays when it is needed. Staff carrying out patient transfers should be familiar with bag layout and contents.	met = checked with log and tagged, partially = daily check but not tagged or logged, unmet = no checking or significant deficiencies in kit available	2=Fully met	
4	The patient's vital signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy any physiological deterioration during the transfer.	met = audit evidence of obs or transfer forms, unmet = no evidence	2=Fully met	Supported by operating theatre
5	Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be scrutinised within a robust audit system, allowing eventual or substandard transfers to be investigated and lessons learnt to be shared widely, as well as numbers and reasons for transfers.	met = use of a network wide agreed form or electronic recording system, unmet = no standard system	2=Fully met	
6	Where an adverse event occurs during a transfer, this should be reported and investigated using the healthcare organisation incident reporting system at the transferring unit. All learning should be widely shared.	met / not met	2=Fully met	
7	Every acute healthcare organisation should have a designated consultant and nurse who are responsible for maintaining standards of transfer of critical care patients, guideline production, training, governance, audit and reporting.	met = both, partially met - one, not met - none	2=Not met	
8	Training in transfer medicine should be an integral part of Intensive Care Medicine training for doctors and nurses.	Statement		
9	Where multiple teams are involved in a patient's care, appropriate handover should be undertaken between the teams prior to transfer. This should not delay the transfer.	met / not met	2=Fully met	
10	The patient, where possible, and their next-of-kin should be informed of the decision to transfer and an explanation given to them of the need for transfer. This discussion should be documented.	met = 95%, partially = 80-95%, unmet <80% documented	2=Fully met	
11	There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area. The definition of 'delay' will vary according to the reason for the transfer. For patients being transferred from a specialist critical care unit to a general critical care unit at the completion of specialist care, a delayed transfer is one that has not been undertaken 48 hours after the time of referral to the general critical care unit.	met / not met	2=Fully met	
12	Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who are at a high risk of harbouring such infections both during transfer and in the receiving hospital; their availability should be such that this does not delay a patient transfer. Similarly, isolation facilities must be available for immunocompromised patients who require them.	met / not	1=Partially met	
13	Critical care units should have an agreement with their local ambulance providers in relation to the contracted transport provision for intensive care services, and to ensure these standards are met throughout the entire patient pathway.	met / not met	2=Fully met	
14	There should be a system for monitoring the quality of initial inter-hospital transfer and post-arrival arrangements which includes capture of numbers, indication for transfer, incidents, delayed transfers and outcomes. Audit measures and learning should be widely shared.	met = well established processes, data available, partially met - reviewed, limited data available, not met - rarely undertaken or not at all	2=Fully met	
15	There should be standardised network wide transfer documentation and training programmes.	met = both / partially met = one or the other / not met = neither		
16	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and prevent the adverse impact of transfers on the transferring unit due to loss of key staff.	Statement		
<b>3.11 Care at the End of Life</b>				
<b>STANDARDS</b>				
1	Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and communicated to patients and their families. The latest national reference is patients last capacity (deed).	met = 98% with clear documentation, partially = 95-98% documented but gaps found in documentation on audit, unmet = <95% or major failings in what is documented	2=Fully met	
2	Decision making surrounding end of life care (ELC) must be performed in accordance with relevant statutory requirements and professional guidance: a) Mental Capacity Act 2005 (MCA 2005), England and Wales; b) Adults with Incapacity Act (2000), Scotland; c) Mental Capacity Act (Northern Ireland) 2016; d) Human Tissue Act, England; e) General Medical Council's Good Medical Practice, specifically Treatment and Care Towards the End of Life; Good Practice in Decision Making.	met / not met	2=Fully met	
3	Declaration of death by cardiorespiratory or neurological criteria must be done in accordance with professional guidance.	met / not met	2=Fully met	
4	Consideration must be made as to whether organ and tissue donation can be offered to every dying patient, and where appropriate the specialist nurse organ donor (SNOD) should be contacted.	met = considered with audit data on referral rates reviewed quarterly, partially = considered but no audit data or <10% referral rate, unmet = not done		
5	In order to identify dying patients and respond to changes in their condition, those at high risk of dying must have their condition regularly reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.	Statement		
<b>RECOMMENDATIONS</b>				
1	Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying. Best practice dictates that those close to the patient should also be informed.	met / not met	2=Fully met	
2	Decision making related to care at the end of life should, wherever possible, involve patients and people close to them, as well as medical professionals. If the patient lacks capacity and there is no individual with Lasting Power of Attorney, responsibility for determining treatment rests with treating clinicians. Previous decisions should also be taken into account e.g. treatment escalation plans (TEP), Do Not Attempt Resuscitation (DNAR), Care Plan for Emergency Care and Treatment.	met / not met	2=Fully met	
3	At least two consultants, supported by senior ICU nursing agreement, should contribute to the process of recommending withdrawal or withholding treatments. Such provisions are decided on an on-by-case basis and clarity of communication can be improved by outlining clearly burdens and benefits of acts or omissions.	met = 7 days per week, partially met 5 days per week,	2=Not met	Only 1 ICU Consultant
4	Once patients are recognised as being in their final day/hours of life, therapeutic goals should be reviewed and accordingly altered to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn. The discussion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is intrinsic to palliative care in critically ill patients. This should be discussed with patients and families within that context. If initiated in emergency situations for incapacitated patients, DNACPR decisions should be discussed with patients' surrogates (as defined by the MCA or equivalent) at the earliest opportunity. The British Medical Association, Resuscitation Council UK and Royal College of Physicians all recommend audit of DNACPR.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	2=Fully met	
5	Dying patients should be managed by multi-professional teams that include senior medical and nursing staff from intensive care and referral teams. It may also include specialist palliative care teams.	met / not met	2=Fully met	
6	Therapeutic plans should be made and anticipatory medications prescribed for all patients in their final hours/days of life, enabling prompt symptom control. This includes therapeutic options for analgesia, dyspnoea, anxiety and agitation. Doses should be titrated for symptom relief based on explicit assessments. Where appropriate, the double effect of drugs used should be transparent to patients, staff and family.	met = systematic documentation used 95%, partially 90-95% or no systematic documentation, unmet no evidence	2=Fully met	
7	Care should address dying patients' need for spiritual and emotional support, and include that of their families and others close to them. The needs of loved ones to be with, care for and otherwise attend to dying patients should be met as far as is possible. If appropriate, religious or secular expertise should be sought (e.g. referral to chaplaincy, psychological services or patients' GPs). Staff should also have access to bereavement support services.	met / not met	2=Fully met	
8	If death is considered to be very close, patients should not normally be transferred out of the critical care unit unless it is to facilitate (via discussion with patients and loved ones) significant improvements in care. If practical to do so, patients should be given the opportunity to die at home or in a hospice. All transfers should include a handover of care and details of care.	met / not met	2=Fully met	
9	Intensive care clinicians often have a responsibility for decision making and care of acutely unwell and deteriorating patients outside of the critical care unit. When reviewing such patients for potential treatment escalation, they should work with patients' clinical teams to ensure that decisions and communication regarding care at the end of life are made to the same standards as on the critical care unit.	met / not met	2=Fully met	
<b>3.12 Organ Donation</b>				
<b>STANDARDS</b>				
1	If a patient is close to death, doctors must explore with those close to them whether they had expressed any views about organ or tissue donation. Doctors must follow any national procedures for identifying potential organ donors and, in appropriate cases, for notifying the Specialist Nurse-Organ Donor (SNOD).	met = routinely done with collaborative requesting when possible, partially met = routinely done but not with collaborative requesting, unmet = poor results on referral rates	2=Fully met	
2	The National Institute for Health and Clinical Excellence guidance requires that the intensive care team caring for the patient should initiate discussions about potential organ donation with the SNOD whenever a patient meets the criteria for undertaking the tests, to confirm death using neurological criteria or when there is an intention to withdraw life-sustaining treatment in patients with a life-limiting condition which will not be expected to result in a further death.	met >85% of the time, partially met 75-85% of the time, unmet < 75% of the time or no data collected.	2=Fully met	
3	Intensive care units must comply with the criteria for diagnosing death using neurological or circulatory criteria as set by the Academy of Medical Royal Colleges.	met / not met	2=Fully met	
4	All units must contribute data to the national potential donor audit.	met / not met	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	Each acute hospital should have an Organ Donation Committee to oversee all aspects of deceased organ donation as recommended by the Department of Health's Organ Donor Taskforce. Funding for the committee's activities is provided by NHS Blood and Transplant (NHSBT).	met / not met	2=Fully met	HB Committee
2	Each acute hospital should have a clinical lead for organ donation (CLOD) funded by NHSBT, with responsibility to implement organ donation policies, promote the addition of best practice guidelines and to address any local barriers to donation.	met / not met	2=Fully met	HB Lead
3	Each critical care unit should have an embedded or assigned SNOD employed by NHSBT to provide advice on all issues relating to donation, organise donor coordination, support the intensive care staff in donor management, complete the potential donor audit, engage in teaching and training and support donor families.	met / not met	2=Fully met	SSNOD x 2 based across four hospitals
4	Guidelines on end of life care and withdrawal of life-sustaining treatments (WLST) should be compliant with the Mental Capacity Act 2005, and based on the guidance provided by the General Medical Council, and should be followed irrespective of any potential for organ donation. Determining best interests at the end of life should include an assessment of a patient's preferences and wishes regarding organ donation. Guidance on decisions regarding WLST in patients with devastating brain injury (DBI) should be based on the recommendations of EBMAT2 and other professional bodies.	met / not met	2=Fully met	
5	A planned and collaborative approach to the family for organ donation between the intensive care team and the SNOD team should be routine practice as recommended by NICE in 2016.	met / not met	2=Fully met	
6	Consultants in Intensive Care Medicine should actively manage brain stem dead consented donors to optimise organ quality and increase the number of organs successfully retrieved and transplanted. Donor optimisation care bundles or protocols should be available and used.	met / not met	2=Fully met	

7	The intensive care team should manage resources flexibly to facilitate organ donation and/or end of life care for patients outside the critical care unit, whenever appropriate.	met / not met	2=Fully met	
3.13 Legal Aspects of Capacity and Decision Making				
STANDARDS				
1	Units must have regular, minuted, multidisciplinary team meetings to review cases where dispute have or may have arisen.	met / not met	1=Partially met	
2	All patients must be presumed to have capacity to consent or withhold consent.	Statement		
3	If the patient has made a valid and applicable Advance Decision Refusing Treatment (ADRT), it must be respected (although an ADRT does not have formal legal standing in Scotland, they are likely to be highly persuasive to the court).	Statement		
4	Final determination of capacity for a specific treatment must be made by the treating clinician and documented.	Statement		
5	If a patient has capacity, their decision must be respected, even if the treating clinician considers the decision to be unwise.	Statement		
6	Patients who lack capacity must only be treated in their best interests (England & Wales) or if it is of benefit to the patient (Scotland, family and friends).	Statement		
7	Determination of best interests/benefit must involve consultation between the treating consultant and individuals close to the patient.	Statement		
8	The aim is to achieve consensus between team and family/friends as to what is in the best interests/benefit to the patient. When there is continued disagreement about best interests/benefit, the treating clinician must not act unilaterally.	Statement		
9	If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application must be made.	Statement		
RECOMMENDATIONS				
1	A written departmental protocol for resolution of disagreements should be in place. Disagreements may be within the team, between different clinical teams or between team and family/friends.	met / not met	1=Partially met	Hospital concerns policy (from family)
2	An ADRT that does not meet the criteria to be formally legally binding should nevertheless be taken into account as part of the best interests assessment as a strong indication of the patient's wishes and opinions.	Statement		
3	In situations of intractable disagreement, mediation should be considered prior to approaching the Court of Protection (England & Wales)/Court of Session (Scotland). NHS Resolution or the Civil Mediation Council provide access to individual mediators or recognised groups.	Statement		
4	Independent Mental Capacity Advocates (IMCA) should be consulted (in England and Wales) when a patient is 'unbefriended'. This only applies when there is no one who can be consulted about best interests, i.e. no family or friends. IMCAs should not be consulted because there is dispute about best interests between the medical team and family.	Statement		

Section 4		CRITICAL CARE SERVICES: CLINICAL CARE		Level description	Level	Comments
4.1 Respiratory Support						
STANDARDS						
1	Units must have access to sufficient modern invasive and non-invasive ventilators which will support pressure/volume controlled ventilation, titration of inspired oxygen concentration, support spontaneous ventilation and allow application of PEEP.	met / not met		2=Fully met		
2	Pulse oximetry, capnography, ECG, blood pressure monitoring and ventilator alarms must be used for all ventilated patients whose trachea is intubated.	met / not met		2=Fully met		
3	An accurate height must be measured on admission for every patient requiring invasive mechanical ventilation to calculate predicted body weight (PBW) and corresponding target tidal volume to allow protective ventilation (8ml/kg PBW in those with ARDS or at risk of ARDS).	met / not met		2=Fully met		
4	Units must have evidence-based, written guidelines covering the use of non-invasive ventilation, the management of ARDS, prevention of ventilator-associated pneumonia and weaning from ventilation (including the use of sedation).	met - guidelines for all and review date within last 3 years , partially met - one or more guidelines missing or not reviewed within the last 3 years. not met - limited guidelines and / or older than 3 years		2=Fully met		
5	Referral pathways for patients with severe but potentially reversible acute hypoxaemic respiratory failure must be in place with Regional Extra-corporeal Membrane Oxygenation-capable (ECMO) Centres.	met / not met		2=Fully met		
6	Units must have written guidelines on the indication, risks and practice of prone positioning in hypoxaemic respiratory failure.	met / not met		2=Fully met		
7	Units must have immediate access to point-of-care testing to enable arterial blood gas analysis.	met - all recorded daily , partially met - one / two not recorded daily, not met - more than two not recorded		2=Fully met		
8	Standard operating procedures, including checklists, should be developed for intubation, extubation, bronchoscopy, prone positioning, tracheostomy and any high risk/invasive procedures.	met - guidelines for all and review date within last 3 years , partially met - one or more guidelines missing or not reviewed within the last 3 years. not met - limited guidelines and / or older than 3 years		1=Partially met		
9	Non-invasive ventilation must be considered and available for patients with acute hypercapnic respiratory failure.	met / not met		2=Fully met		
10	High flow nasal oxygen must be available for the management of patients with acute hypoxaemic respiratory failure.	met / not met		2=Fully met		
RECOMMENDATIONS						
1	Tidal volume (ml/kg PBW), plateau airway pressures and cumulative fluid balance should be monitored and recorded daily in all patients requiring invasive ventilation.	met - all recorded daily , partially met - one / two not recorded daily, not met - more than two not recorded		2=Fully met		
2	Audit of compliance with ARDS, ventilator associated pneumonia and weaning guidelines should be undertaken quarterly.	met / not met		0=Not met		
3	Units should have standardised systems to monitor VAP rates and antibiotic resistance patterns.	met / not met		1=Partially met		
4	There is insufficient evidence at present to inform clinicians about the role of Extracorporeal Carbon Dioxide Removal (ECCO2R) in acute hypoxaemic respiratory failure and ARDS. Patients should only receive ECCO2R within the governance framework set out in NICE Guidance.	met / not met		0=Not met		
4.2 Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services						
STANDARDS						
1	Level 3 units must have access to a regional home ventilation and weaning unit. Arrangements must be in place to collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex weaning problems to the Regional Centre.	met / not met		1=Partially met		
2	Units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.	met / not met		1=Partially met		
RECOMMENDATIONS						
1	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or neurological co-morbidities. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure.	met / not met		2=Fully met		
2	Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietitian members.	met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved		1=Partially met		
3	These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols.	met protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols in place/not reviewed in last 2 years		1=Partially met		
4	Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and resources to provide these services as described in the section of this document on rehabilitation (Chapter 3.6).	met / not met		2=Fully met		
5	The use of non-invasive ventilation (NIV) as a bridge to spontaneous breathing should be considered in selective groups. Resources and skill in NIV should be available in all units managing patients with prolonged ventilatory needs.	met / not met		2=Fully met		
6	Early discussion with regional domiciliary ventilation services should occur in any patient with chronic neuromuscular impairment, and in those requiring more than 21 days of ventilation. Regional weaning centres should offer advice to referring units to assist with weaning.	met / not met / NA if no regional weaning service		0=Not met		
7	The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation centres and protocols should be in place to aid these decisions.	met / not met / NA if no regional weaning service		0=Not met		
4.3 Renal Support						
STANDARDS						
1	Critical care units must have the necessary facilities and expertise to provide acute RRT for patients with AKI on a 24/7 basis.	met / not met		2=Fully met		
2	Patients receiving acute RRT, where the cause of AKI is unclear or where RRT will be needed on intensive care discharge, must be discussed with the local renal team as per the NICE guideline.	met / not met		2=Fully met		
3	Patients receiving acute RRT must be cared for by a multi-professional team that is trained and experienced in delivering and monitoring RRT.	met / not met		2=Fully met		
4	Acute RRT for patients with progressive or severe AKI must be started before the onset of life-threatening complications associated with renal dysfunction.	met / not met		2=Fully met		
RECOMMENDATIONS						
1	The decision to initiate RRT should be based on the condition and prognosis of the patient as a whole, and not on isolated urea or creatinine values as per Kidney Diseases Improving Global Outcomes (KDIGO) recommendations and the NICE guideline.	met / not met		2=Fully met		
2	Where life-threatening complications of AKI occur, such as intractable hyperkalaemia, RRT should be started emergently unless a decision has been made not to initiate dialysis.	met / not met		2=Fully met		
3	Patients with end-stage renal failure who are not in a renal unit/dialysis centre and require urgent RRT may require critical care admission. In such cases, there should be close liaison with the regional renal service regarding transfer and vascular access.	met / not met		2=Fully met		
4	Continuous and intermittent RRT should be considered as complementary therapies for AKI. The choice of therapy should be based on patient status, expertise of the clinical staff and availability of machines.	met / not met		2=Fully met		
5	The dose of RRT should be prescribed at the beginning of the RRT session. It should be reviewed daily and tailored to the needs of the patient.	met = clear standardised RRT prescription with evidence of daily review and audit, partial = done but not clearly evidenced, no audit, unmet = no standardised RRT prescription		2=Fully met		
6	The decision to use anticoagulation to maintain circuit patency and the choice of anticoagulant should be based on the potential risks and benefits in an individual patient, the expertise of the clinical team and the options available. KDIGO guidelines suggest using regional citrate anticoagulation for CRRT rather than heparin in patients who do not have contraindications for citrate.	citrate anticoagulation should be available Met/umet		2=Fully met		
7	Bicarbonate, rather than lactate should be used as a buffer in dialysate and replacement fluid for acute RRT.	met / Partially met = daily prescription chart but compliance not audited / not met				
8	Drug dosing may need adjusting whenever RRT is started or the RRT prescription is altered. Close collaboration with an intensive care pharmacist with suitable experience in AKI and the effects of RRT is essential.	met / not met		2=Fully met		
9	Patients treated with acute RRT should receive standard enteral nutrition as long as there are no significant electrolyte abnormalities or fluid overload refractory to RRT.	met / not met		2=Fully met		
10	When discharged from critical care, the accepting team and GP should be informed that the patient had received RRT for AKI while in intensive care so that appropriate follow-up arrangements can be made.	met / not met		2=Fully met		
4.4 Gastrointestinal Support and Nutrition						
STANDARDS						
1	The type and position of nasogastric feeding tubes (NGTs) used for enteral feeding, hydration and/or drug administration, must comply with NHS Improvement guidelines.	met / not met		2=Fully met		
2	Intensive care services must have a nutrition support guideline with institutional strategies to promote nutrition delivery and to overcome EN intolerance. It is suggested that it should include: a) Measures to minimise the risk of EN aspiration, b) Criteria for the use of prokinetic medications, c) Criteria for naso-jejunal feeding, d) Criteria for use of parenteral nutrition, e) Consistent times for stopping and restarting EN around anaesthetic, surgical or bedside procedures and f) A protocol for initiation of nutrition without waiting for a specialist plan.	met = clear guideline in place meeting these criteria, partial = guideline in place with some omissions or >3y since review, unmet = no guideline or fails many of these criteria		2=Fully met		
3	Intensive care services must have guidance in place relating to the identification of, and nutrition support for, those at risk of re-feeding syndrome.	met = clear guideline in place meeting these criteria and audit evidence, partial = guideline in place with some omissions or >3y since review or no audit evidence, unmet = no guideline or fails many of these		1=Partially met		Guidance needs updating
4	Intensive care services must ensure that there is access to a range of parenteral nutrition bags which include vitamins, trace elements and minerals. A 'standard' bag of parenteral nutrition must be available within 24 hours.	met = all elements listed, partial = TPN available but limited range, unmet = not available or a single standard bag only available		2=Fully met		
5	Intensive care services must have access to a range of enteral nutrition products to include: a) Low electrolyte, b) High protein, c) Fluid restricted and d) Tolerance (semi-elemental).	met / not met		2=Fully met		
RECOMMENDATIONS						
1	Nutritional status and risk should be assessed on admission, and energy, protein and micronutrient needs determined by a critical care dietitian or clinician with appropriate specialist training or experience.	met / not met		2=Fully met		
2	It is recommended that nutrition support (PN if EN is not possible) should be instigated within 48 hours in patients expected not to be on a full oral diet within three days.	met / not met		2=Fully met		
3	Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them.	met / not met		2=Fully met		
4	Efforts need not be made to cover full energy targets with EN or PN until clinical stability has been achieved. Delivering a calorie load which exceeds energy expenditure appears harmful and should be avoided, whereas hypocaloric nutrition may be safe initially.	met / not met		2=Fully met		
5	The energy content from certain drugs (e.g. Propofol, IV glucose and citrate anti-coagulation renal replacement therapy) should be accounted for to avoid overfeeding.	met / not met		2=Fully met		
6	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines.	met / not met		2=Fully met		
7	Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly infusion rate of EN to optimise delivery after interruptions.	met / not met		0=Not met		
8	There should be access to nasal bridges to secure NGTs in agitated patients and guidelines for their use and aftercare.	met / not met		0=Not met		No bridges across the HB
9	Nutrition support targets should be included in the rehabilitation of critically ill patients.	met / not met		2=Fully met		
10	There should be bowel management guidelines which include: a) Regular monitoring and documentation of bowel habits (frequency & type), b) Minimising the use of drugs that can cause constipation or diarrhoea, c) The need for rectal examinations and treating faecal loading/impaction, d) When to use laxatives, enemas and suppositories, e) Management of ileus.	met = bowel management guideline and audited, partially met = protocol but not audited, unmet = no guideline		0=Not met		No guidelines in place for this
4.5 Liver Support						
STANDARDS						
1	Contact with regional liver and/or liver transplant centre must be made early following admission to a critical care unit of a patient with ACUTE liver failure. Advice about management, prognosis and possible transfer can be discussed.	Statement				
2	Patients with ALF must be managed in a liver transplant centre if liver transplantation is clinically indicated.	Statement				
RECOMMENDATIONS						
1	Patients with liver failure plus any other organ dysfunction should be managed in a critical care environment. Attention should be made to cardiovascular support, rapid correction of actual or relative hypothermia, early renal and metabolic support.	met / not met		2=Fully met		
2	Sepsis is very common in patients with liver failure and intravenous antibiotics should be prescribed in any patient with a suggestion of sepsis on admission to critical care. The choice of antibiotic will be driven by knowledge of local microbiological flora and resistance patterns.	met / not met		2=Fully met		
3	The use of prophylactic blood products and other procoagulants products prior to interventions should be avoided. In general, patients with liver failure develop a balanced coagulation disorder. Both pro- and anti-coagulant protein production is reduced. Viscoelastic tests, such as thromboelastography or ROTEM, may help in management.	met: thromboelastography available, partially: principles followed but no TE available, unmet		1=Partially met		
4	Patients with ALF should have access to plasma exchange therapies.	met / not met / not applicable		0=Not met		
5	Patients with ALF should have access to therapeutic plasma exchange (TPE) or solvent detergent plasma exchange (SDPE) if intracranial hypertension being a recognised complication in patients with ALF. Strategies to monitor and manage ICH should	met / not met / not applicable		0=Not met		

6	Advice should be sought from a specialist hepatologist for help with diagnosis, specific therapies and prognosis.	met / not met	2=Fully met	
7	Centres managing liver failure and liver trauma should have access to interventional radiologists.	met / not met / not applicable	3=Not applicable to Unit	
8	Links should be made with regional centre providing transjugular intrahepatic portosystemic shunt (TIPS) for patients with bleeding varices.	met / not met	2=Fully met	
9	Units that manage patients with liver failure should have 24-hour access to both diagnostic and therapeutic upper GI endoscopy services.	met = both, unmet if not available or no intervention available	2=Fully met	
10	Drug dosing may need adjusting in patients with liver failure. Close collaboration with an intensive care pharmacist with suitable experience in liver failure is essential.	met / not met	2=Fully met	
<b>4.6 Cardiovascular Support</b>				
<b>STANDARDS</b>				
1	Electrocardiography, chest X-Ray and transthoracic echocardiography (includes focused echo) although expertise may not be a unit and could be provided by other specialty such as cardiology, must be available at all times at the patient's bedside.	met = all available, partial = echo availability in hospital 24/7 but not always on unit, unmet = no echo available	1=Partially met	
2	A consultant cardiologist must be available at all times either locally or through a formal network.	met / not met	1=Partially met	
3	Adults with acute heart failure must be reviewed within 24 hours of admission by a dedicated specialist heart failure team (or equivalent), and their management should follow the guidelines detailed in the NICE Quality Standards.	met / not met	1=Not met	
4	Protocols for immediate transfer to a facility able to provide percutaneous revascularisation of patients presenting a myocardial infarction must be in place.	met / not met	1=Partially met	
5	The intensive care team must facilitate the implementation of national standards, guidelines and pathways pertaining to the patients with a cardiac disease, to be delivered in addition to the other organ support being provided.	met / not met	1=Partially met	
6	The advanced management of patients with acute valvular insufficiency or acute heart failure secondary to valve disease must be guided in consultation with a local cardiologist and the specialist cardiothoracic surgical unit.	met / not met	1=Partially met	
<b>RECOMMENDATIONS</b>				
1	A validated method for advanced haemodynamic assessment with a skilled operator in both the practical use of the device and interpreting the data it provides should be available at all times.	met / not met	2=Fully met	
2	An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.	met / not met	3=Not met	
3	Local protocols in the use of vasoactive drugs should be in place, although there is little evidence to support the use of any single agent in practice.	met / not met	2=Fully met	
<b>4.7 Echocardiography and Ultrasound</b>				
<b>STANDARDS</b>				
1	The gold standard investigation is a comprehensive study, performed and reported by a fully trained clinical specialist.	Statement		
2	A more limited study, focusing on a specific clinical question, is appropriate in many instances. This must be performed by a trained and competent practitioner.	met / not met	1=Not met	
3	Individuals who scan and report independently must be trained to a level that is appropriate for their clinical practice.	met / not met	3=Not met	
4	The service must have a nominated lead consultant with dedicated time that is sufficient to reflect the demands of the service and associated governance processes.	met / not met	3=Not met	
5	Ultrasound equipment must be readily available, serviced regularly and up to date. There must be sufficient equipment to ensure immediate access for ultrasound guided vascular access at all times. Linear, curvilinear and phased array probes are required to provide a comprehensive ultrasound service.	met = immediate availability (in on unit) of ultrasound machine for vascular access and rapid access of machine for focused echocardiography ultrasound / partially = not all elements eg only 1 machine on a large unit / not all probe types/ not met	2=Fully met	
6	Infection control measures must be adhered to at all times.	met / not met	2=Fully met	
7	The distribution and storage of transoesophageal echocardiography probes must follow national guidelines. A record must be retained in order to identify and track patients after device usage in the event of future complication/infection.	met / not met / not applicable (no TOE)	2=Fully met	
8	All images must be securely stored for quality assurance purposes with appropriate data governance. Reliance on the ultrasound machine storage capacity is not a secure method.	met = all images are stored, reviewed by trained echo specialist and uploaded to PACS; partial = uploaded but not reviewed or reviewed but not centralised storage; unmet = images not safely archived in PACS	1=Not met	
9	Whenever scans are performed to inform clinical decision making, a structured report must be generated and stored in the patient record.	met = structured report and audited, with > 90% compliance, partially met reported but not structured, not audited or < 90% compliance, not met = < 50% reported/documented in notes	3=Not met	
10	Training scan reports must not be stored in the patient record unless someone suitably trained verifies the document first.	met / not met	3=Not met	
11	Quality improvement, audit, and peer review activity must occur regularly.	Fully met = peer review process at least monthly; partially met = peer review less frequently; not met = no regular system of peer review (excludes ad hoc peer review)	1=Not met	
12	Transoesophageal echocardiography (TOE) must be immediately available in all cardiothoracic critical care units and those units providing extra-corporeal circulatory support.	met / not met / not applicable (no TOE)	3=Not applicable to Unit	
<b>RECOMMENDATIONS</b>				
1	All critical care units should be able to ensure the provision of point-of-care ultrasound.	met / not met	2=Fully met	
2	The service should be supported by a fully trained link-person within the cardiology and radiology departments, as appropriate.	met / not met	1=Partially met	
3	Individuals who participate should regularly attend their institutional ultrasound meetings.	met / not met	3=Not applicable to Unit	
4	Individuals who scan and report independently should keep a personal logbook of their images and reports.	met / not met	3=Not applicable to Unit	
5	Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to more advanced accreditation.	met / not met	3=Not applicable to Unit	
6	Images and reports should be uploaded together to the same archive used by the host institution's cardiology or radiology department, as appropriate. Reports should identify the focused nature of the investigation and the clinical context. Scans undertaken as part of training should not be archived before they have been verified by a trainer.	met / not met	3=Not applicable to Unit	
7	Regional networks and electronic image transfer systems should be created to allow for prompt access to review scans by a specialist with Level 2 accreditation, or equivalent, when this is required.	met / unmet	3=Not applicable to Unit	
8	Consideration should be given to the development of fully qualified physiologists with dedicated intensive care commitment and experience under joint supervision to deliver echocardiography services within intensive care.	met / not met / not applicable	3=Not applicable to Unit	
9	Regular replacement of ultrasound equipment is required to ensure it remains up to date. Normal guidance states that electrical equipment is replaced every seven years, however ultrasound equipment may need to be updated more frequently to keep up with technological advances.	met / not met	3=Not met	
<b>4.8 Neurological Support</b>				
<b>STANDARDS</b>				
1	Adult patients with refractory convulsive status epilepticus must be admitted to critical care and have EEG monitoring established. The primary endpoint of treatment being the suppression of epileptic activity on EEG.	met - continuous EEG or processed EEG available on unit, not met, no EEG / Processed EEG available	1=Not met	
2	Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infarction must be considered for coronary angiography with follow on primary percutaneous coronary intervention if indicated.	met / not met	2=Fully met	
3	Following traumatic spinal cord injury, a specialist neurological or spinal surgeon at the major trauma centre or trauma unit must consult the linked spinal cord injury centre consultant within four hours of diagnosis to establish a partnership of care.	met / not met	2=Fully met	
4	Previously fit adults, admitted to critical care following a primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation.	met / not met	2=Fully met	
5	Adults under the age of 60 with middle cerebral artery infarction admitted to intensive must have access to a decompressive craniectomy service at a dedicated neurosurgical centre.	met / not met	2=Fully met	
6	Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice.	met / not met	2=Fully met	
7	Prognostication in hypoxic-ischaemic brain injury after resuscitation from cardiac arrest should follow the European Advisory Statement on Neurological Prognostication in comatose survivors of cardiac arrest.	met - able to fully follow partially met - able to undertake some additional testing beyond CT, unmet - unable to meet any additional investigations	2=Fully met	
<b>RECOMMENDATIONS</b>				
1	Protocols should be available to deliver post-resuscitation care to comatose survivors following cardiac arrest as per the Resuscitation Council (UK) guidelines.	met / not met	2=Fully met	
2	The management of traumatic brain injury should follow national and international best practice guidance.	met / not met	2=Fully met	
3	Management of patients with prolonged disorders of consciousness should follow national guidance.	met / not met	2=Fully met	
4	Patients with perceived devastating brain injury should be admitted to the critical care unit to aid prognostication as per national guidance.	met / not met	2=Fully met	
5	Intracerebral haemorrhage should be managed in accordance with international guidance with particular attention to the reversal of anticoagulation and acute control of blood pressure.	met / not met	2=Fully met	
6	The management of suspected viral encephalitis or acute meningitis in adults should follow national guidance.	met / not met	2=Fully met	
7	The management of patients with ventilatory insufficiency due to neuromuscular disease should follow BTS/ICS guidelines.	met / not met	2=Fully met	
8	The management of decompensated acute inflammatory neuropathy should follow best practice guidance.	met / not met	2=Fully met	
9	Autoimmune encephalitis should be suspected and investigated in all adults presenting with the internationally described criteria proposed to identify this disease.	met / not met	2=Fully met	
10	Adults admitted with an acute neurological problem should have access to daily consultation or advice from neurology specialists, if necessary by telemedicine.	met - as per recommendation, partially met - less frequently than daily consultation, no telemedicine, unmet - difficult to access neurology advice	3=Not met	
11	Critical care units caring for patients with neurological pathology should have agreed venous thromboembolism (VTE) policies that balance the risk of recurrent haemorrhage with the need to provide prophylaxis against VTE.	met / not met	2=Fully met	
12	Fever control to normothermia following traumatic brain injury, aneurysmal subarachnoid haemorrhage, ischaemic stroke, or haemorrhagic stroke may improve outcomes.	a temperature controlling device with a closed feedback loop must be available met / not met	2=Fully met	
13	Appropriate patients with acute ischaemic stroke should be referred for mechanical thrombectomy in accordance with national consensus policy.	met - referral pathway in place 24/7 partially met - referral pathway less than 24/7, unmet - no referral pathway	1=Partially met	
<b>4.9 Burns</b>				
<b>Burns units only</b>				
<b>STANDARDS</b>				
1	Staffing models must promote joint care between burn and critical care teams as this may improve safety and confer a significant survival benefit.	met / not met	3=Not applicable to Unit	
2	A burns theatre must be located in immediate proximity (preferably within 50 metres) to any service providing critical care for burn injured patients.	met / not met	3=Not applicable to Unit	
3	Burn injured patients who require critical care must be managed by consultants in Intensive Care Medicine who have an appropriate level of training in this field and have acquired the relevant knowledge and skills needed to care for these patients.	met / not met	3=Not applicable to Unit	
4	Burn injured patients must be cared for in an appropriate service as determined by the National Burn Care Referral Guidance.	met / not met	3=Not applicable to Unit	
5	Transfer of critically ill burn patients between services must comply with Intensive Care Society guidelines.	met / not met	3=Not applicable to Unit	
<b>RECOMMENDATIONS</b>				
1	All burns over 20% total body surface area (TBSA) should have access to thermally controlled single-bedded cubicles.	met / not met	3=Not applicable to Unit	
2	Fibre-optic bronchoscopy should be used to assess inhalation injury.	met / not met	3=Not applicable to Unit	
3	Services providing centre level care should be co-located with a major trauma centre. Where this is not the case, mechanisms for ensuring appropriate integration with trauma centre care should be in place.	met / not met	3=Not applicable to Unit	
4	In specialist centres, clinical guidelines should include: a) Fluid resuscitation and management of associated complications, b) Assessment and management of burns to the face and airway, c) Management of smoke inhalation injury and its sequelae, including carbon monoxide and cyanide poisoning, d) Recognition and management of the acutely unwell and deteriorating burn injured patient, including burn specific criteria for the diagnosis of sepsis, e) Management of hypothermia and hyperpyrexia, f) Management of burn wound infections including antimicrobial stewardship, g) Nutritional assessment, h) Rehabilitation. These guidelines should be subject to periodic review and update.	met - all guidelines and reviewed within 3 years, partially met - one / two missing guidelines or not reviewed within 3 years, not met - more than two missing or not reviewed within 3 years	3=Not applicable to Unit	
5	The implementation of end of life care as a result of burn injury should only be made following assessment by at least two consultants, one of whom should be a specialised burn care surgeon.	met / not met	3=Not applicable to Unit	
6	There should be a nominated lead consultant for burns, who participates in network and national morbidity and mortality audit meetings.	met / not met	3=Not applicable to Unit	
<b>4.10 Care of the Critically Ill Pregnant (or Recently Pregnant) Woman</b>				

STANDARDS					
1	Any critical care unit that admits antenatal women over 20 weeks' gestation must have rapid access to obstetric and paediatric services able to attend in an emergency. There must be a clear plan and equipment immediately available for performing a post-mortem caesarean section in the event of maternal cardiac arrest, with appropriate neonatal resuscitation equipment.	met / not met	3=Not applicable to Unit	Patients transferred out straight away	
2	An obstetric team (normally a consultant obstetrician, a consultant obstetric anaesthetist and a midwife) must review all emergency women admitted to critical care at least once in every twenty-four hour period.	met - as per standard, partially met - less frequent, unmet - difficult to achieve	3=Not applicable to Unit		
3	In antenatal ICU admissions, when fetal viability is a possibility, a health care professional trained in neonatal resuscitation must be available within 10 minutes and a senior neonatologist or paediatrician must be able to attend within 30 minutes.	met / not met	3=Not applicable to Unit		
4	All critical care units that admit pregnant or recently pregnant women must have a named lead clinician for maternal critical care (MCC). The main function of this role is to be the point of liaison between critical care and obstetric services (including obstetric anaesthesia).	met / not met	3=Not applicable to Unit		
5	Breast feeding (including the use of breast pumps) must be encouraged and supported in all post-natal women admitted to critical care.	met / not met	3=Not applicable to Unit		
6	Women who require care that falls outside Enhanced Maternal Care (EMC) must be referred as soon as possible to the general critical care services. The costs of escalation to critical care services must be clearly defined.	met / not met	3=Not applicable to Unit		
7	Critical care outreach or equivalent must be available and provide clinical support and education into EMC.	met / not met	3=Not applicable to Unit		
8	Critically ill pregnant or recently pregnant women who undergo intra- or inter-facility transfer must be transferred in accordance with standards equivalent to the Intensive Care Society's Guidelines for the transport of the critically ill adult.	met / not met	2=Fully met		
RECOMMENDATIONS					
1	Level 3 antenatal ICU admissions and post-natal admissions that are anticipated to last more than 48 hours should be considered for transfer to a regional or supra-regional critical care unit with experience in MCC.	met / not met	3=Not applicable to Unit		
2	Physical contact between a mother and her baby should be maintained during post-natal critical illness, even if the mother is unconscious. This contact and other events of the admission should be recorded in a critical care diary which can be used in psychological rehabilitation after critical care or in bereavement counselling.	met / not met	3=Not applicable to Unit		
3	All women admitted to critical care should be offered an appointment in a critical care follow-up clinic or a post-natal review, which includes input from a clinician with experience in critical care follow-up.	met / not met	3=Not applicable to Unit		
4	Recognition of EMC should be incorporated into midwifery pre & post registration curricula and feature in obstetric, anaesthetic and critical care training programmes.	Statement			
5	Health-care professionals looking after critically ill women should undergo regular, cross-specialty, multidisciplinary team training, to encourage sharing of knowledge and skills and to promote teamwork and effective communication.	met / not met	3=Not applicable to Unit		
6	Simulation-based learning should be considered to assist healthcare professionals to develop the technical and non-technical skills for EMC.	met / not met	3=Not applicable to Unit		
7	Critical care networks should consider nominating specific units as the nominated regional or supra-regional unit for MCC.	met / not met	3=Not applicable to Unit		
8	Obstetric units delivering EMC or level 2 critical care should be members of a regional MCC network which itself should have a formal relationship with the local Critical Care Operational Delivery Network and Strategic Clinical Networks.	met / not met	3=Not applicable to Unit		
9	MCC quality indicators should be monitored, using data reported through the ICNARC Case Mix Programme and the Scottish Intensive Care Society Audit Group and used to improve local performance.	met / not met	3=Not applicable to Unit		
4.11 Care of the Critically Ill Child in an Adult Critical Care Unit					
STANDARDS					
1	Critically ill children under 16 years old must only be admitted to and stay on an adult critical care unit if a PICU bed is unavailable, or where there is an expected short duration of critical care such as an older child with overdose or alcohol excess.	met / not met	3=Not applicable to Unit		
2	Admission must be discussed and agreed by the local consultant in Intensive Care Medicine, local consultant paediatrician and the consultant in paediatric intensive care medicine (this may be the regional paediatric transport team consultant).	met / not met	3=Not applicable to Unit		
3	A nominated lead intensive care consultant and lead nurse in the adult critical care unit must be responsible for intensive care policies, procedures and training related to the care of children.	met / not met	3=Not applicable to Unit		
4	An adult critical care unit that may provide care for critically ill children must have an appropriately equipped area for providing paediatric critical care.	met / not met	3=Not applicable to Unit		
5	Medical staff with responsibility for the resuscitation and airway management of the critically ill child on an adult unit must have up-to-date competencies in advanced paediatric life support and advanced airway management. This medical cover may be provided by anaesthetists or consultants in Intensive Care Medicine according to local arrangements.	met / not met	3=Not applicable to Unit		
6	Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer of critically ill children and the provision of paediatric critical care must be available.	met / not met	3=Not applicable to Unit		
7	Education, end of life and organ donation decisions must be discussed in collaboration with the regional consultant in paediatric intensive care (this may be the regional paediatric transport team consultant), under a shared care and shared responsibility model.	met / not met	3=Not applicable to Unit		
8	There must be collaborative working between the adult critical care unit and the regional PICU to ensure that staff are supported to work outside their normal core competencies. There must be 24/7 access to paediatric medical and paediatric nursing advice.	met - as per standard, partially met - no formal arrangement, unmet - not anticipated to happen	3=Not applicable to Unit		
9	A local consultant paediatrician and consultant in paediatric intensive care medicine must be available for advice at all times.	met / not met	3=Not applicable to Unit		
10	There must be 24-hour access for parents/carers to visit their child.	met / not met	3=Not applicable to Unit		
RECOMMENDATIONS					
1	A registered paediatric nurse should be available at all times to support the care of the child.	met / not met	3=Not applicable to Unit		
2	The child should be reviewed by a consultant paediatrician twice a day during their stay on the adult unit.	met - as per standard, partially met - visited as requested / required , unmet unlikely to achieve standard	3=Not applicable to Unit		
3	There should be access to specialist paediatric healthcare professional and pharmacy advice at all times.	met - as per standard, partially met - visited as requested / required , unmet unlikely to achieve standard	3=Not applicable to Unit		
4.12 Standardised Care of the Critically Ill Patient					
STANDARDS					
1	Patients must be assessed daily for risk of thromboembolic disease and receive appropriate prophylaxis.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met		
2	Patients undergoing controlled mechanical ventilation must receive tidal volumes based on predicted body weight (PBW). Patients with ARDS must receive a tidal volume of less than or equal to 6 ml/kg PBW.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met		
3	Ventilated patients must have respiratory function evaluated daily and undergo spontaneous breathing trials where appropriate.	met / not met - no SBTs	2=Fully met		
4	Sedation must be individualised to patient needs and the appropriateness of a sedation hold considered daily.	met / not met	2=Fully met		
5	All patients must be assessed regularly for evidence of pain, with analgesia optimised to minimise sedation requirements.	met / not met	2=Fully met		
6	All patients must be screened daily for evidence of delirium using a validated method such as the Confusion Assessment Method for the ICU (CAM-ICU) or the Intensive Care Delirium Screening Checklist (ICDSC).	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met		
7	Indwelling intravascular catheters must be inspected daily for evidence of infection using a suitable scoring system e.g. Visual Infusion Phlebitis Score (Jackson 1998) to guide necessity for removal.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met		
8	The continued need for indwelling catheters (intravascular or urinary) must be considered daily.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met		
9	Monitoring of invasively ventilated patients must include continuous waveform capnography.	met / not met	2=Fully met		
10	Care bundles must be in place for Intubation Associated Pneumonia (IAP) prevention, Central Venous Catheter (CVC) insertion and maintenance, and Peripheral Venous Cathula (PVC) insertion and maintenance.	met / not met	2=Fully met		
RECOMMENDATIONS					
1	For patients without ARDS, a tidal volume of 4-6 ml/kg PBW and a peak/plateau pressure (depending on mode) of below 30 cmH2O should be targeted.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met		
2	A ventilated patient care bundle should be in place with appropriate mechanisms for ensuring adherence.	met / not met	2=Fully met		
3	Ventilated patients should receive H2 receptor blockade (e.g. ranitidine) or a proton pump inhibitor for gastric protection until established on full enteral nutrition.	met / not met	2=Fully met		
4	Unless clinically contra-indicated, ventilated patients should be nursed in a semi-recumbent position at 30 to 45 degrees.	met / not met	2=Fully met		
5	Where there is no contraindication, enteral nutrition (EN) should be initiated within 48 hours after admission to the ICU.	met / not met	2=Fully met		
6	When EN is not feasible or insufficient, parenteral nutrition should be started as soon as possible in patients with (or at high risk of) malnutrition (which may be a combination of cachexia (disease related) and malnutrition (inadequate consumption of nutrients)).	met / not met	2=Fully met		
7	All intubated patients should have sedation levels monitored hourly using a scoring system such as the Riker Sedation-Agitation Scale or the Richmond Agitation-Sedation Scale to ensure sedation is minimised.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	1=Partially met		
8	Noise levels and patient interventions should be minimised overnight to facilitate natural sleep.	met / not met	2=Fully met		
9	A transfusion threshold of 70g/L should be used in general intensive care patients. A higher target Hb may be beneficial in patients with sepsis (in the first six hours), ischaemic stroke, traumatic brain injury with cerebral ischaemia, or acute coronary syndromes.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, un met = no guideline or compliance < 50%	3=Not met		
10	Critical care units should consider standardisation of drug concentrations in line with FICMICS guidance.	met / not met	2=Fully met		



Section 5		CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS		Level description	Level	Comments
5.1		Research and Development				
STANDARDS						
1	All individuals participating in R&D activity must have completed Good Clinical Practice (GCP) training for research and keep this up to date.	met / not met		2-Fully met		
RECOMMENDATIONS						
1	Critical care units should nominate a lead for R&D activities who should coordinate activity and ensure it is carried out to UK Policy Framework for Research and Development.	met / not met or not applicable		2-Fully met		
2	Critical care units should participate in research networks, which are organised at Local Critical Care Network (LCCN) level through the regional National Institute of Healthcare Research (NIHR) Critical Care research network lead.	met / not met or not applicable		2-Fully met		
3	All research studies should be registered on the UK Critical Care Research Portfolio whenever they fulfil eligibility criteria.	met / not met or not applicable		2-Fully met		
4	Critical care units participating in research should provide information to patients, relatives, and surrogate decision-makers (SDMs) about research, research, for example through auditors, leaflets, or written consent, intensive care information resources.	met / not met or not applicable		2-Fully met		
5	Critical care units participating in research should have clear procedures for approaching patients, families and SDMs in a manner that minimises stress, but provides adequate information in a timely manner.	met / not met or not applicable		2-Fully met		
6	Critical care units participating in multiple research studies should have clear co-enrolment policies based on the UK co-enrolment guideline.	met / not met or not applicable		2-Fully met		
5.2		Audit and Quality Improvement				
STANDARDS						
1	Critical care units must have a structured and planned clinical audit programme to compare practice to published standards. There must be an identified lead for the audit programme.	met / not met		1-Partially met		
2	Critical care units must participate in a National Audit Programme for Adult Critical Care, such as the Scottish Intensive Care Society Audit Group (SICISAG) or Intensive Care National Audit and Research Centre (ICNARC) programmes.	met / not met		2-Fully met		
3	Critical care units must have a surveillance system in place for audit and feedback of nosocomial infection, for example, catheter-related bacteraemia and other blood stream infections, reported to the national scheme where applicable. Critical care units should also report the incidence of intubation-associated pneumonia. All units must participate in national audit programmes for nosocomial infections in intensive care, for example, the Public Health England Infections in Critical Care Programme (ICCOIP) and Scottish nosocomial infections in ICU audit programme.	met / not met		2-Not met		
4	Critical care units must measure night-time discharges in order to encourage and support local improvement to reduce night-time intensive care discharges.	Discharges after 21:59 as percentage of all eligible admissions - met <2% partially met, 2-4% not met-2%		2-Fully met		
5	Critical care units must obtain regular feedback about the care that patients and relatives receive during their critical care admission in order to learn from and act on the feedback received.	Met - annual process, partially met, undertaken every 1-2 years, unmet, never done or less than 2 yearly.		2-Fully met		
RECOMMENDATIONS						
1	Units should have nominated medical and nursing leads for quality improvement and audit. Appropriate time should be made available in job plans for these duties. Time to participate in audit and quality improvement programmes should also form part of the job plans of all intensive care staff (medical, nursing, pharmacists, healthcare professionals and ancillary staff).	met/ unmet		2-Not met		
2	Hospitals should have a quality improvement (QI) programme in place for each critical care unit in their organisation. The programme should aim to deliver safe, efficient, effective, patient-centred, timely and equitable patient care, which is evidence based, and should follow recognised quality improvement methodology.	met / unmet		1-Partially met		
3	Staff should be encouraged and supported to train in quality improvement methodology and all projects should be multidisciplinary, recognising the necessity for a team approach and the contribution of all staff groups.	met / unmet		1-Partially met	EQUIP Programme available	
4	Audit should be linked to QI programmes. Units should have robust data collection systems in place that support the collection of activity and quality data for local and national audit programmes.	Met - robust data collection and feedback for both local and national audit, partially met - robust data collection and feedback for national audit only, not met - no robust systems for data collection or		2-Not met		
5	Critical Care Networks should have a formal, multi-professional, peer-review programme in place for the units in their jurisdiction. Peer reviews should be based on published national standards, but are likely to include other areas that are agreed locally.	met / not met - not applicable		2-Fully met		
6	All critical care units must measure and report their delayed discharges, out of hours discharges, out of hours transfers and readmissions within 48 hours of discharge, as a potential indicator of resource pressures. It is recommended that units should also measure early discharges as they may be a marker of insufficient resources.	Met - submit all data to ICNARC / SICISAG data tools, partially met - one or more data submissions missing, not met - poor data compliance with ICNARC / SICISAG		2-Fully met		
5.3		Clinical Governance				
STANDARDS						
1	There must be an appropriately trained consultant and senior nurse identified as leads for clinical governance. The consultant must not be the clinical lead or clinical director for critical care.	met / not met		2-Fully met		
2	There must be a robust system in place for reporting, investigating, and learning from all patient safety incidents. Appropriate action plans must be formulated in response to incidents. Units should also learn from things that go well, a process described in excellence reporting.	met / not met		2-Fully met		
3	Units must hold regular structured multidisciplinary clinical governance meetings, where they discuss unit morbidity and mortality, including all deaths, critical incidents and near misses. A written record of actions taken and lessons learnt should be kept and a timely and reliable method for dissemination of shared learning should be in place. There should be clear structures in place for dissemination findings to staff, and decisions that are made should be made in a timely manner.	met - meets full standard with minimum of quarterly meetings, partially met - meets standard but less than quarterly, unmet - doesn't meet the standards		2-Not met		
4	Regular feedback must be obtained from service users and staff about the quality of care delivered, for example by the use of safety surveys and patients' questionnaires.	met - undertake critical care led staff safety and relative surveys at least once a year, partially met is less frequently or only one group surveyed, Not met - no patient or staff survey		2-Not met		
5	Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care. Appropriate actions must be taken whenever preventable factors are found.	met - mortality review process that includes all deaths in ICU / not met		2-Not met		
6	All units must maintain a risk register that is regularly reviewed and updated by both senior managerial and clinical staff.	met - in place, quarterly review, partially met, in place less than quarterly review, unmet - not in place		2-Fully met		
7	The unit must have processes to ensure clinical staff are aware, in a timely fashion, of key learning points from national safety alerts and local learning (for example from patient safety incidents, excellence reports, patient concerns and complaints). Staff must also be able to easily access important information to inform patient care (for example information about medications and unit policies) whenever needed.	met / not met		2-Fully met		
8	Staff who have to conduct reviews of patient safety incidents, root cause analysis and appreciative enquiry must be trained in the management of these processes so the review is conducted safely and constructively. Similarly, effective quality improvement requires staff that are trained in quality improvement methodology.	met / not met		2-Fully met		
9	Each unit must have local safety standards for invasive procedures (including tracheostomy, bronchoscopy, central line and chest drain insertion and lumbar puncture). They must also have safe standards for the handling of information for patients going to have invasive procedures in other departments. These standards should include documentation of invasive procedures, handovers and information transfer, procedural verification, a safety briefing and time out, and a sign out and debriefing. An example of this process is the NHS England Safety standards for invasive procedures.	met / not met		2-Fully met	Critical care LocSSIP in place	
10	Critical care units must comply with reviews and visits by national organisations, (for example the CQC in England).	met / not met		2-Fully met		
RECOMMENDATIONS						
1	Intensive care staff should work with other clinical teams in the hospital with respect to joint learning from morbidity and mortality review and ensuring best practice around handovers of care.	met - done quarterly, partially met, done annually, not met, not done - use comments box		2-Not met		
2	Units should regularly review guidelines from professional organisations and other sources of evidence to ensure that the unit complies with best practice. These evidence sources should be translated into comprehensive locally agreed guidelines or Standard Operating Procedures.	met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed		1-Partially met		
3	The unit should identify key performance indicators (KPIs) that describe outcomes of their service. Such KPIs may be generic and common to most units, such as complication rates, e.g. delirium rates, pain scores or pressure sores. Alternatively, these may be unit specific, for example rates of emergency intubations on cardiac critical care units.	met / not met		2-Not met		
4	Staff should be recognised as the key resource in intensive care. A fully engaged, well-motivated well-trained and well-led workforce is essential to allow excellence in clinical care to flourish. Staff sickness rates, turnover rates and information from appraisal, staff feedback and exit interviews should all be monitored to ensure staff wellbeing.	Met - all staff wellbeing criteria stated are monitored, partially met - some criteria are monitored, not met - none of criteria are monitored.		1-Partially met		
5	Units should work with other units within their network, and nationally, to share learning, disseminate best practice, quality improvement and best benchmarking for quality purposes. The involvement of critical care units is tightly audited by outside agencies, including intensive care networks. The external responsibility for the oversight of governance arrangements varies between the different agencies.	met - Units participate in Network led program to share best practice and QI / not met		2-Fully met	Follow up national & WICS implementation	
6	The unit should be able to demonstrate that it is continuously working to improve patient care using recognised quality improvement techniques delivered by appropriately trained staff.	met- Unit have undertaken at least one local patient centric QI program in previous 12 months / unmet		2-Not met		
5.4		Critical Care Networks				
		*These may not be applicable for countries which do not have networks				
STANDARDS						
1	Critical care ODNs must support the activity of provider healthcare organisations in service redesign and delivery of the commissioned pathway, quality improvements, innovation and standardisation of clinical practice. They provide a mechanism for peer review and benchmarking self assessment in the network.	met / not met / not applicable		2-Fully met		
2	Critical care ODNs must support commissioners in the delivery of their commissioning functions, through creating and delivering innovation, quality improvements and efficiency across the pathway, and developing, defining and supporting local strategies for adult critical care services across the geographical footprint, including advice on procurement.	met / not met / not applicable		2-Not applicable to Unit		
3	Critical care ODNs must support delivery of a resilient critical care service within a geographical area to meet emergency requirements.	met / not met / not applicable		2-Fully met		
4	Each provider of adult critical care must engage, contribute and participate in activities of their local critical care ODN and will contribute to the funding of their local ODN through a nationally agreed mechanism; this is currently a 10% CQUIN top slice, but may be supplemented by local agreements made in conjunction with key stakeholders through the ODN Executive Oversight Governance Board.	met / not met / not applicable		2-Fully met	Unsure of funding	
5	The intensive care team in provider organisations must engage, contribute and participate in a critical care ODN, including audit activity, peer review and quality improvement processes.	met / not met / not applicable		2-Fully met		
RECOMMENDATIONS						
1	ODNs should take a whole-system, collaborative-provision approach to facilitate the delivery of safe and effective services across the patient pathway, with an emphasis on the quality and equity of access to service provision.	met / not met / not applicable				
2	ODNs should identify and implement improvements to enhance patient care, enabling the design of effective clinical flows and pathways of care for networked provision of services. This will allow for more local determination, innovation and efficiency across the pathway.	met / not met / not applicable				
3	ODNs should focus on quality and effectiveness through facilitation of comparative benchmarking and auditing of services, with implementation of required improvements. This should span the wider hospital system, to include dedicated critical care units, as well as resources to support acutely unwell patients on general wards. This includes rehabilitation of patients recovering from critical care in hospital and in the community.	met / not met / not applicable				
4	ODNs should create an operational model that allows effective work programmes for the delivery of local and regional priorities, service specification standards, national programme of care outcomes and outcome framework targets.	met / not met / not applicable				
5	ODNs should have robust governance arrangements that ensure functionality, working with both providers and commissioners, to enable the development of improved service standards to continually enhance the patient, family and care experience.	met / not met / not applicable				
6	ODNs should have a core management team capable of delivering the work of the network according to local requirements. They should provide clinical and executive management leadership to support the delivery of established network plans, enabling action in response to adverse situations or outlying practices. As a minimum, this would include senior management, lead medical and nursing roles and administrative support. These roles are independent of both the host organisation and the substantive employer where this is not the host.	met / not met / not applicable				
7	Each participating member organisation should ensure appropriate representation at critical care ODN meetings, task groups and other forums in accordance with the ODN's terms of reference. Through the baseline contract agreement (local or national), member organisations should comply with ODN standards, policies and guidelines.	met / not met / not applicable		2-Fully met		
8	Each adult critical care provider should adhere to requirements to measure and evaluate quality indicators and service delivery, in line with the national Adult Critical Care Service Specification (2009). This specification may be supplemented by additional requirements by the local ODN (for example GPCIS V2 standards and recommendations). Such supplemental standards should be agreed by the ODN through their local governance structure.	met / not met / not applicable				
9	ODNs should provide leadership support in network-wide emergency preparedness, have a role in clinical contingency planning and respond to increased demand through national, regional and local determination. ODNs should act on identified challenges as they arise, e.g. a local critical care bed crisis or large-scale major incidents.	met / not met / not applicable				
10	ODNs should encourage the positive engagement of adult critical care providers in their networks and support critical care units in developing their service to its maximum potential by implementing the recommendations outlined above.	met / not met / not applicable				
5.5		Critical Care Commissioning				
STANDARDS						
1	All units must comply with national commissioning arrangements in place in England, Wales, Scotland and Northern Ireland.	met / not met		2-Not applicable to Unit		
2	COMDS must be collected and reported in all designated Adult Critical Care locations in England.	met / not met / NA		2-Not applicable to Unit		
3	Data collection must commence from the date and time that the patient first occupies a designated critical care bed or, if in a non-designated critical care unit, the date and time that the patient first occupies a designated critical care area / not met - data is collected on critical care episodes delivered outside of designated critical care area / not met	Met - data is collected on critical care episodes delivered outside of designated critical care area / not met		2-Fully met		
4	Adult critical care reference cost submissions must assign costs to individual HRGs.	Statement				
5	All providers in England, Wales and Northern Ireland with adult critical care services must be members of a Critical Care Operations Delivery Network.	met / not met				



RECOMMENDATIONS				
These recommendations may not be applicable to these units outside of England and Wales				
1	Collection of all 34 fields in CCMS is recommended. This should be done by dedicated trained personnel.	met / not met	Is/Not applicable to Unit	
2	There should be clinical oversight of the CCMS data entry/data submission to ensure accuracy of data.	met / not met	Is/Not applicable to Unit	
3	Preparation of reference costs should include experienced clinician involvement.	met / not met	Is/Not applicable to Unit	
4	Agreement should be in place to support early notification to a patient's CCG for longer-stay patients who are likely to have complex home needs, such as home ventilation to aid discharge planning including the identification of a funding package.	met / not met	Is/Not applicable to Unit	
5	A lead commissioner should be identified with a commissioning forum for each critical care service.	met / not met	Is/Not applicable to Unit	

Section 6		CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS		Level description	Level	Comments
6.1	Fire					
STANDARDS						
1	All units must have well marked fire call points, fire extinguishers and oxygen shut-off valves.	Met or unmet	2=Fully met			
2	Each unit must have a specific fire evacuation policy in place, which takes account of: a) the layout of the building, including any need to negotiate stairs during an evacuation, b) the provision of ventilatory support, intravenous therapies and invasive monitoring for patients during such an evacuation, c) the fact that critical care staff may themselves be affected by a fire and therefore be unfit to continue working. Action cards summarising the evacuation procedure should be displayed within the unit, ideally next to fire call points, so that they can be referred to in an emergency.	Met or unmet	1=Partially met		Departmental fire plans currently being updated to include guidance from the Ass	
3	Recommendations for the safe use of oxygen cylinders must be adhered to at all times and include: the safe use of oxygen cylinder bed brackets, b) the safe storage of oxygen cylinders and c) following the recommended sequence of events when turning on an oxygen cylinder.	Met / unmet	2=Fully met			
4	Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring and curtains.	Met / unmet	2=Fully met			
5	New units must be designed using Department of Health guidance and in conjunction with the Trust fire safety officer, with consideration given to the provision of: a) multiple exit routes, b) ski pad, ski sheets or other evacuation aids for all bed spaces which are readily available, c) adopting small bays rather than open areas and d) splitting ICU departments into separate clinical and non-clinical areas.	met / not met / not applicable	3=Not applicable to Unit			
6	Units must have a major incident plan in place which allows for the transfer in of multiple critical care patients from a neighbouring hospital's critical care unit should it need to carry out an emergency evacuation.	Met / unmet	2=Fully met		Major Incident plans in place, along with Business Continuity plans. Activity 18 rel	
7	Any problem with oxygen cylinders and associated equipment must be reported immediately to both the medical gas supplier and the Medicines and Healthcare products Regulatory Authority (MHRA).	Met / unmet	2=Fully met			
8	All staff must undergo regular training in fire prevention and fire procedures, to include training in-situ in the specific clinical areas in which they work. All staff must know: a) the location of fire call points within their own unit and how to operate them, b) the location of fire extinguishers within their unit and which type to use in the event of a fire. Medical and senior nursing staff must also know the location of the medical gas pipeline shut-off valves in their unit, how to operate them and the implications of doing so.	met = > 90% of staff compliant , partially met > 75%, not met < 75%	2=Fully met			
9	All intensive care staff must be given basic training regarding the safe use of oxygen cylinders.	met = > 90% of staff compliant , partially met > 75%, not met < 75%	2=Fully met			
10	Local unit evacuation policies must be drawn up, with consideration for: a) other locations within the hospital where critical care might be provided on a temporary basis; b) provision of equipment and drugs; c) evacuation case at each bed space; d) triage of patients (the least unwell patients being evacuated first and the most unwell patients last); e) possible co-existing power and/or equipment battery failure; f) use of transport ventilators and hand ventilation if needed; g) temporary discontinuation of renal replacement therapy; and h) transfer of hospital notes especially if electronic patient monitoring is in use. In a major fire, it is possible that serial evacuations will be required with a staged move to the outside, and that the whole hospital may need to be evacuated.	Met / unmet	0=Not met		Departmental fire plans currently being updated to include guidance from the Ass	
RECOMMENDATIONS						
1	Evacuation policies should include liaison with the Bronze (Operational), Silver (Tactical) and Gold (Strategic) commanders in conjunction with the senior fire officer on scene. Timing of evacuation is crucial: if evacuation occurs too early, then patients may be harmed by a transfer: if evacuation occurs too late, then patients and staff may be harmed by fire and smoke.		1=Partially met		Fire evacuation plan discusses Liaison with hospital fire response team. Patients i	
2	Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be practised.	Met - tested annually , partially met tested daytime only and / or less than annually, unmet, not tested in the last 2 years	0=Not met		Fire evacuation exercises have been requested from the fire team. Current Covic	
3	Units should have a system whereby staff involved in a traumatic incident, such as a fire in the critical care unit, receive debriefing and are followed up for signs of a trauma stress reaction or Post Traumatic Stress Disorder (PTSD). The Trauma Resilience Management (TRiM) system is a screening tool used in the military and more recently used successfully in healthcare which could be considered.	Met - system available / unmet - no system in place to do this	2=Fully met			
4	Critical care networks should develop systems to support planning for, and management of, a major incident in one critical care unit within the network, so that other units can cooperate to accommodate all critically ill patients in this type of situation. A retrieval team approach, with staff from neighbouring units travelling to the affected unit to transfer patients, should be planned. Liaison with neighbouring units and local ambulance services at an early stage is advised.	met / not met / not applicable	3=Not applicable to Unit		Local BCP and Major Incident plans apply	
6.2	Major Incidents					
STANDARDS						
1	All hospitals designated receiving hospitals with Level 3 critical care capability must be prepared to double their normal Level 3 ventilated capacity and to maintain this for up to 96 hours.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard	0=Not met		innadequate logistics to double capacity	
2	All nominated supporting hospitals with Level 3 critical care capability must be prepared to double their normal capacity for Level 3 beds for general use and to support the decant of patients from other receiving hospitals.	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box here ) unmet - no plans in place to meet this standard	0=Not met		Inadequate logistics to double capacity	
3	All hospitals with intensive care capacity must have in place plans to support the retrieval or transfer of patients; supporting hospitals must have to support patient transfers by providing suitably skilled transfer teams for each patient needing to be moved within Critical Care Operational Delivery Network areas and beyond.	Met / unmet	1=Partially met		Network call	
4	All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but not exclusively intensive care patients, should the intensive care areas become unusable for any reason.	Met / unmet	2=Fully met		Patients will be taken to Theatres/Recovery or the day surgery unit depending up	
5	All hospitals must have a lock down plan that includes all intensive care areas, preventing unauthorised access.	met / unmet	2=Fully met		Yes to Critical Care	
6	All hospitals must have a recovery plan to ensure a rapid return to normality once the incident is closed. This must include adequate rest and psychological support for staff.	met / unmet	2=Fully met		Business Continuity plans in place.Dedicated Psychologist working in Critical Care	
7	Action cards must be available for use on activation of plan and must include information and communication routes that are to be used.	met / unmet	2=Fully met			
RECOMMENDATIONS						
1	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response (EPRR) leads and clinical colleagues to create the intensive care response to a major incident, hospital evacuation or mass casualty plans.	met / unmet	0=Not met			
2	Intensive care should have access to emergency planning and response training including strategic/crisis leadership.	met / unmet	0=Not met			
3	Intensive care service staff should participate in the local and regional multidisciplinary exercises including 'table top' and 'live' exercises to further refine local and regional plans and communication routes between organisations and networks.	met / unmet - within the last 2 years	0=Not met			
4	Intensive care leads should work with their EPRR team to facilitate exercises in the evacuation of very dependent patients from any part of their hospital. This should include practical use of ski sheets, and other patient handling aids, as well as rehearsing the decision making and forward planning required by shift leads to support a controlled, staged evacuation.	met / unmet - within the last 2 years	0=Not met			
5	Intensive care staff should be prepared to take a central leadership role in any major incident and should be prepared to send teams forward to the Emergency Department, as well as any preoperative hold areas and recovery.	met - plans in place to enable to do so, unmet - no plans	0=Not met		Would participate as designated in local major incident response	
6	The plan to double the number of intensive care beds should include an inventory of where equipment is to come from, where the beds should be located and who should staff them. This should be near the permanent critical care unit, where possible allowing the normal functioning of the hospital around it.	met / unmet	0=Not met		Inadequate logistics to double capacity	
7	Advance consideration of staff workforce requirements, including mutual aid from colleagues in neighbouring hospitals should form part of the intensive care service planning.	met / unmet	2=Fully met			
8	Staff welfare should be actively supported during an incident and critical care staff access to informal, immediate debrief or later formal counselling.	met - plan in place , unmet - no plan in place	2=Fully met			
9	Clinical standards should be maintained as long as possible, critical incident reporting encouraged and contemporaneous note kept to enable quality post-incident lessons to be investigated, communicated and learnt.	met - within plan , unmet - not in plan	0=Not met			
6.3	High Consequences Infectious Diseases: Initial Isolation and Management					
STANDARDS						
1	Each critical care unit must ensure there are local contingency plans for the initial isolation and management of critically ill patients with suspected HCIDs. These plans must be regularly practiced and reviewed, including the use of table-top exercises and simulations.	Met - plan in place and tested within 2 years, partially met - plan in place but not tested within 2 yrs, unmet - no plan	2=Fully met			
2	Units must liaise with local Directors of Infection Prevention and Control to ensure the correct personal protective equipment (PPE) is procured and sufficient stocks are readily available for use by appropriately trained intensive care staff in the event it is required.	met / unmet	2=Fully met			
RECOMMENDATIONS						
1	A consultant in Intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience preparations, incorporating plans for the appropriate isolation and management of suspected patients with HCID.	met / unmet	2=Fully met			
2	A clinical area where critically ill patients with suspected high consequence infectious diseases may be isolated, either within the unit or elsewhere, should be prospectively identified. Ideally plan to utilise negative pressure rooms with anterooms where available.	met / unmet	2=Fully met			
3	All clinical equipment used in the management of a patient with a HCID should be dedicated to that patient alone. Equipment should be single use where possible.	met - within a plan to do so, unmet - no plan	2=Fully met			
4	Training should be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provided. This should incorporate annual fit testing of respiratory protective equipment (e.g. FFP3 masks).	met - annual fit testing done unmet - not annual fit testing	2=Fully met			
5	Critical care staff providing care for a patient with a suspected or confirmed HCID should be dedicated to the care of that patient on a clinical shift and should not provide concurrent care for other patients, thus limiting the risk of cross-infection.	met - within plan to do so, unmet - no plan	2=Fully met			
6	Contingency planning should incorporate plans for holding securely the large volume of clinical waste resulting from clinical care including discarded contaminated PPE. Once a HCID is confirmed, further advice on correct disposal of the waste will be provided.	met - within plan to do so, unmet - no plan	2=Fully met		Hospital plan	
7	Patients with a suspected viral haemorrhagic fever should be risk assessed in accordance with the Advisory Committee on Dangerous Pathogens Viral Haemorrhagic Fever (ACDP VHF) Risk Assessment algorithm and investigations to exclude malaria promptly undertaken, in keeping with local procedures.	met - local procedure in place, unmet - no local procedure	0=Not met			
8	Patients with suspected airborne HCIDs should be risk assessed according to national guidelines where they exist (disease-specific e.g. MERS guidance collections3.4 or generic airborne HCID guidelines, as appropriate).	met - local procedure in place, unmet - no local procedure	2=Fully met			
9	Following recognition of a patient with a suspected HCID: a) local infectious disease and/or microbiology and virology services should be notified and advice sought, including guidance on obtaining appropriate diagnostic clinical specimens, b) Local clinicians should liaise with the Imported Fever Service (note this service is available to clinicians across the UK) for further clinical advice and to facilitate access to specialist diagnostics (as required, and c) all suspected cases should be reported immediately to local health protection authorities (e.g. the local Health Protection Team).	met - local procedure in place, unmet - no local procedure	2=Fully met			
10	Critical care units accepting international medical transfers should perform a risk assessment prior to transfer if a patient is being transferred from a country with known HCID outbreaks or countries where there is a significant risk of specific HCIDs; refer to national guidance (disease-specific or generic HCID guidance).	met - local procedure in place, unmet - no local procedure	2=Fully met			
6.4	Surge and Business Continuity Planning					
STANDARDS						
1	Adult critical care units (in England) must submit twice-daily information on their bed capacity through NHS Pathways Directory of Services (DoS).	met / unmet / NA ( if non English units)	3=Not applicable to Unit			
2	Each organisation with an adult critical care unit must have their own escalation plan and business continuity plan.	met / unmet	2=Fully met			
RECOMMENDATIONS						
1	Unit managers and senior clinical staff should develop plans and checklists for scenarios such as: a) supply chain disruption (road/fuel crisis, extreme weather, industrial action or civil disturbance), b) Infrastructure failures (intermittent power cuts or 'brownouts', failure of water or heating), c) interruption of normal staffing patterns (e.g. transport disruption, school closures). Checklists should include, for example, which drugs and consumables would run out first if supplies are disrupted.	met / unmet	2=Fully met			
2	Plans should also include options for: a) Unit evacuation, both internally and externally to other sites in the event of major infrastructure failure, or other events (e.g. fire) which threaten the ongoing operation of intensive care facilities, b) Capability for accommodating intensive care patients evacuated from another site.	met / unmet ( repetition )	2=Fully met			
3	As lack of critical care capacity is frequently the bottleneck in other surge-events, managers and clinicians should have identified areas within their acute hospital sites to allow for expansion of critical care capacity. This may include use of operating theatres, recovery and augmented higher care areas, or upgrading Level 2 critical care areas to permit mechanical ventilation and Level 3 care.	met / unmet	2=Fully met			
4	If increased activity is anticipated, the increase in requirement for consumables should be quantified using the concept of 'days of supply' (i.e. what is needed to run one intensive care bed for a 24-hour period). This should include consideration of oxygen and air supplies.	met - within plan , unmet - not in plan	2=Fully met		Hospital plan	
5	Expansion may also require consideration of essential equipment and possible alternatives.	met - within plan , unmet - not in plan	2=Fully met			

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## Background

The work undertaken on the Critical Care Service as part of the Clinical Services Plan reviews activity data between 1<sup>st</sup> August 2018 and 31<sup>st</sup> July 2023 and includes activity from Withybush, Glangwili, Prince Phillip and Bronglais Hospitals.

This data is accurate as of quarter 3 2023/24.

## Temporary Service change:

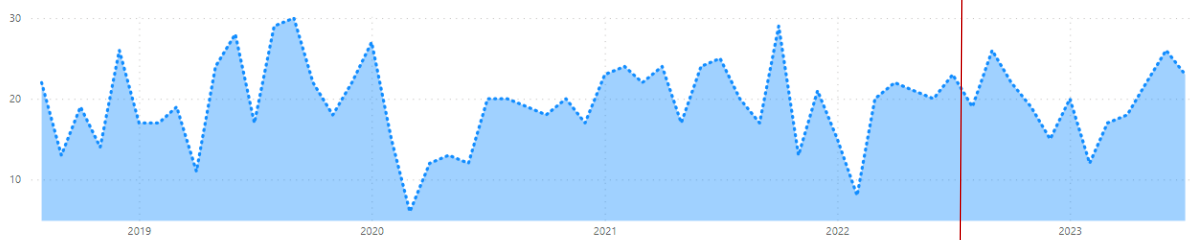
On 25<sup>th</sup> July 2022, an operational decision was implemented to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital. From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted/transferred to neighbouring Critical Care units, appropriate to their clinical needs.

This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

## Critical Care Admissions

### Bronglais Hospital admissions August 2018 to July 2023

WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
BGH - Intensive Care Unit	147	249	220	233	236	89	1,174
<b>Total</b>	<b>147</b>	<b>249</b>	<b>220</b>	<b>233</b>	<b>236</b>	<b>89</b>	<b>1,174</b>



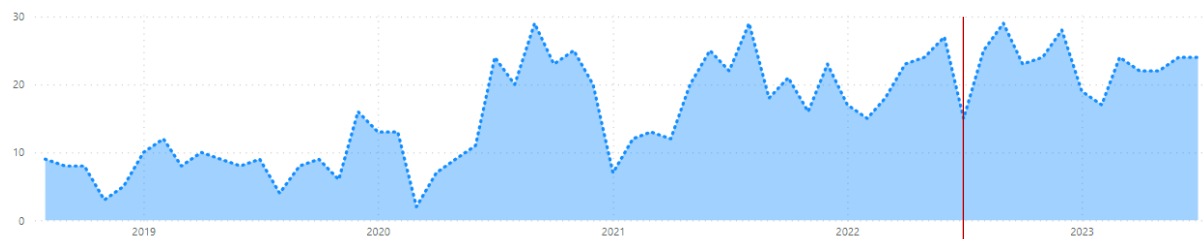
### Glangwili Hospital admissions August 2018 to July 2023

WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
GGH - Critical Care Unit	342	478	488	501	463	156	2,428
<b>Total</b>	<b>342</b>	<b>478</b>	<b>488</b>	<b>501</b>	<b>463</b>	<b>156</b>	<b>2,428</b>



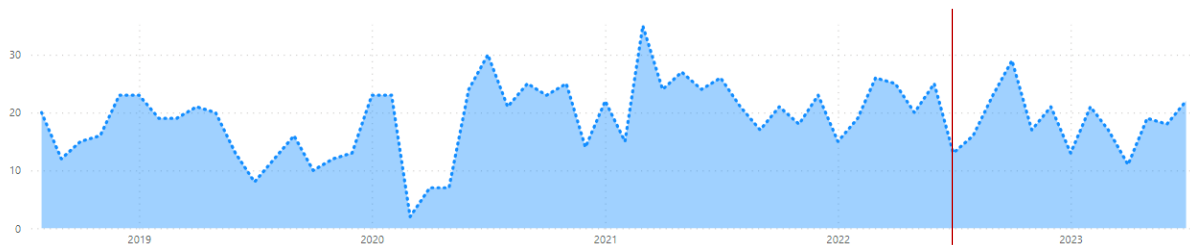
### Prince Philip Hospital admissions August 2018 to July 2023

WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
PPH - Intensive Care Unit	63	107	200	236	278	92	976
<b>Total</b>	<b>63</b>	<b>107</b>	<b>200</b>	<b>236</b>	<b>278</b>	<b>92</b>	<b>976</b>



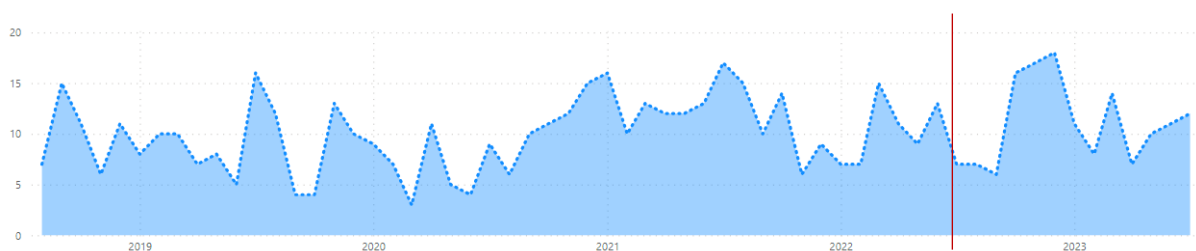
### Withyburn Hospital (High Dependency Unit) admissions August 2018 to July 2023

WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
WGH - High Dependency Unit	147	173	248	261	240	70	1,139
<b>Total</b>	<b>147</b>	<b>173</b>	<b>248</b>	<b>261</b>	<b>240</b>	<b>70</b>	<b>1,139</b>



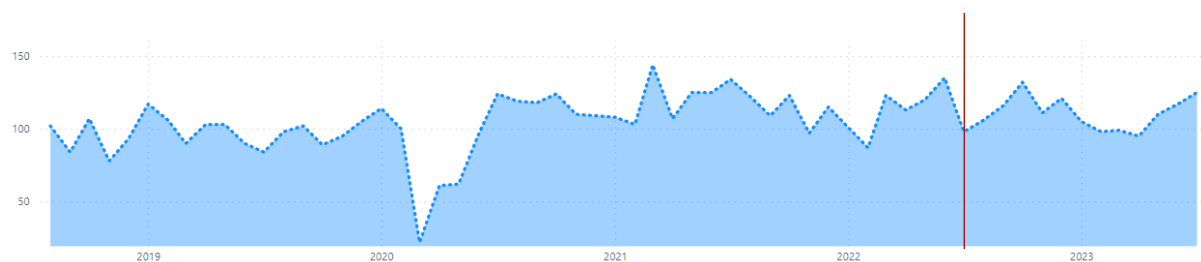
### Withyburn Hospital (Intensive Care) admissions August 2018 to July 2023

WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
WGH - Intensive Care Unit	78	98	122	137	137	40	612
<b>Total</b>	<b>78</b>	<b>98</b>	<b>122</b>	<b>137</b>	<b>137</b>	<b>40</b>	<b>612</b>



### HDdHB Critical Care admissions August 2018 to July 2023

WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
BGH - Intensive Care Unit	147	249	220	233	236	89	1,174
GGH - Critical Care Unit	342	478	488	501	463	156	2,428
PPH - Intensive Care Unit	63	107	200	236	278	92	976
WGH - High Dependency Unit	147	173	248	261	240	70	1,139
WGH - Intensive Care Unit	78	98	122	137	137	40	612
<b>Total</b>	<b>777</b>	<b>1,105</b>	<b>1,278</b>	<b>1,368</b>	<b>1,354</b>	<b>447</b>	<b>6,329</b>

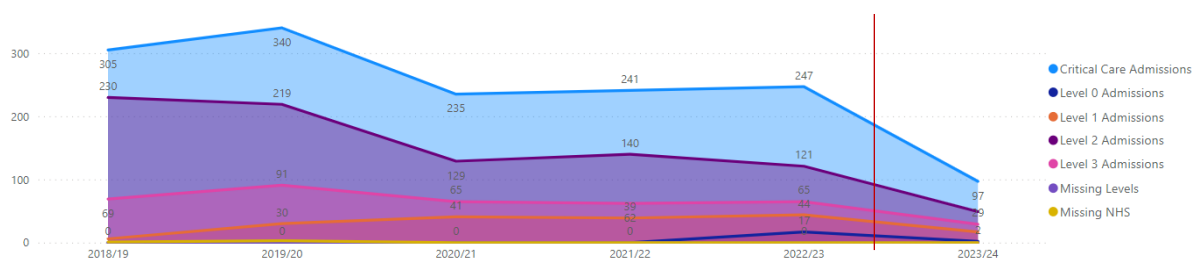


### Breakdown of admissions by levels of care by hospital

The breakdown by admissions for levels of care is reflected for a wider reporting period and the data has not been able to be broken down to match the timeline and scope of the Programme. The data in this section relates from 2018 – 2023.

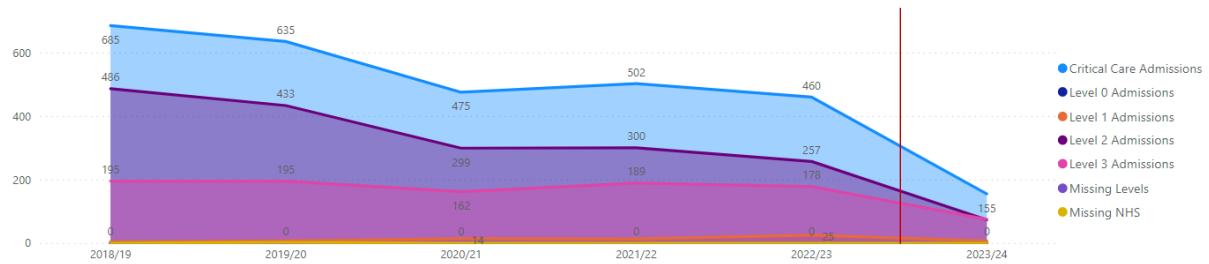
### Bronglais Hospital by level 2018 - 2023

Metric	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Critical Care Admissions	305	340	235	241	247	97	1465
Level 0 Admissions	0	0	0	0	17	2	19
Level 1 Admissions	6	30	41	39	44	17	177
Level 2 Admissions	230	219	129	140	121	49	888
Level 3 Admissions	69	91	65	62	65	29	381
Missing Levels	0	0	0	0	0	0	0
Missing NHS	1	3	0	0	0	0	4



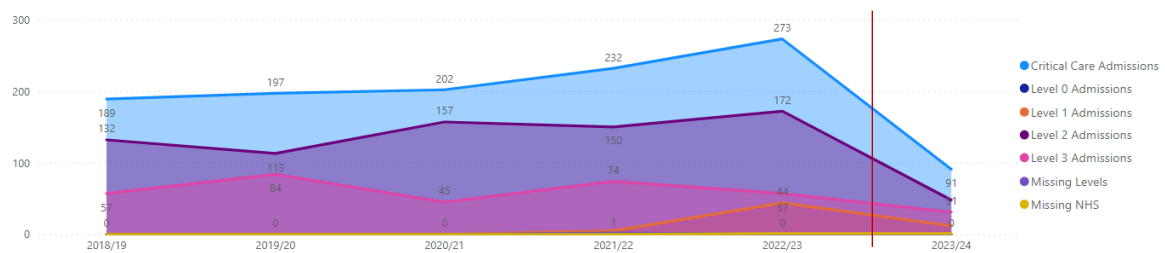
### Glangwili Hospital by level 2018 - 2023

Metric	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Critical Care Admissions	685	635	475	502	460	155	2912
Level 0 Admissions	0	0	0	0	0	0	0
Level 1 Admissions	4	7	14	13	25	7	70
Level 2 Admissions	486	433	299	300	257	73	1848
Level 3 Admissions	195	195	162	189	178	75	994
Missing Levels	0	0	0	0	0	0	0
Missing NHS	0	2	0	0	0	0	2



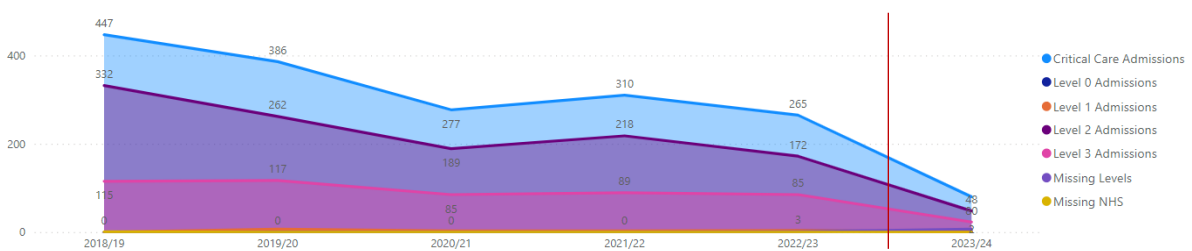
## Prince Philip Hospital by level 2018 - 2023

Metric	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Critical Care Admissions	189	197	202	232	273	91	1184
Level 0 Admissions	0	0	0	1	0	0	1
Level 1 Admissions	0	0	0	5	44	12	61
Level 2 Admissions	132	113	157	150	172	48	772
Level 3 Admissions	57	84	45	74	57	31	348
Missing Levels	0	0	0	2	0	0	2
Missing NHS	0	0	0	0	1	1	2



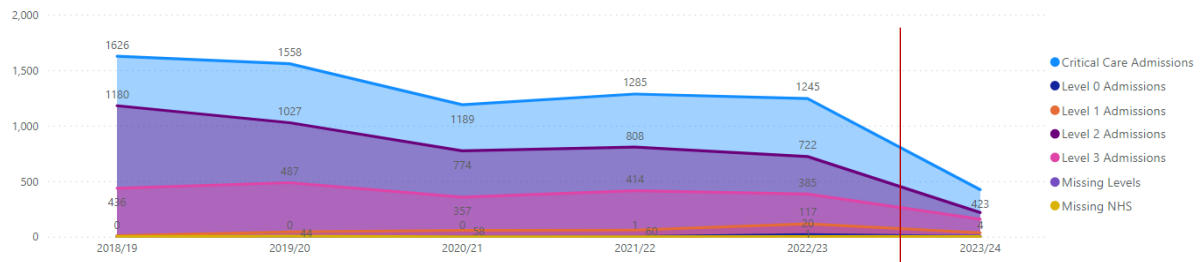
## Withybush Hospital (Intensive Care) by level 2018 - 2023

Metric	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Critical Care Admissions	447	386	277	310	265	80	1765
Level 0 Admissions	0	0	0	0	3	2	5
Level 1 Admissions	0	7	3	3	4	0	17
Level 2 Admissions	332	262	189	218	172	48	1221
Level 3 Admissions	115	117	85	89	85	23	514
Missing Levels	0	0	0	0	1	7	8
Missing NHS	1	0	0	0	0	0	1



## Hywel Dda by level 2018 - 2023

Metric	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Critical Care Admissions	1626	1558	1189	1285	1245	423	7326
Level 0 Admissions	0	0	0	1	20	4	25
Level 1 Admissions	10	44	58	60	117	36	325
Level 2 Admissions	1180	1027	774	808	722	218	4729
Level 3 Admissions	436	487	357	414	385	158	2237
Missing Levels	0	0	0	2	1	7	10
Missing NHS	2	5	0	0	1	1	9



## Admissions by source – Overview

The table below illustrates the location of referrals before admission into a Critical Care Unit. This data covers the period of August 2019 – July 2023.

Routes of Admission (1st August 2019 - 31st July 2023)												
Site	A&E / AMAU (Front Door)		Internal (InPatient) Inside HDdUHB						External (Transfers) Outside of HDdUHB			
	Emergency	%	Ward	%	Theatre	%	Other routes	%	Critical Care Units	%	Another Hospital	%
Bronglais Hospital	379	36%	197	19%	428	41%	40	4%	7	1%	1	0.1%
Glangwili Hospital	637	32%	557	28%	621	31%	47	2%	142	7%	10	0.5%
Prince Philip Hospital	184	20%	395	42%	299	32%	6	1%	45	5%	2	0.2%
Witthbybush Hospital	477	41%	367	31%	308	26%	0	0%	19	2%	0	0.0%
<b>Totals</b>	<b>1677</b>	<b>32%</b>	<b>1516</b>	<b>29%</b>	<b>1656</b>	<b>32%</b>	<b>93</b>	<b>2%</b>	<b>213</b>	<b>4%</b>	<b>13</b>	<b>0.3%</b>
<b>Grand Total</b>	<b>1677</b>		<b>3265</b>						<b>226</b>			

HDdUHB - Admission Routes Analysis (as at 1st August 2019 - 31st July 2023)			
A&E / AMAU (Front Door)		Internal (InPatient)	
32%		63%	
		External (Transfers)	
		4%	

Key:
A&E Accident and Emergency Department
AMAU Accute Medical Admissions Unit - this is specifically relevant to Prince Philip Hospital



## Critical Care Incident Data Review

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## **Background**

As per the approved Clinical Services Plan methodology, Incidents reported between 1 August 2018 and 31<sup>st</sup> July 2023 have been recorded for Withybush Hospital, Glangwili Hospital, Prince Philip Hospital and Bronglais Hospital. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

### **Temporary Service change:**

On 25th July 2022, an operational decision was implemented to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital. From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted/transferred to neighbouring Critical Care units, appropriate to their clinical needs.

This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

It should be noted that the incident data is recorded by the patient's treatment code as such there maybe complaints data from other services or sites outside of the scope of the clinical services plan in the analysis below.

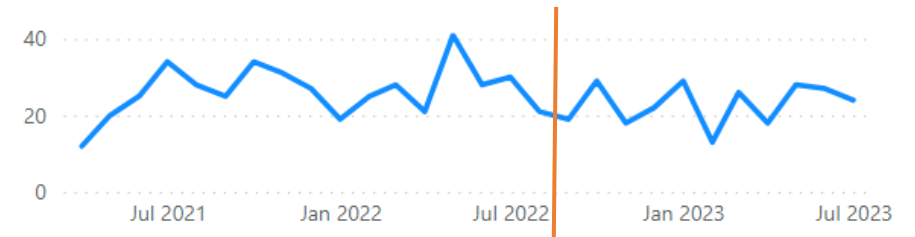
## Incidents

**All sites (1st August 2018 – 31st March 2021)**



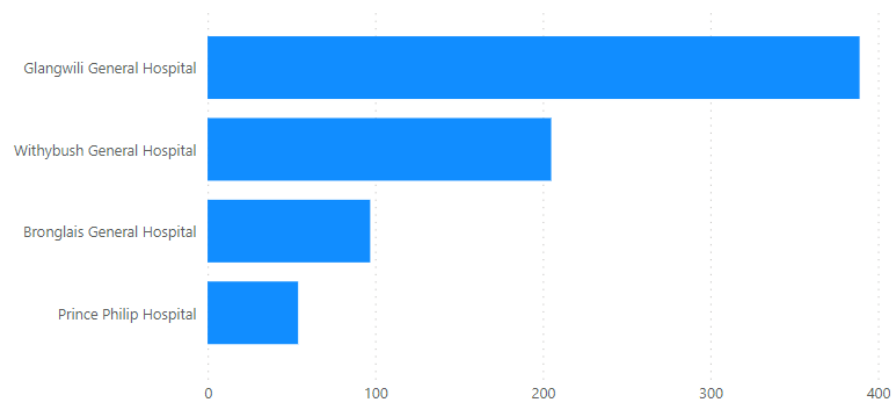
							Au g 18	Se p 18	O ct 18	No v 18	De c 18	201 8
							28	23	27	21	14	113
Ja n 19	Fe b 19	Ma r 19	Ap r 19	Ma y 19	Ju n 19	J ul 1 9	Au g 19	Se p 19	O ct 19	No v 19	De c 19	201 9
29	23	40	20	31	25	2 9	28	21	22	22	15	305
Ja n 20	Fe b 20	Ma r 20	Ap r 20	Ma y 20	Ju n 20	J ul 2 0	Au g 20	Se p 20	O ct 20	No v 20	De c 20	202 0
22	21	15	13	13	20	2 2	25	21	24	24	19	239
Ja n 21	Fe b 21	Ma r 21										202 1
38	31	19										88
												122 5

**All sites (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)**



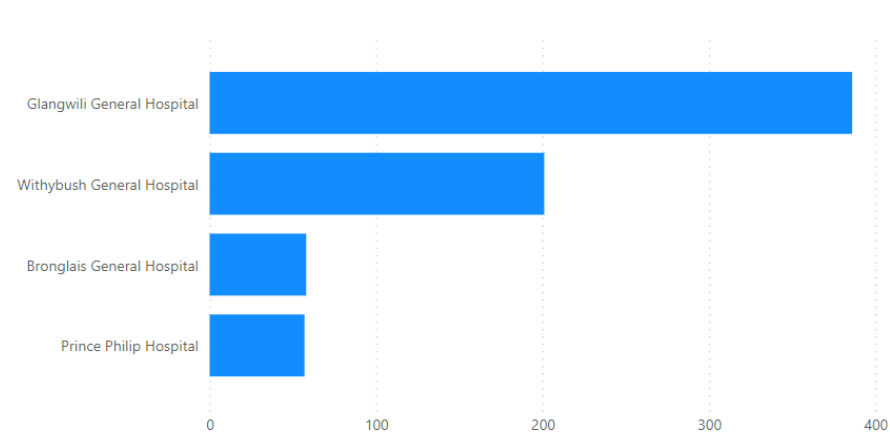
			Ap r 21	Ma y 21	Ju n 21	J ul 2 1	Au g 21	Se p 21	O ct 21	No v 21	De c 21	202 1
			12	20	25	3 4	28	25	34	31	27	236
Ja n 22	Fe b 22	Ma r 22	Ap r 22	Ma y 22	Ju n 22	J ul 2 2	Au g 22	Se p 22	O ct 22	No v 22	De c 22	202 2
19	25	28	21	41	28	3 0	21	19	29	18	22	301
Ja n 23	Fe b 23	Ma r 23	Ap r 23	Ma y 23	Ju n 23	J ul 2 3						202 3
29	13	26	18	28	27	2 4						165
												702

**By Location (1st August 2018 – 31st March 2021)**



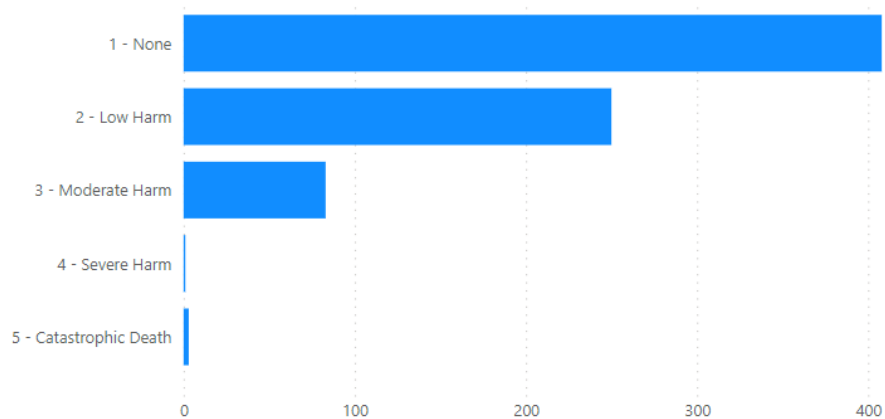
Primary Location	Count
Glangwili General Hospital	389
Withybush General Hospital	205
Bronglais General Hospital	97
Prince Philip Hospital	54

**By Location (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)**



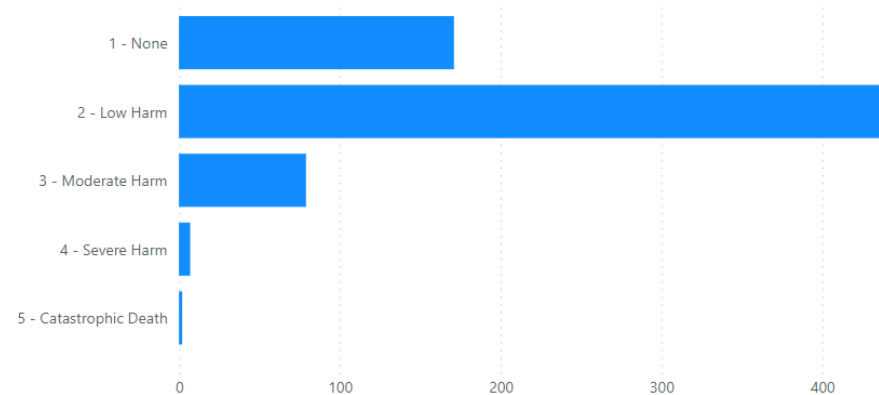
Primary Location	Count
Glangwili General Hospital	386
Withybush General Hospital	201
Bronglais General Hospital	58
Prince Philip Hospital	57

### By Severity/Level (1st August 2018 – 31st March 2021)



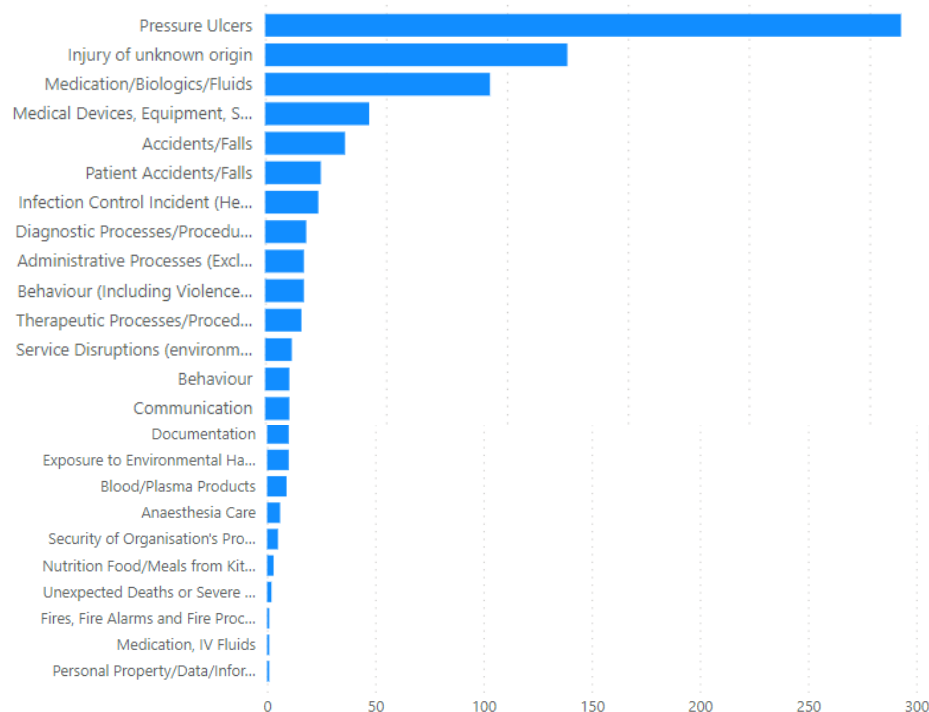
Severity	Count
1 - None	408
2 – Low Harm	250
3 – Moderate Harm	83
4 – Severe Harm	1
5 – Catastrophic Death	5

### By Severity/Level (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)



Severity	Count
1 - None	171
2 – Low Harm	443
3 – Moderate Harm	79
4 – Severe Harm	7
5 – Catastrophic Death	2

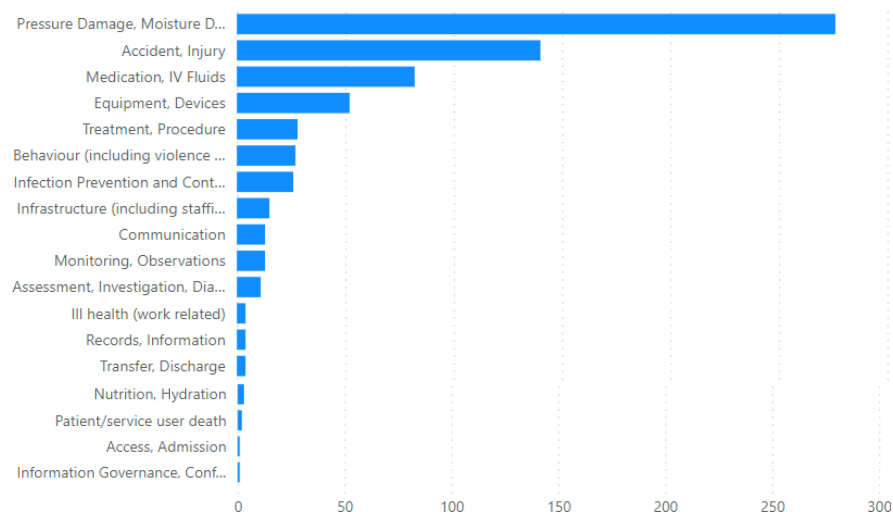
## By Type (1st August 2018 – 31st March 2021)



Diagnostic Processes/Procedures	17
Administrative Processes (Excluding Documentation)	16
Behaviour (Including Violence and Aggression)	16
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	15
Service Disruptions (environment, infrastructure, human resources)	11
Behaviour	10
Communication	10
Documentation	10
Exposure to Environmental Hazards	10
Blood/Plasma products	9
Anaesthesia Care	6
Security of organisations property, data and buildings	5
Nutrition/Meals from kitchen	3
Unexpected death or severe harm	2
Fires, Fire alarms and fire procedures	1
Medication/IV fluids	1
Personal Property/Data/ Information	1

Incident type tier one	Count
Pressure Uclers	263
Injury of know origin	125
Medication/Biologics/Fluids	93
Medical devices. Equipment, supplies	43
Accidents and falls	33
Patient accidents and falls	23
Infection Control Incident (Healthcare Associated Infection)	22

## By Type (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)



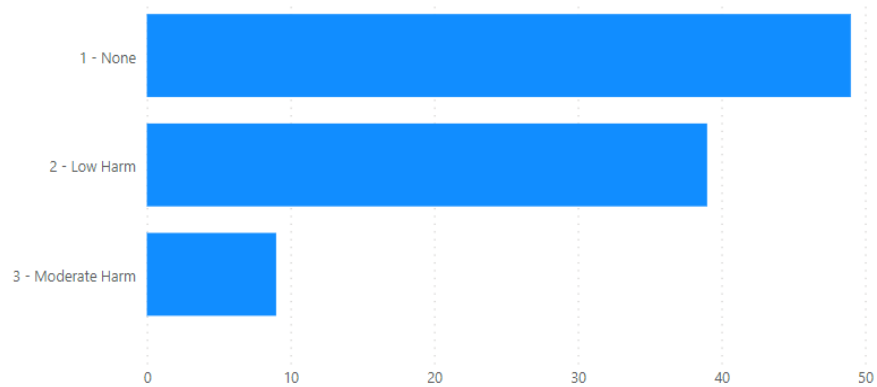
Incident type tier one	Count
Pressure Damage, Moisture Damage	276
Accident injury	140
Medication IV fluids	82
Equipment, Devices	52
Treatment, Procedure	28
Behaviour (including violence and aggression)	27
Infection prevention control	26
Infrastructure (including staffing, facilities, environment)	15
Monitoring & Observation	13
Communication	13
Assessment, investigation, diagnosis	2
Ill Health work related	4
Records, Information	4
Transfer, Discharge	4
Nutrition & hydration	3

Patient service user death	2
Access, Admission	1
Information Governance, Confidentiality	1



## Bronglais Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

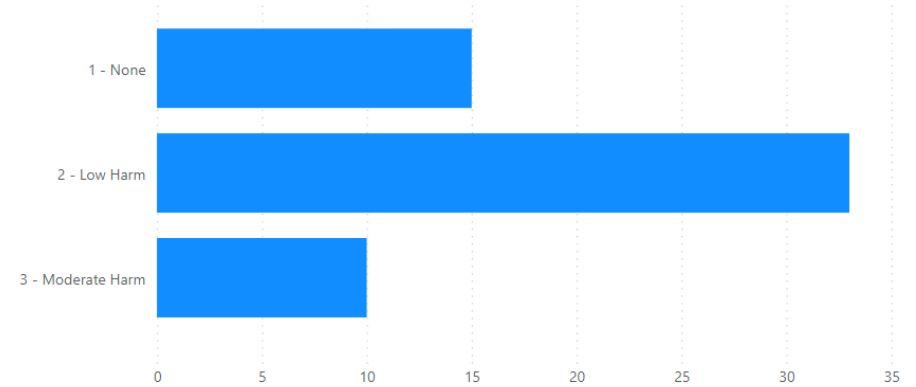
### By Severity/Level



Severity	Count
1 - None	49
2 – Low Harm	39
3 – Moderate Harm	9
4 – Severe Harm	0
5 – Catastrophic Death	0

## Bronglais Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

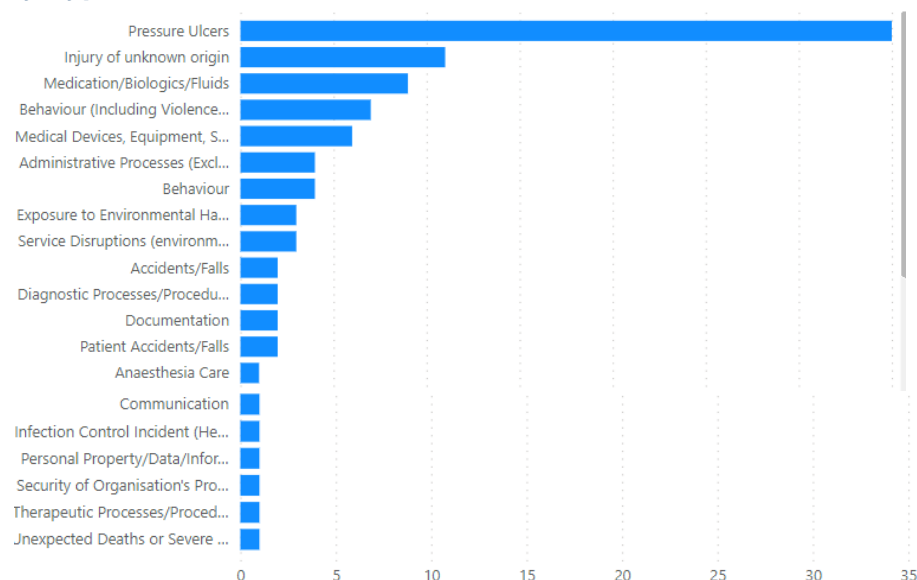
### By Severity/Level



Severity	Count
1 - None	15
2 – Low Harm	33
3 – Moderate Harm	10
4 – Severe Harm	0
5 – Catastrophic Death	0

## Bronglais Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

### By Type

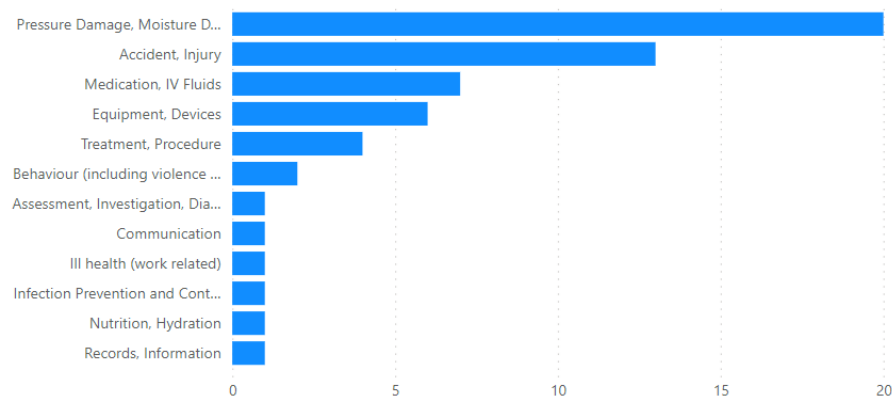


Incident type tier one	Count
Pressure ulcers	35
Injury of know origin	11
Medication/Biologics/Fluids	9
Behaviour including violence & aggression	7
Medical devices. Equipment, supplies	6
Exposure to Environmental Hazards	3
Administrative Processes (Excluding Documentation)	4
Behaviour	4
Service Disruptions (environment, infrastructure, human resources)	3
Accidents & falls	2

Diagnostic processes and procedures	2
Patient accidents and falls	2
Infection control incidents (healthcare associated infection)	1
Personal property/data/information	1
Security of organisations property, data and buildings	1
Therapeutic processes/procedures (except medications/fluids/blood. Plasma products administration)	1
Unexpected death or severe harm	1

## Bronglais Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

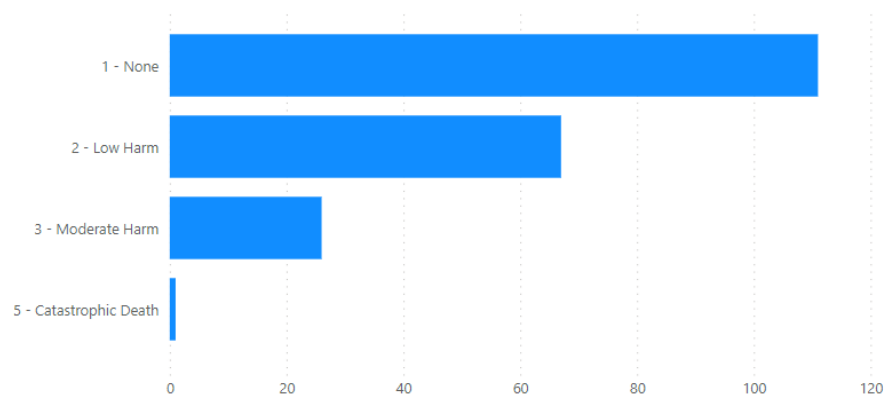
### By Type



Incident type tier one	Count
Pressure Ulcers	20
Accident/Injury	13
Medication IV Fluid	7
Equipment/Devices	6
Treatment/procedure	4
Behaviour (including violence and aggression)	2
Assessment, investigation, diagnosis	1
Communication	1
Ill Health (work related)	1
Infection prevention and control	1
Nutrition , Hydration	1
Records/information	1

## Withybush Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

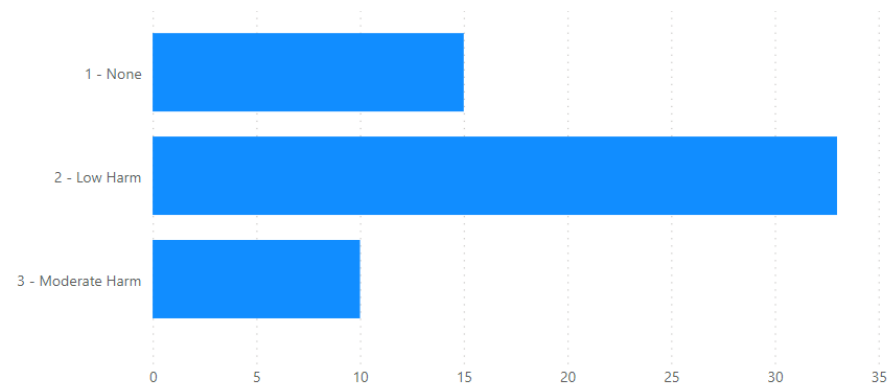
### By Severity/Level



Severity	Count
1 - None	111
2 – Low Harm	67
3 – Moderate Harm	26
4 – Severe Harm	0
5 – Catastrophic Death	1

## Withybush Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

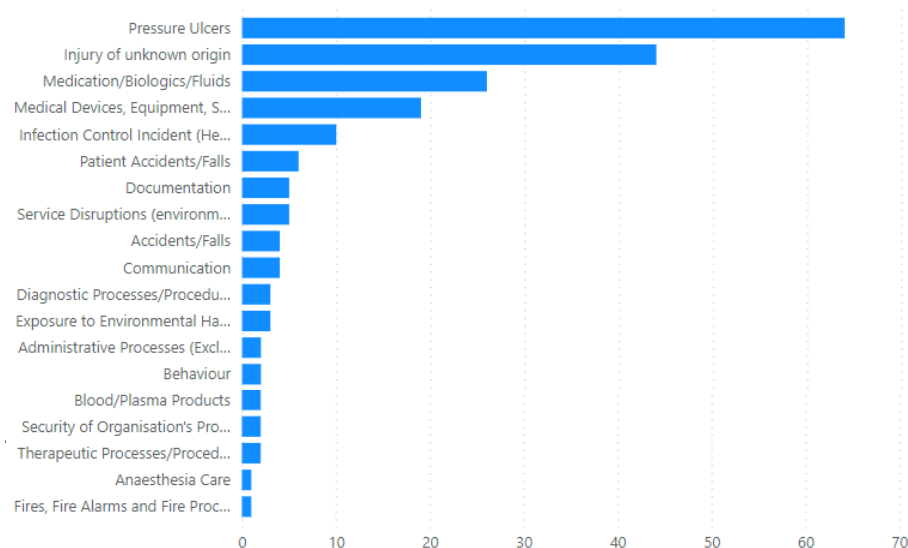
### By Severity/Level



Severity	Count
1 - None	15
2 – Low Harm	33
3 – Moderate Harm	10
4 – Severe Harm	0
5 – Catastrophic Death	0

## Withybush Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

### By Type

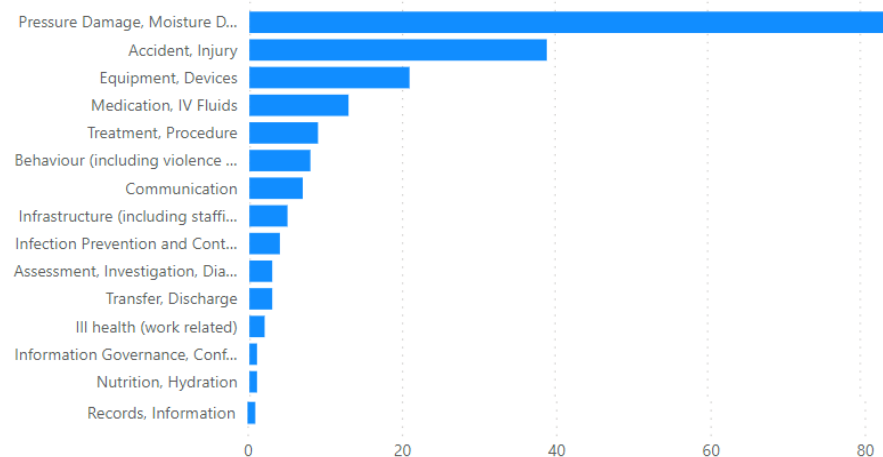


Incident type tier one	Count
Pressure Ulcers	64
Injury of unknow origin	44
Medication/Biologics/Fluid	26
Medical devices. Equipment, supplies	19
Infection Control Incident (Healthcare Associated Infection)	10
Patient accidents/falls	6
Documentation	5
Service disruption (environment, infrastructure, human resources)	5
Accidents/falls	4
Communication	4

Diagnostic process/procedure	3
Exposure to Environmental hazards	3
Administrative Processes (Excluding documentation)	2
Behaviour	2
Blood/plasma products	2
Security of organisations property, data and buildings	2
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	2
Anaesthesia care	1
Fires.Fire alarm and fire procuedures	1

## Withybush Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

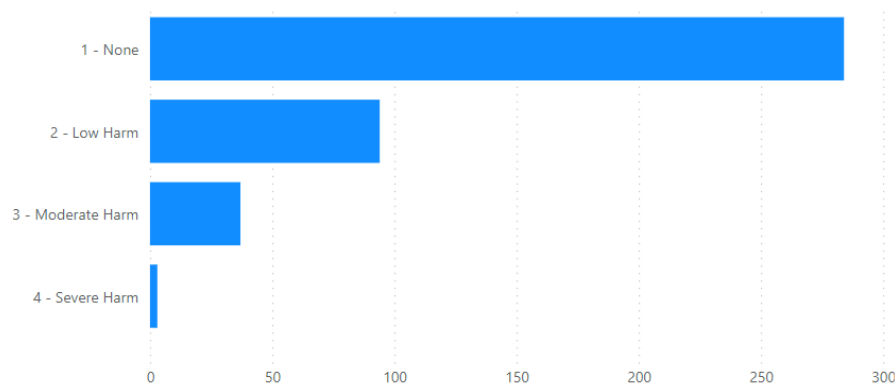
### By Type



Incident type tier one	Count
Pressure Damage, Moisture Damage	84
Accident injury	39
Medication IV fluids	13
Equipment, Devices	21
Treatment, Procedure	9
Behaviour (including violence and aggression)	8
Infection prevention control	4
Infrastructure (including staffing, facilities, environment)	5
Communication	7
Assessment, investigation, diagnosis	3
Ill Health work related	2
Records, Information	1
Transfer, Discharge	2
Nutrition & hydration	1
Information Governance, Confidentiality	1

## Glangwili Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

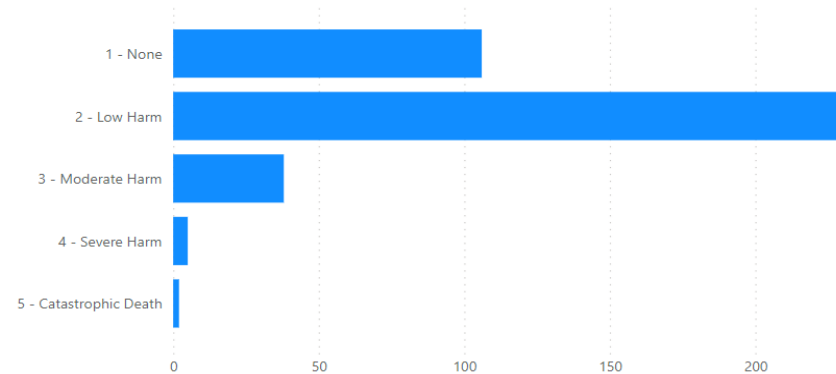
### By Severity/Level



Severity	Count
1 - None	220
2 – Low Harm	130
3 – Moderate Harm	36
4 – Severe Harm	1
5 – Catastrophic Death	2

## Glangwili Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

### By Severity/Level

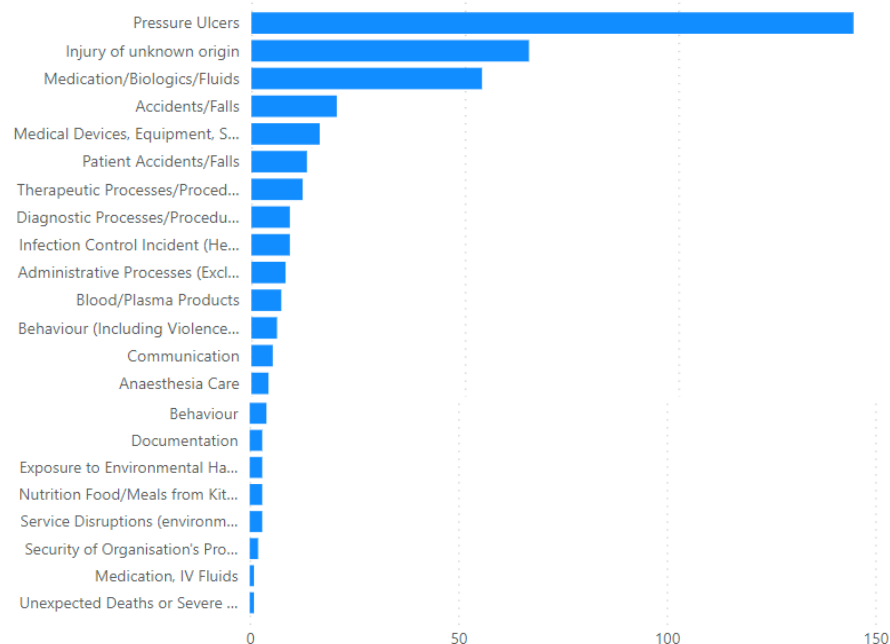


Severity	Count
1 - None	106
2 – Low Harm	235
3 – Moderate Harm	38
4 - Severe Harm	5
5 – Catastrophic Death	2



## Glangwili Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

### By Type

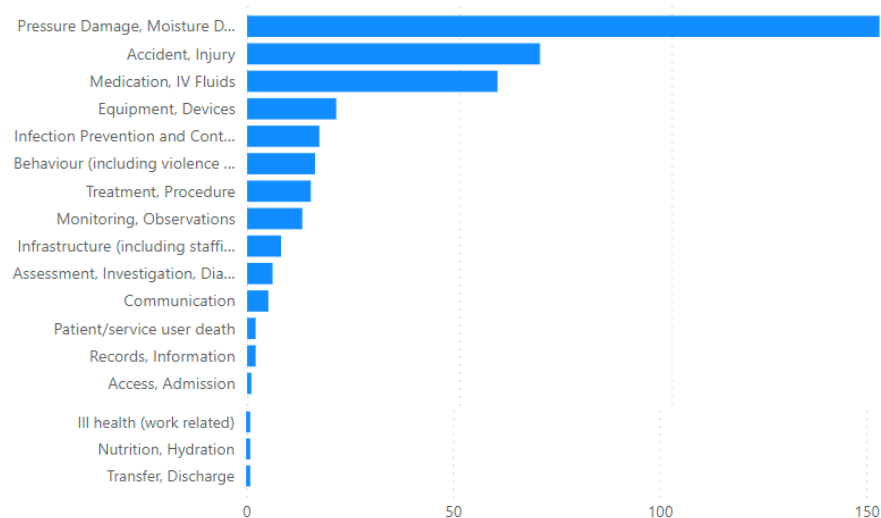


Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	12
Diagnostic process/procedure	9
Infection Control Incident (Healthcare Associated Infection)	9
Administrative Processes (Excluding documentation)	8
Blood/plasma products	7
Behaviour (Including Violence and Aggression)	6
Communication	5
Anaesthesia Care	4
Behaviour	4
Documentation	3
Exposure to environmental hazards	3
Nutrition food/meals from kitchen	3
Service disruption (environment, infrastructure, human resources)	3
Security of Organisations Property & buildings	2
Medication & IV fluids	1
Unexpected deaths or severe harm	1

Incident type tier one	Count
Pressure Ulcers	141
Injury of unknow origin	65
Medication/Biologics/Fluid	54
Accidents/falls	20
Medical devices. Equipment, supplies	16
Patient accidents/falls	13

## Glangwili Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

### By Type

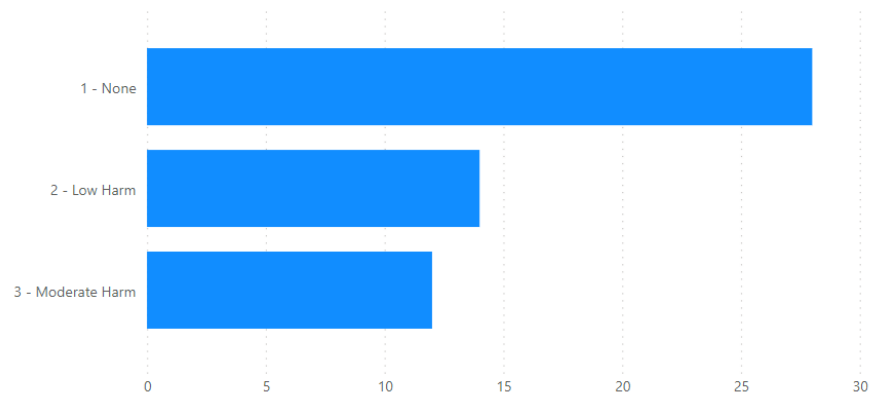


Incident type tier one	Count
Pressure Damage, Moisture Damage	149
Accident injury	69
Medication IV fluids	59
Equipment, Devices	21
Infection prevention control	17
Behaviour (including violence and aggression)	16
Treatment, Procedure	15
Monitoring observation	13
Infrastructure (including staffing, facilities, environment)	8
Assessment, investigation, diagnosis	6
Patient/service user death	2
Records, Information	2

Access admission	1
Ill Health (work related)	1
Nutrition, hydration	1
Transfer discharge	1

## Prince Philip Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

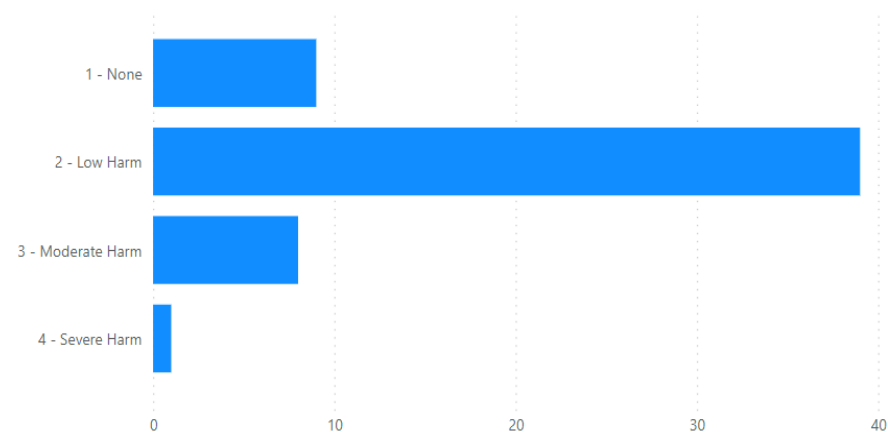
### By Severity/Level



Severity	Count
1 - None	28
2 – Low Harm	14
3 – Moderate Harm	12
4 – Severe Harm	0
5 – Catastrophic Death	0

## Prince Philip Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

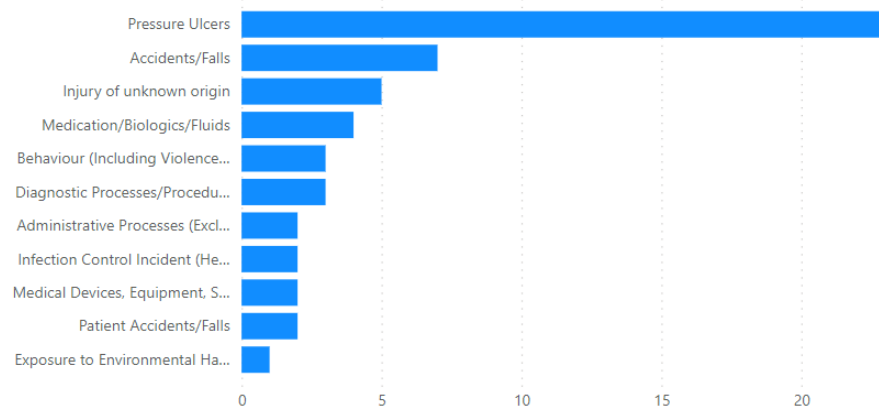
### By Severity/Level



Severity	Count
1 - None	9
2 – Low Harm	39
3 – Moderate Harm	8
4 – Severe Harm	1
5 – Catastrophic Death	0

## Prince Philip Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

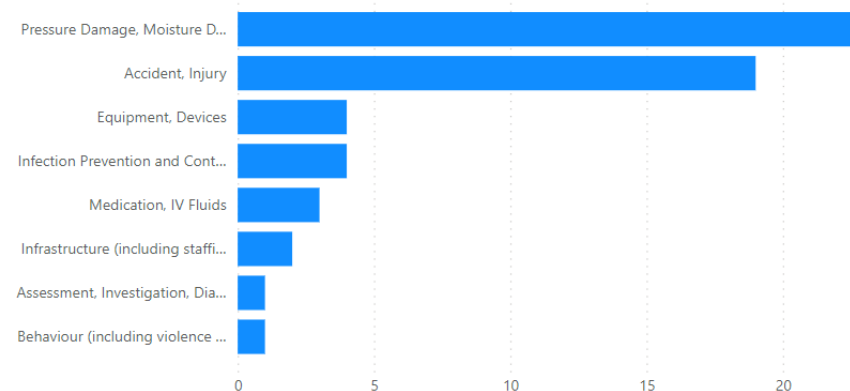
### By Type



Incident type tier one	Count
Pressure Ulcers	23
Accidents/falls	7
Injury of unknow origin	5
Medication/Biologics/Fluid	4
Behaviour (Including Violence and Aggression)	3
Diagnostic process/procedure	3
Administrative Processes (Excluding documentation)	2
Infection Control Incident (Healthcare Associated Infection)	2
Medical devices. Equipment, supplies	2
Patient accidents/falls	2
Exposure to environmental hazards	1

## Prince Philip Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

### By Type



Incident type tier one	Count
Pressure Damage, Moisture Damage	23
Accident injury	19
Equipment, Devices	4
Infection prevention control	4
Medication IV fluids	3
Infrastructure (including staffing, facilities, environment)	2
Assessment, investigation, diagnosis	1
Behaviour (including violence & aggression)	1

## Critical Care Complaints Data Review

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## **Background**

As per the approved Clinical Services Plan methodology, Complaints reported between 1<sup>st</sup> August 2018 and 31<sup>st</sup> July 2023 have been recorded for Withybush Hospital, Glangwili Hospital, Prince Philip Hospital and Bronglais Hospital. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

### **Temporary Service change:**

On 25th July 2022, an operational decision was implemented to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital. From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted/transferred to neighbouring Critical Care units, appropriate to their clinical needs.

This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

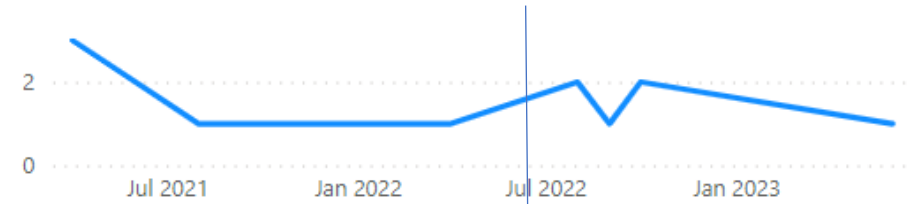
It should be noted that the complaints data is recorded by the patient's treatment code as such there may be complaints data from other services or sites outside of the scope of the clinical services plan in the analysis below.

## Complaints

All sites (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



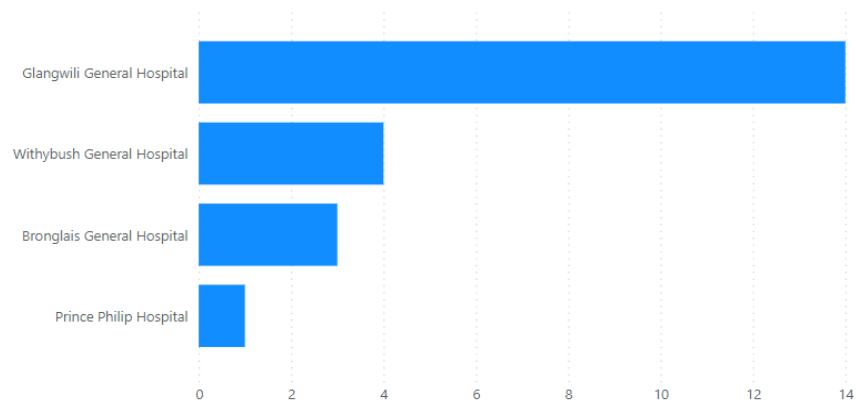
All sites (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)



Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	2018
1	1	0	0	1	1	1	0	1	1	0	0	2
Jan 20	Feb 20	Mar 20	Apr 20	May 19	Jun 20	Jul 20	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
1	1	0	0	2	0	1	2	1	2	1	3	14
Jan 21	Feb 21	Mar 21	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
0	0	0	0	2	0	1	1	0	0	0	0	6
Jan 22	Feb 22	Mar 22	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
0	0	0										0
												22

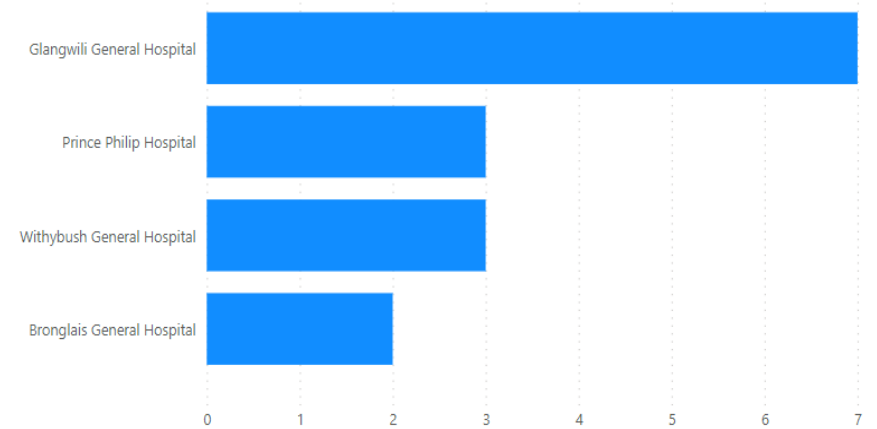
Jan 22	Feb 22	Mar 22	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
1	1	1	3	0	0	0	1	1	0	0	0	5
Jan 23	Feb 23	Mar 23	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
0	0	0	1	0	0	0	2	1	2	0	0	9
Jan 24	Feb 24	Mar 24	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	2023
			0	0	1	0						1
												15

By Location (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



Primary Location	Count
Glangwili General Hospital	14
Prince Philip Hospital	1
Withybush General Hospital	4
Bronglais General Hospital	3

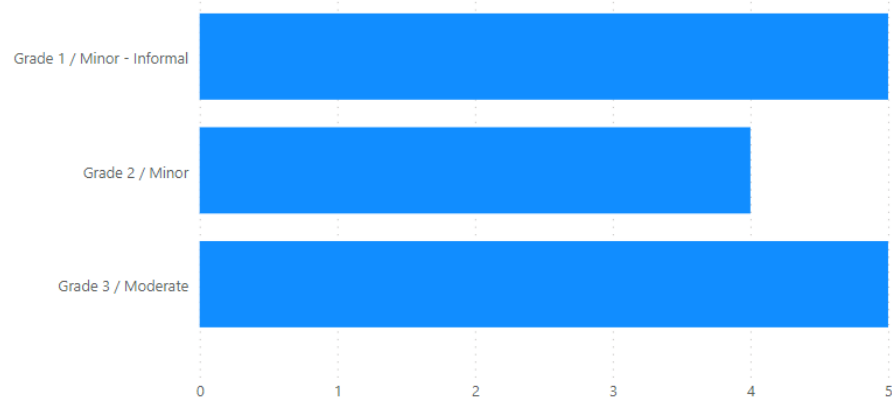
**By Location (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)**



Primary Location	Count
Glangwili General Hospital	7
Prince Philip Hospital	3
Withybush Hospital	3
Bronglais General Hospital	2

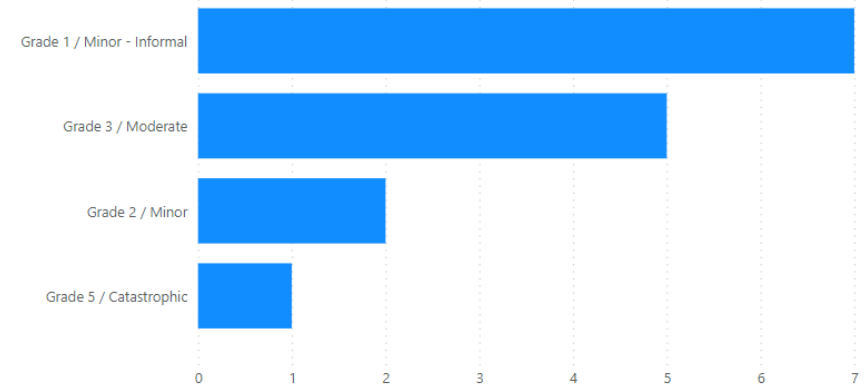
**By Grading (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)**





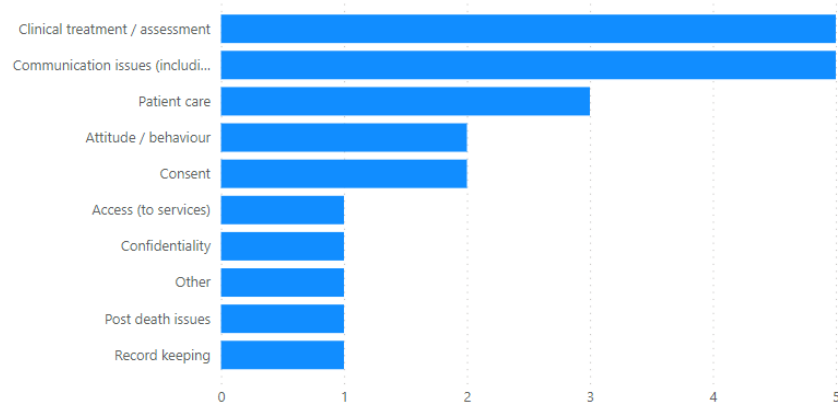
Grade	Count
Grade 1 – Minor - Informal	5
Grade 2 - Minor	4
Grade 3 - Moderate	5
Grade 4 - Major	0
Grade 5 - Catastrophic	0

### By Grading (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)



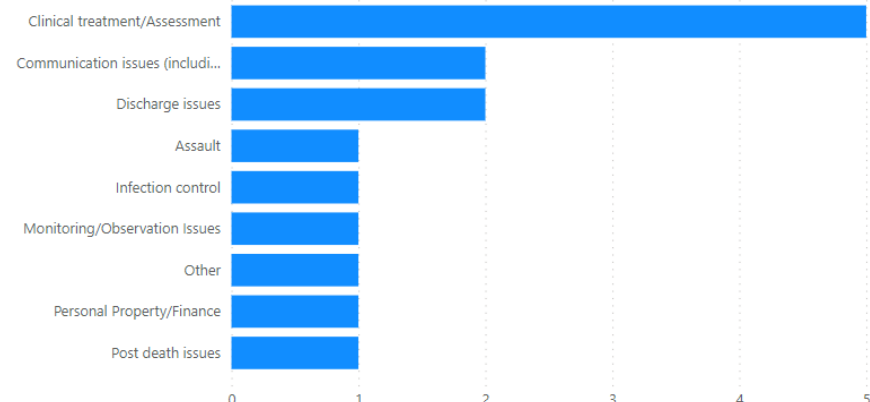
Grade	Count
Grade 1 – Minor - Informal	7
Grade 2 - Minor	2
Grade 3 - Moderate	5
Grade 4 - Major	0
Grade 5 - Catastrophic	1

### By Type (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



Subject (primary)	Count
Clinical treatment / assessment	5
Communication issues (including language)	5
Patient care	3
Attitude / behaviour	2
Consent	2
Access (to services)	1
Confidentiality	1
Other	1
Post death issues	1
Record keeping	1

### By Type (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)



Subject (primary)	Count
Clinical treatment/Assessment	5
Communication issues (including language)	2
Discharge issues	2
Assault	1
Infection control	1
Monitoring/Observation issues	1
Other	1
Personal property/Finance	1
Post death issues	1

## Bronglais Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

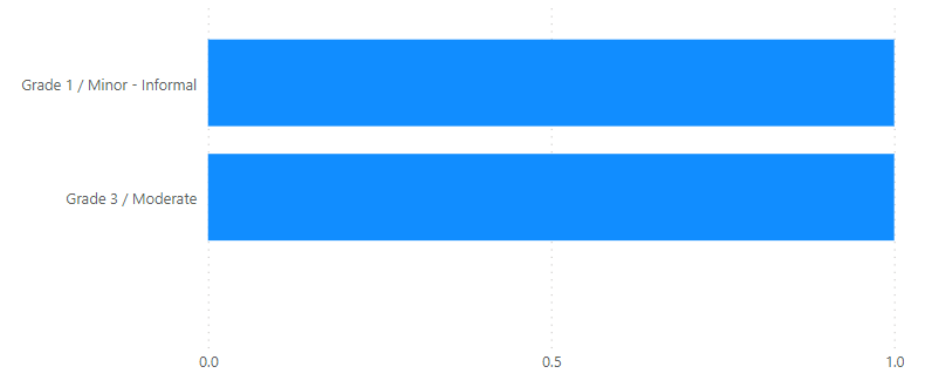
### By Grading



Grade	Count
Grade 1 – Minor - Informal	0
Grade 2 - Minor	1
Grade 3 - Moderate	2
Grade 4 - Major	0
Grade 5 - Catastrophic	0

## Bronglais Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

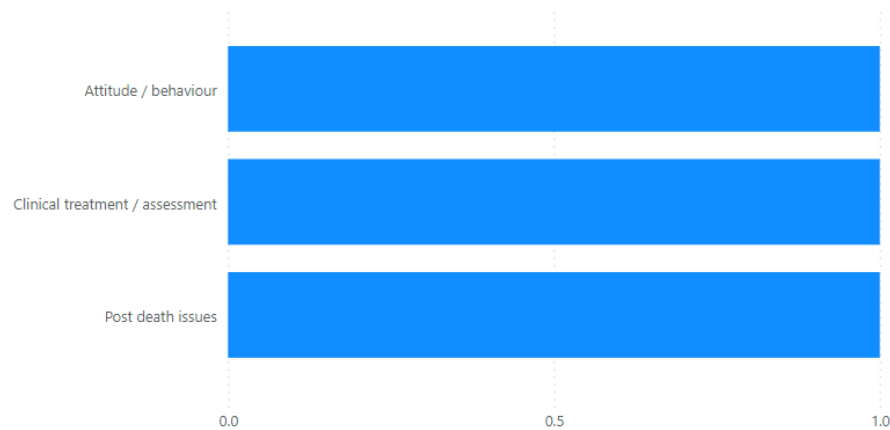
### By Grading



Grade	Count
Grade 1 – Minor - Informal	1
Grade 2 - Minor	0
Grade 3 - Moderate	1
Grade 4 - Major	0
Grade 5 - Catastrophic	0

## Bronglais Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

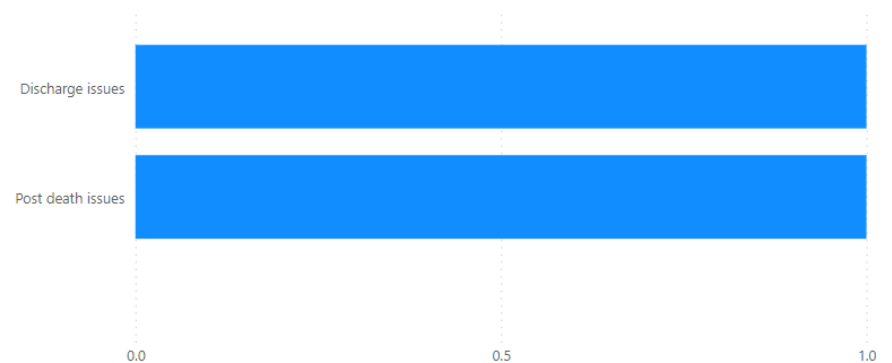
### By Type



Subject (primary)	Count
Attitude/ behaviour	1
Clinical Treatment / assessment	1
Post death treatment	1

## Bronglais Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

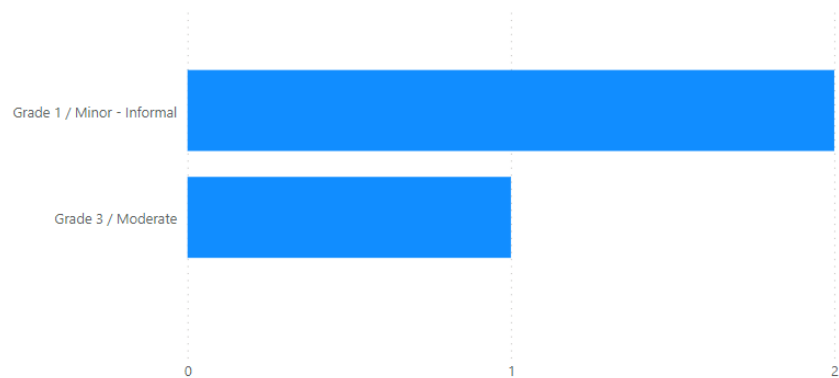
### By Type



Subject (Primary)	Count
Discharge issues	1
Post death issues	1

## Withybush Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

### By Grading



Grade	Count
Grade 1 – Minor - Informal	0
Grade 2 - Minor	2
Grade 3 - Moderate	1
Grade 4 - Major	0
Grade 5 - Catastrophic	0

## Withybush Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

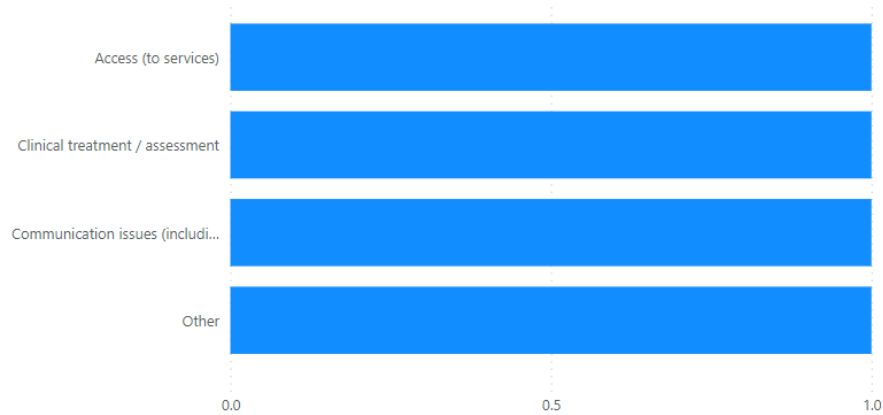
### By Grading



Grade	Count
Grade 1 – Minor - Informal	0
Grade 2 - Minor	0
Grade 3 - Moderate	3
Grade 4 – Major	0
Grade 5 - Catastrophic	0

## Withybush Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

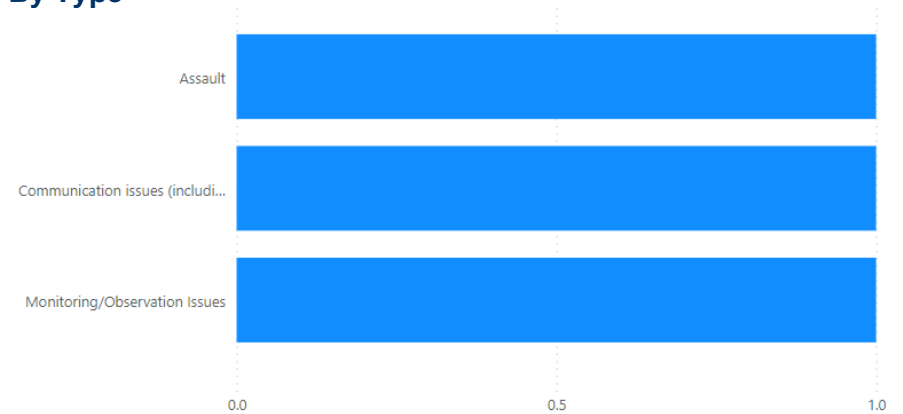
### By Type



Subject (primary)	Count
Access to services	1
Clinical Treatment/Assessment	1
Communication issues inc Language	1
Other	1

## Withybush Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

### By Type



Subject (primary)	Count
Assault	1
Communication issues including language	1
Monitoring & Observation issues	1

## Glangwili Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

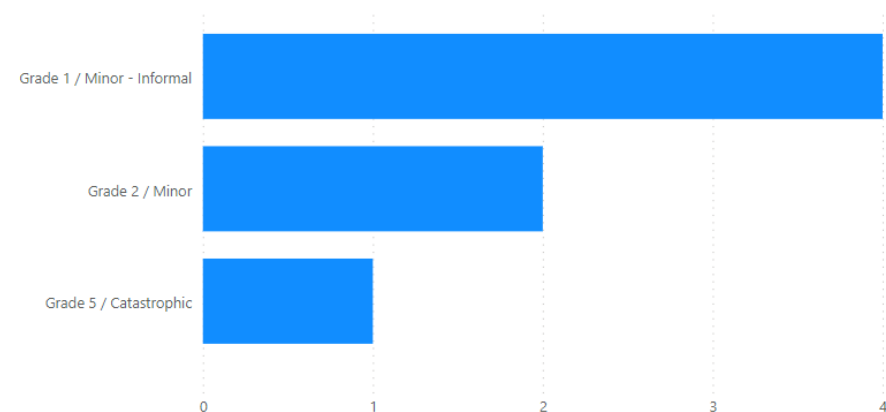
### By Grading



Grade	Count
Grade 1 – Minor - Informal	2
Grade 2 - Minor	3
Grade 3 - Moderate	2
Grade 4 - Major	0
Grade 5 - Catastrophic	0

## Glangwili Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

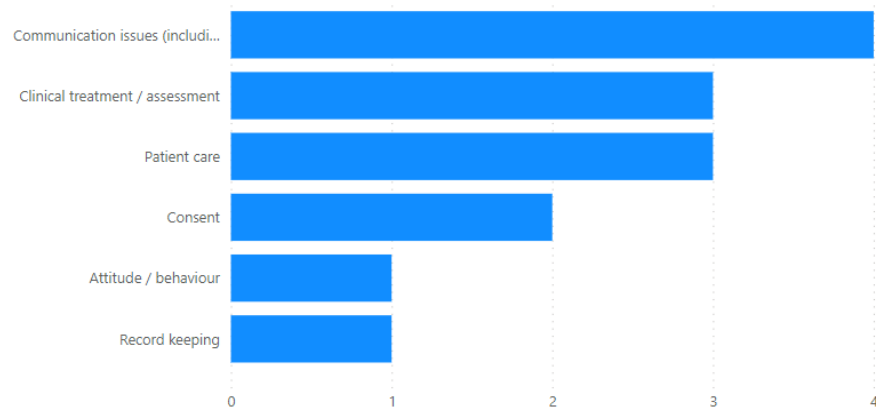
### By Grading



Grade	Count
Grade 1 – Minor - Informal	4
Grade 2 - Minor	2
Grade 3 - Moderate	0
Grade 4 - Major	0
Grade 5 - Catastrophic	1

## Glangwili Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

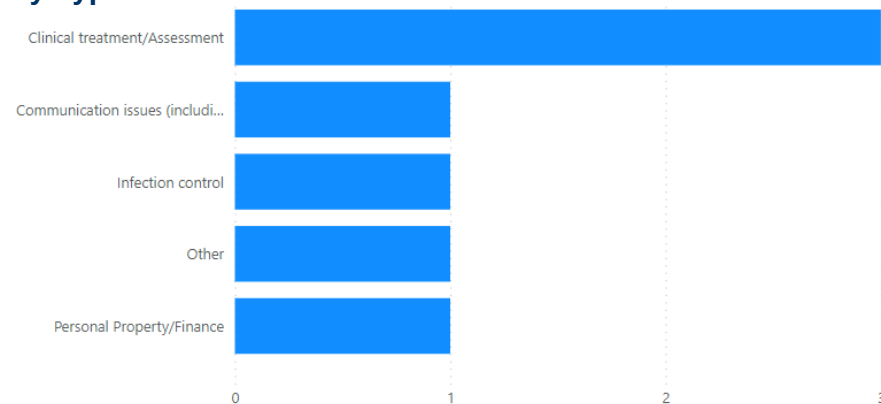
### By Type



Subject (primary)	Count
Communication issues (including language)	4
Clinical treatment/assessment	3
Patient Care	3
Consent	2
Attitude / behaviour	1
Record Keeping	1

## Glangwili Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

### By Type

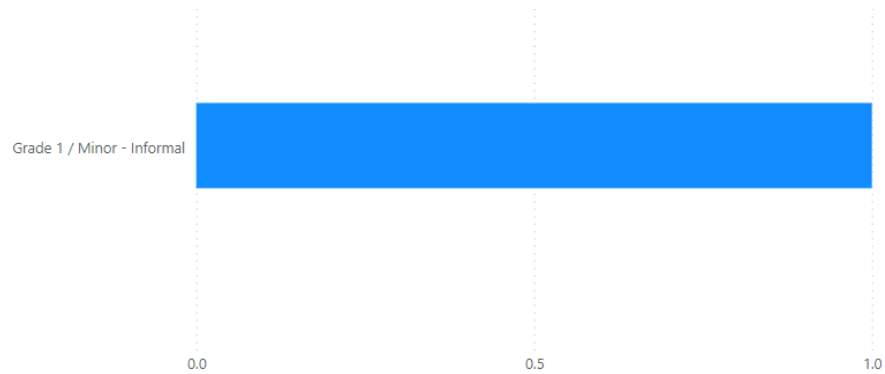


Subject (primary)	Count
Clinical treatment / assessment	3
Communication issues (including language)	1
Infection control	1
Other	1
Personal Property/Finance	1



## Prince Philip Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

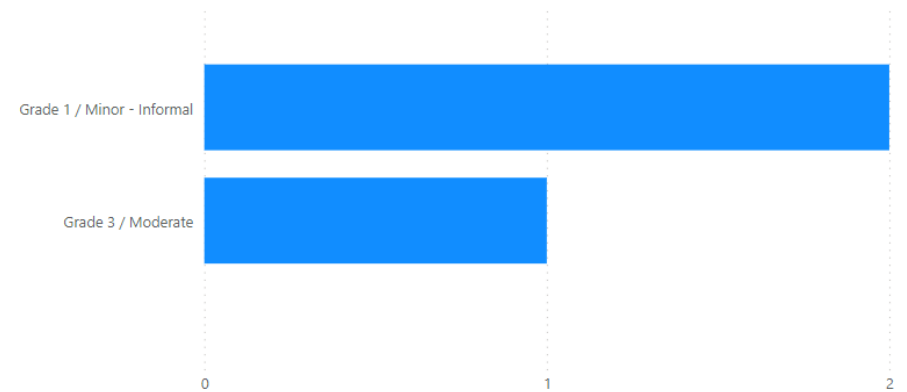
### By Grading



Grade	Count
Grade 1 – Minor - Informal	1
Grade 2 - Minor	0
Grade 3 - Moderate	0
Grade 4 – Major	0
Grade 5 - Catastrophic	0

## Prince Philip Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

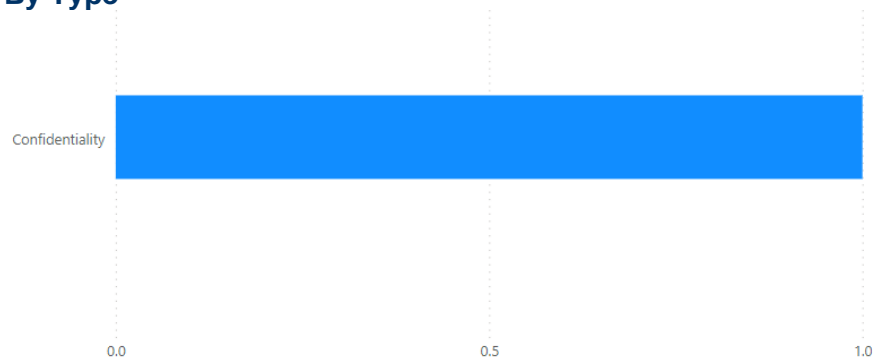
### By Grading



Grade	Count
Grade 1 – Minor - Informal	2
Grade 2 - Minor	0
Grade 3 - Moderate	3
Grade 4 - Major	0
Grade 5 - Catastrophic	0

### Prince Philip Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

#### By Type



Subject (primary)	Count
Confidentiality	1

### Prince Philip Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

#### By Type



Subject (primary)	Count
Clinical treatment / assessment	2
Discharge issues	1

## Critical Care Patient Experience Data Review

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## Background

As per the approved Clinical Services Plan methodology, Patient Experience data captured has been included for Critical Care Services at Bronglais Hospital, Withybush Hospital, Glangwili Hospital and Prince Philip Hospital.

Due to data formatting across the current Civica system and historical records, data has only been analysed from 1<sup>st</sup> April 2021 to 31<sup>st</sup> July 2023. Historical records, pre-April 2021, cannot be assigned to particular Services in their entirety and so the methodology was updated to only analyse the current Civica system data.

Data that has been analysed includes All Wales Patient Experience data, Friends and Family Test data and Compliments data. The Big Thank You has been discarded in its entirety as the formatting of the data follows the same structure as pre 2021 data and therefore cannot be assigned to a particular service.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system. Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of Patient Experiences simpler and therefore this may account for the rise in Patient Experience reports seen in April 2021.

The thematic analysis was undertaken using Microsoft Copilot and has been used to provide a summary of themes per Service per year based on the patient feedback received.

## Service Changes

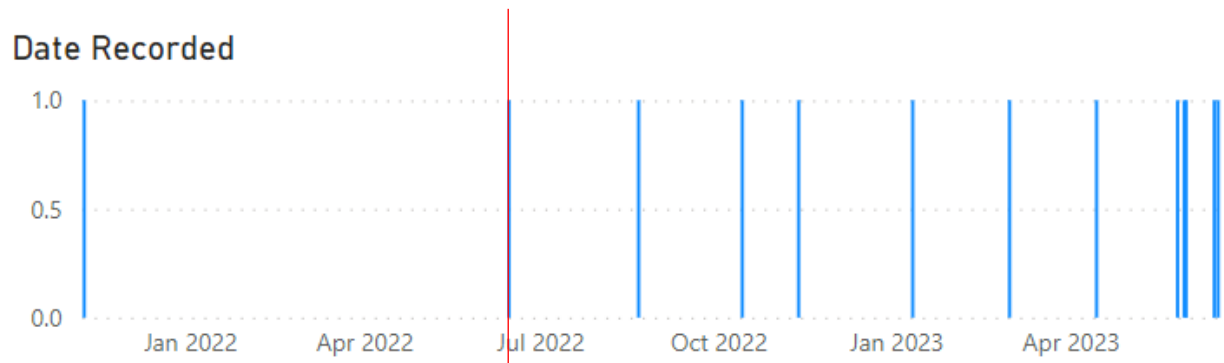
The temporary service change in July 2022 to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital. From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted or transferred to neighbouring Critical Care units, appropriate to their clinical needs.

### All Wales Experience – Health Board Survey (1<sup>st</sup> April 2021 to 31<sup>st</sup> July 2023)

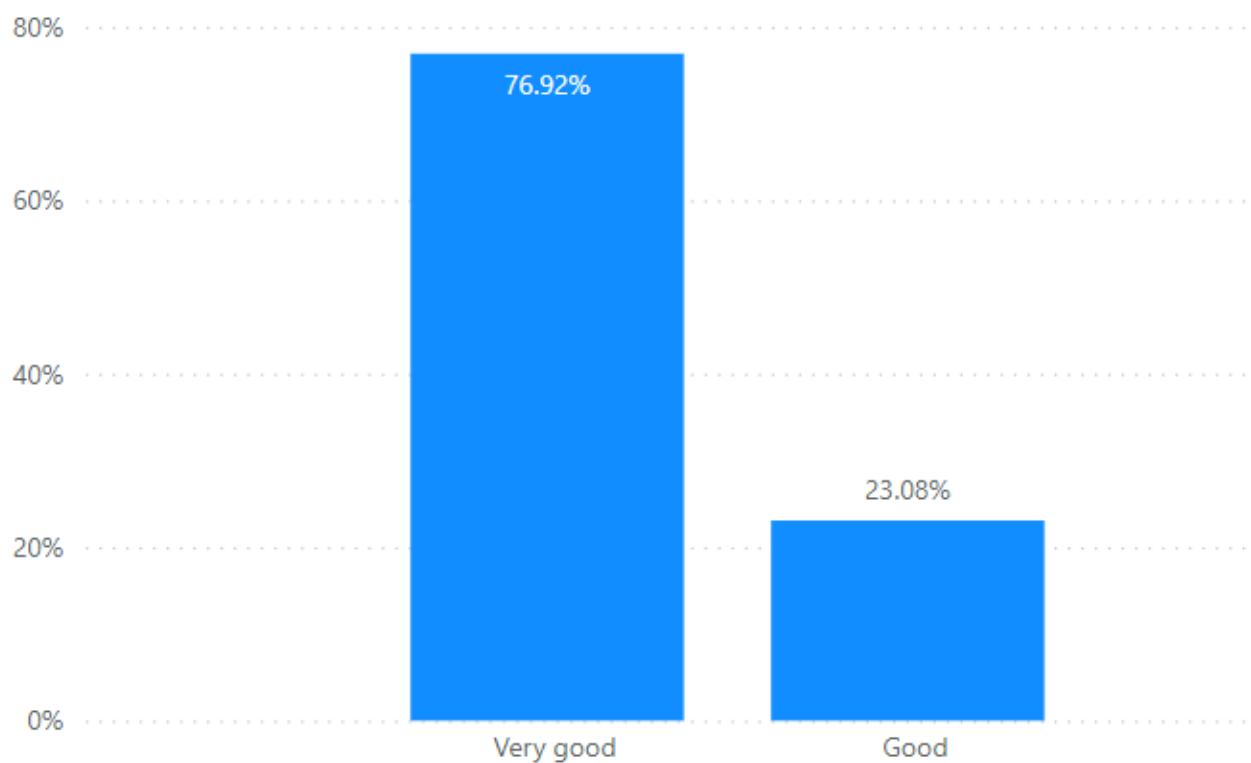
No data available for Critical Care from the All Wales Experience.

## Patient Experience

## Friends and Family Test (1<sup>st</sup> April 2021 to 31<sup>st</sup> July 2023)



During this visit overall, how was your experience in this department?



## **Theme**

The themes arising are that staff delivered kind and professional care and provided comfort to the patients while communicating well about the care they received.

## **Patient Experience**

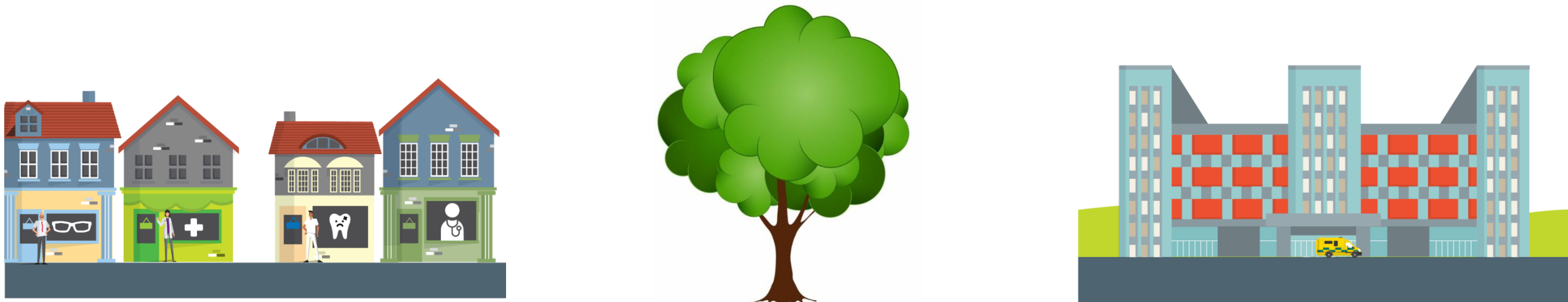
### **Compliments (1<sup>st</sup> April 2021 to 31<sup>st</sup> July 2023)**

No data available for Critical Care.

# Workforce Data

Clinical Services Plan : Activity Modelling Workstream

CRITICAL CARE



## Glossary of terms

Term/Acronym	Definition
ESR	Electronic Staff Record – This is the National recording system within the NHS that houses all staff information. The majority of the workforce information contained within this report will have been extracted from the reporting functionality within the system.
WTE	Whole Time Equivalent – For the medical workforce 1WTE equates to 10 sessions or above. For all other staff working in the NHS under AfC terms and conditions 1WTE equates to a full time position of 37.5 hour working week.
AfC	Agenda for Change is the current NHS grading and pay system for NHS staff across Wales, with the exception of doctors, dentists, apprentices and some very senior managers.
Cost code	The Health Board Budget is structured to take into account all areas that incur a cost and is therefore broken down into different directorate areas. The cost code is the lowest level of organisational hierarchy which would denote the department/service/ward e.g. Ward 1
Staff group	There are 9 staff groups to which workforce will belong, dependent on their role. These are: Additional Professional Technical & Scientific; Additional Clinical Services; Administrative & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists; Medical & Dental; Nursing & Midwifery Registered and Students
TRAC	NHS Recruitment system
SLE	Single Lead Employment model – Since 2019, all Junior doctors are now under an SLE contract and co-located within NHS Wales Shared Services Partnership (NWSSP) ESR data to allow doctors to rotate across health boards easily.



## Workforce Data Methodology overview

As part of the Activity Modelling workstream of the Clinical Services Plan the Strategic Workforce Planning team has provided the following report to assist the Workforce picture for the issues paper.

For the 9 Service areas noted, it is agreed that the Workforce data supplied will be based on the staffing consisted within the defined cost codes provided for each area. Where needed, additional information will be discussed with Service Managers as part of the current Task & Finish groups for each service.

As the scope of the project is to look at potential configuration changes for specific services, the workforce supporting the wider pathway will not be included within the data.

The data will focus on the clinical roles within the services i.e. Medical and Nursing workforce, but where available all professional group data from the cost codes will be presented.

To ensure any interdependencies are highlighted, any known workforce risks for the service will be included.

On the following pages the supplied cost codes for the service area are noted along with the intended outputs from each data set.

Due to the complexity of the workforce breakdown of some cost codes which can cover a number of service areas, where we may have not been able to disaggregate the specific workforce aligned to the service. Where these issues are raised within the data, this has been noted within the information provided.

## Workforce Data Sources and outputs

Workforce Area	Data Source	Output
Current Workforce	ESR Staff In Post for: 31 <sup>st</sup> July 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the service areas based on cost codes supplied. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area). Where possible this will also include details of any Temporary Workforce utilised.
Workforce Risks	Risk Register / Datix: 31 <sup>st</sup> August 2023	Information on Current Service specific Workforce risks and any known interdependent service risks associated.
Historic Workforce Trend	ESR Staff in Post for 1 <sup>st</sup> April 2018, 1 <sup>st</sup> April 2019, 1 <sup>st</sup> April 2020, 1 <sup>st</sup> April 2021, 1 <sup>st</sup> April 2022, 1 <sup>st</sup> April 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the 9 service areas based on cost codes supplied for the period April 2018 to 2023. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area).
Starters & Leavers	ESR Staff Movements Yearly data for 1 <sup>st</sup> April to 31 <sup>st</sup> March for each year	Table/Graph denoting number of Starters and Leavers across each of the service areas. As above, where possible additional information will be provided for role and location however we are aware for leavers some of this data is not available within ESR.
Recruitment Issues	TRAC / Recruitment Team	Information in table or narrative format detailing any known targeted campaign activity for each of the service areas across the time period 2018– 2023. Additional data were available on volume of vacancies advertised in the last 12 months for each service.

# Critical Care Workforce Overview

## 31<sup>st</sup> July 2023

## Critical Care Workforce: Medical Workforce

Location / Site	Consultant	SAS	Trainees	Vacancies	Additional Information
Glangwili & Prince Philip General Hospital	<b>YES</b>  5 Substantive 1 Locum	<b>YES</b>  Rota covered by additional hours	<b>YES</b>  From CT2 to ST4 participate in 24/7 rots in GGH ICU. ST6 in addition	3WTE Consultant 3WTE SAS 2WTE FTC	Funded for 9 Consultants for 24 hour coverage and 2 SAS doctors. All staff, bar 1 Consultant, have both Theatre and Critical Care in their job plans. A ST6 Intensive Care Medicine Trainee works exclusively in ICU.
Withybush General Hospital	<b>YES</b>  5 Substantive	<b>YES</b>  8	<b>NO</b>	No Vacancies	All have Theatre and Critical Care in job plans.
Bronglais General Hospital	<b>YES</b>  Consultant led service	<b>NO</b>	<b>NO</b>	1WTE Consultant	Consultant led service - Flexible Theatre and Critical Care in Job plans.

The above table shows the Medical workforce covering critical care across all 4 sites. The medical workforce sit within a combined theatres and critical care budget and support critical care on a rota basis across each site. There is an ongoing vacancy challenge for consultants with a critical care interest within Carmarthenshire.

## Critical Care Workforce: Cost codes 0053, 0060, 0457 & 0701 (as of 31<sup>st</sup> July 2023)

Staff Group	Role	Location/Site				Grand Total
		Bronglais General Hospital	Glangwili General Hospital	Prince Philip Hospital	Withybush General Hospital	
Additional Clinical Services	Assistant Practitioner Nursing	1	1	1	0.6	3.6
	Healthcare Assistant - Band 3	1				1
	Health Care Support Worker - Band 2	2.84	5.54	1	2.8	12.2
Additional Clinical Services Total		4.84	6.54	2	3.4	16.8
Administrative and Clerical	ICNARC Data Clerk	1	1.4		0.4	2.8
	Project Support Officer		1			1
	Ward Clerk		2.4	0.5	0.5	3.4
Administrative and Clerical Total		1	4.8	0.5	0.9	7.2
Nursing and Midwifery Registered	Senior Sister	1	3.8	1.2	2	8
	Charge Nurse	9.3	18.6	4	7.4	39.3
	Staff Nurse	5.2	33.9	14.2	23.1	76.4
Nursing and Midwifery Registered Total		15.5	56.3	19.4	32.5	123.7
TOTAL		21.34	67.7	21.9	36.8	147.7

The table above shows the workforce within Critical Care by role and location as of 31<sup>st</sup> July 2023.

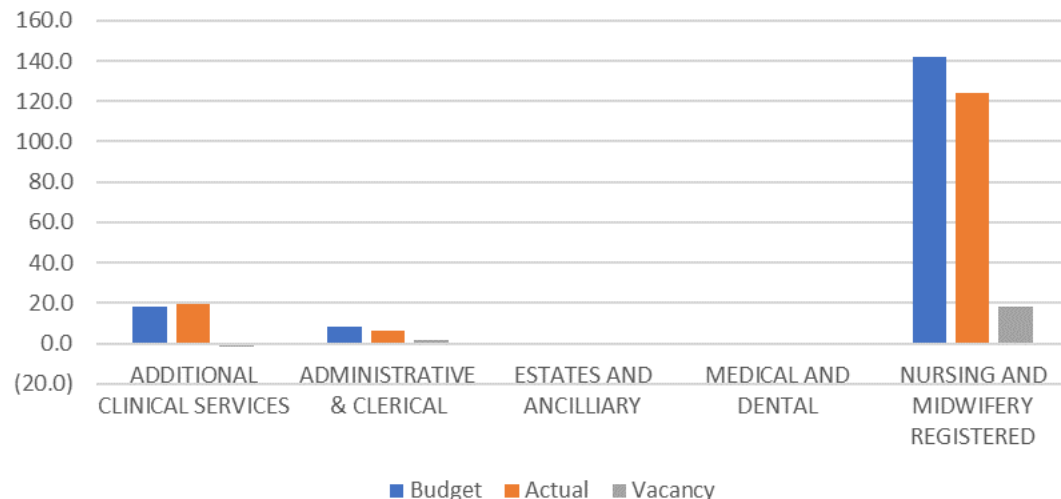
## Critical Care Workforce continued (as of 31<sup>st</sup> July 2023)

Staff Group	Budget	Actual	Vacancy
<b>ADDITIONAL CLINICAL SERVICES</b>	<b>18.5</b>	<b>19.8</b>	<b>(1.3)</b>
<b>ADMINISTRATIVE &amp; CLERICAL</b>	<b>8.1</b>	<b>6.2</b>	<b>1.9</b>
<b>ESTATES AND ANCILLIARY</b>	<b>0.0</b>		<b>0.0</b>
<b>MEDICAL AND DENTAL</b>	<b>0.0</b>		<b>0.0</b>
<b>NURSING AND MIDWIFERY REGISTERED</b>	<b>142.1</b>	<b>123.8</b>	<b>18.3</b>
<b>Grand Total</b>	<b>168.7</b>	<b>149.9</b>	<b>18.8</b>

The table and graph show the Budget, Actual workforce WTE in post and the vacancies within Critical Care as of 31<sup>st</sup> July 2023.

At this time there was a total of 18.8WTE vacancies within the service with the majority within the Nursing workforce, 18.3WTE.

Budget overview as of 31st July 2023



The budget for the medical workforce sits across a number of different cost codes within the health board. The support for critical care is undertaken from these centralised medical workforce budgets as noted on slide 6.

During this period an additional 41.9WTE of temporary staffing was utilised. The majority (19.93WTE) was through Agency usage with the remainder utilising Bank and overtime.

## Workforce Risks

The below Workforce themed risks appeared on Datix (as of 31<sup>st</sup> August 2023).

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Measures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1363	Scheduled Care: Critical Care	<p>There is a risk inability to support a safe roster to maintain safe Consultant Anaesthetic cover of Critical care provision across PPH and GGH.</p> <p>This is caused by Vacancies and long-term sickness across Consultant cadre in Carmarthenshire Anaesthetics. The current roster is not sustainable as is impacting on wellbeing of remaining Consultant body.</p> <p>This will lead to an impact/affect on Timely and appropriate supervision and decision making of critically ill patients. Potential clinical delay resulting in deterioration of patient care. Impact on wellbeing of remaining consultants who are already working to full capacity. There is no capacity to support further emergent consultant sickness which could result from work related pressures.</p> <p>Risk location, Glangwili General Hospital, Prince Philip Hospital.</p>	Recruitment & retention, rota sustainability, health & wellbeing	<p>Adverts out for Consultant vacancies</p> <p>Current staff backfill</p> <p>Requests with Agency for Consultant cover</p>	9	20	↓		Medical
1374	Scheduled Care: Critical Care	<p>There is a risk of inability to support a sustained roster to maintain safe Consultant Anaesthetic cover of Anaesthetics and Critical Care provision in BGH</p> <p>This is caused by vacancies across the Consultant cadre in BGH Anaesthetics. There is funding for 11 Consultant Anaesthetists, (146.5 sessions) with current substantive of group of 8 (90.75 sessions) + 2 Locum Consultant (23 sessions). There is a short fall of 30.75 sessions, which have been recurrently out to advert.</p> <p>This will lead to an impact/affect on the absence of adequate anaesthetic cover, there are limited options to backfill for emergent leave, which after assuring safe cover for critical care and emergency theatre would lead to cancellation of elective surgery.</p> <p>Risk location, Bronglais General Hospital.</p>	Roster sustainability, Recruitment issues, locum sessions.	<p>Current staff backfill - Locum x 2, existing staff supporting as additional sessions, and Medical Bank.</p> <p>Staff from other sites picking up occasional shifts.</p> <p>Requests with MEDACs agency to support vacancies.</p> <p>Continue to work with MEDACs in support of temporary backfill whilst working towards sustained recruitment.</p>	9	12	↓		Medical

## Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Measures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1663	Scheduled Care: Critical Care	<p>There is a risk of patients not receiving appropriate care due to insufficient skill mix in ITU BGH and lack of senior staff.</p> <p>This is caused by staff being off on long-term sick, maternity leave, Band 5 vacancies and onboarding.</p> <p>This will lead to an impact/affect on senior support on shift to take charge of the unit. Resulting in a lack of experienced staff to support junior members of the team. This may have an impact on the quality of patient care and safety of the unit.</p> <p>This may affect patient flow due to no nurse in charge.</p> <p>This may also affect the other ITUs within the HB as they will provide senior support when able.</p> <p>This will have an effect on the Band 7 Senior sister workload whilst managing the roster/covering clinically.</p> <p>Junior members of the team will feel increased pressure due to the possibility of less support on a shift.</p> <p>The band 6 Sisters currently in work will feel pressure to cover extra shifts and may become overworked.</p> <p>Risk location, Bronglais General Hospital.</p>	Vacancies, Long-term sickness/absences	<p>Band 7 Sisters covering deficits.</p> <p>Band 6 Sisters from ITU GGH have covered night shifts.</p> <p>Block booked agency nurses.</p> <p>Early escalation to TNS agency</p> <p>Consultants covering the unit made aware when there are deficits.</p> <p>Site also made aware.</p> <p>Daily review of off duty.</p> <p>Appointed Band 6 secondment</p> <p>Appropriate staff sickness management e.g. regular contact whilst off, return to work interviews, Occupational health etc</p> <p>Senior nurses can provide cover when necessary</p>	8				Nursing



# Critical Care Workforce Overview

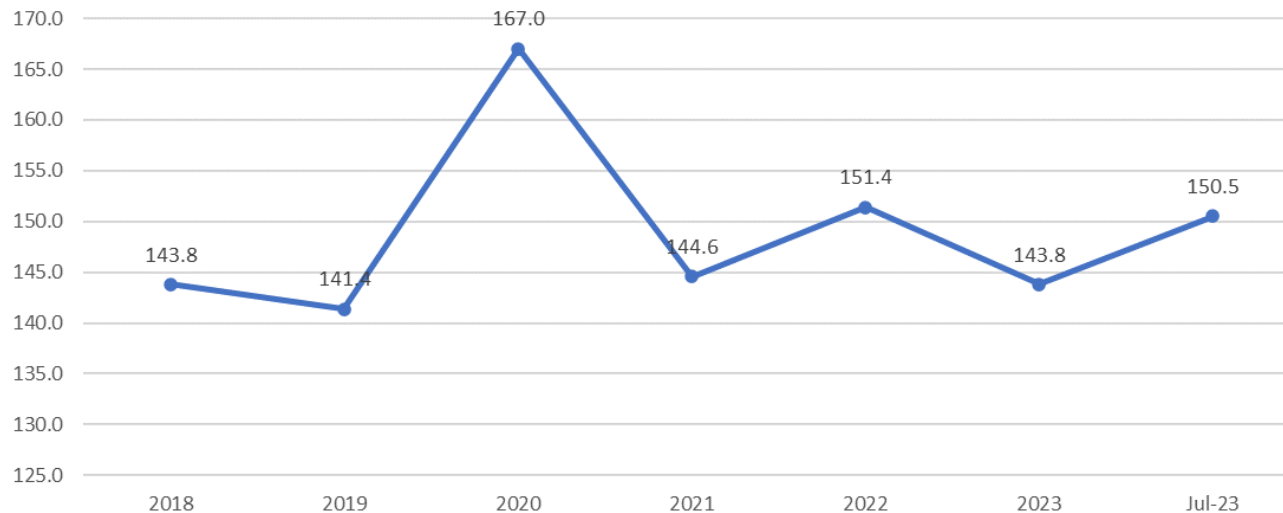
## Historic picture

### April 2018 – April 2023

## Historic Workforce

The data below shows a historic picture of the ESR Staff in post for the Critical Care cost codes as at 1<sup>st</sup> April each year.

Critical Care Cost codes	2018	2019	2020	2021	2022	2023	Jul-23
Additional Clinical Services	10.4	9.3	22.7	12.2	14.2	18.1	19.4
Administrative and Clerical	6.0	6.0	7.2	6.5	8.0	6.3	7.2
Nursing and Midwifery Registered	127.4	126.0	137.1	125.9	129.2	119.4	123.8
<b>TOTAL WTE</b>	<b>143.8</b>	<b>141.4</b>	<b>167.0</b>	<b>144.6</b>	<b>151.4</b>	<b>143.8</b>	<b>150.5</b>



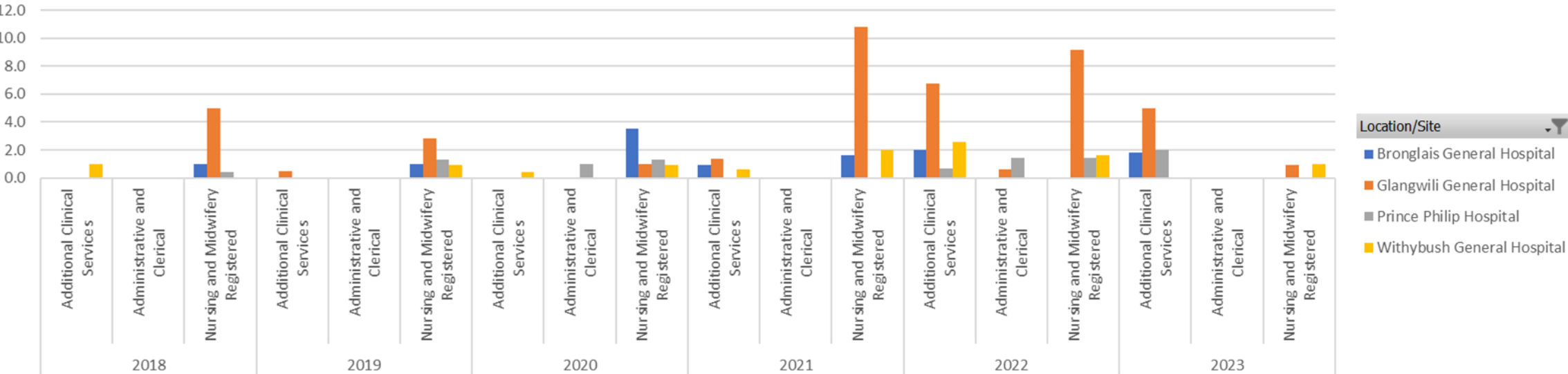
An increase in workforce can be seen in 2020 of 25.6WTE however this followed with a decrease to the service in 2021 of 122.4WTE. There was a significant increase followed by a decrease of Health Care Support Workers at this time with an addition of 13.4WTE during 2020. An increase can also be seen in Nursing roles during this period. This workforce increase during 2020 could be due to the significant impact on critical care during covid.

### Additional service insights

**ANY ADDITIONAL SERVICE INSIGHTS CAN BE ADDED HERE – As there aren't many new starters in 2020, where the additional staff from individuals being transferred from other areas to help the service?**

# Starters

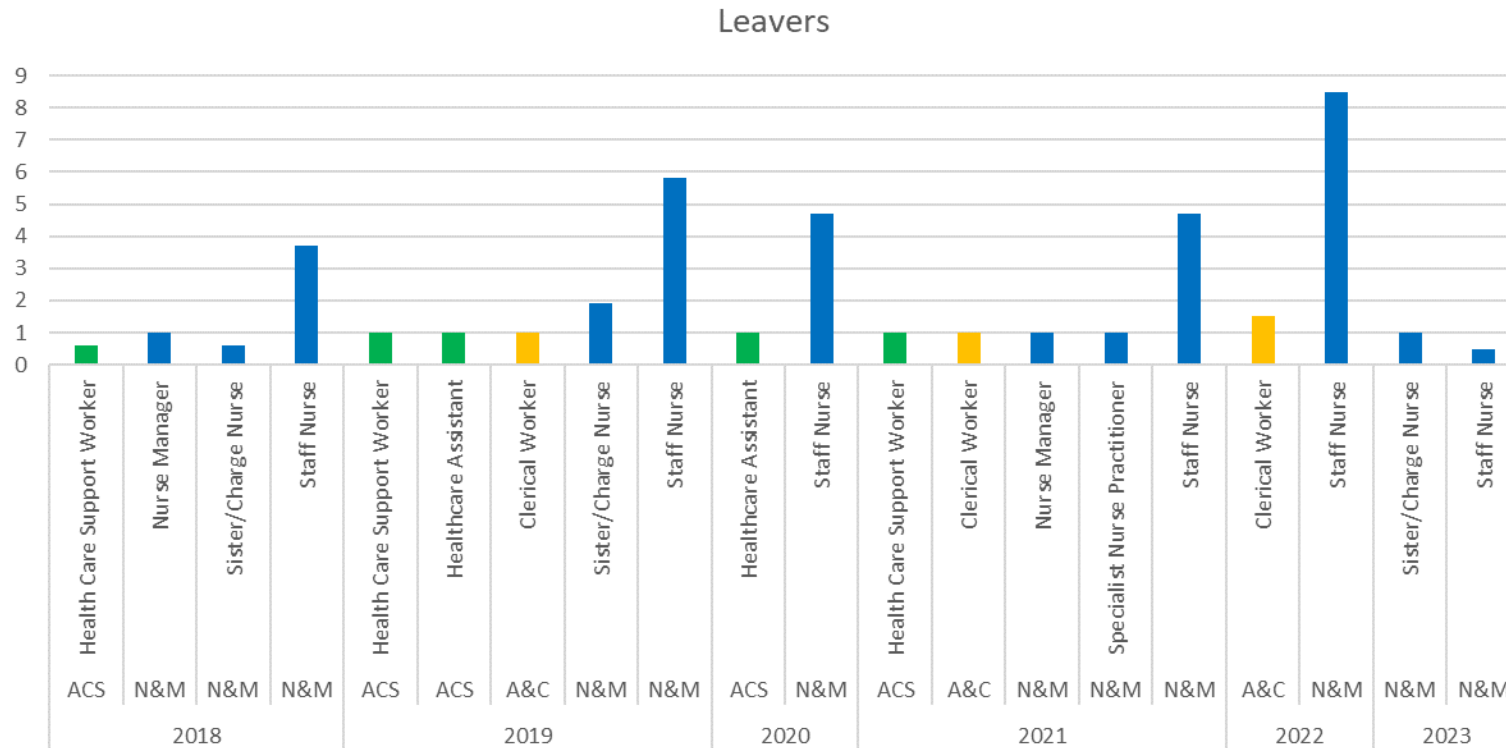
Sum of Starters FTE



	2018	2019	2020	2021	2022	2023
Starters	7.4	6.6	8.2	17.3	26.3	10.8

The largest increase in new starters was seen in 2021 in Nursing and Midwifery across the sites. The highest increase of staff across the five year period with 14.4WTE starting in the year, the majority in Glangwili hospital (10.8WTE).

## Leavers



The majority of leavers across Critical Care have been within the Nursing & Midwifery staff group (denoted in Blue). The highest number of leavers were in 2022 with 8.5WTE leaving in this period with an additional 6.7WTE leaving in 2021.

This correlates with the increase seen across 2021 and 2022 in starters (14.4 & 12.2WTE) within nursing & midwifery across the same time period.

	2018	2019	2020	2021	2022	2023
Leavers	6	10.7	5.7	8.7	10	1.5

## Recruitment

### Targeted Campaigns across the period 2018 – 2023:

No targeted recruitment campaigns were noted during the period for Critical Care however a Full page print was placed in the British Medical Journal for the below Consultant Anaesthetist with an interest in Critical Care post that has been advertised over the last 12 months .

### Vacancy /Recruitment overview:

Vacancy Information (last 12 months)	Role	Outcome
100-MED-GGH-236	Specialty Doctor	3 offered - 3 withdrawn (offered posts elsewhere / salary)
100-MED-GGH-236-A	Specialty Doctor	No candidates attended interview
100-MED-GGH-236-B	Specialty Doctor	3 offered - 2 withdrawn (Personal circumstances)
100-MED-GGH-236-C	Specialty Doctor	2 offered - 2 withdrawn (extended with current employer / salary)
100-MED-GGH-236-D	Specialty Doctor	3 offered
100-MED-GGH-253	Specialty Doctor	1 offered - 1 withdrawn (Personal circumstances)
100-MED-GGH-253-A	Specialty Doctor	1 offered - started in post
100-MED-WGH-120	Specialty Doctor	2 offered - 1 withdrawn (location), 1 started
100-MED-WGH-145	Specialty Doctor	2wte Currently in shortlist
100-MED-GGH-140-A	Consultant Anaesthetist with an interest in Critical Care	1 WTE, no applications received, service confirmed they were going to have further discussion first before deciding to go back out to advert.

### Headhunting:

Targeted headhunting has taken place with 3 doctors headhunted via LinkedIn for a Consultant in Anaesthetics with interest in Critical Care but with no interest. Very hard to headhunt as service confirmed for ICU Substantive/Locum, doctors would need to be on a specialist register. Also need FRCA and ICU experience as well as ideally UK experience. Very hard to find this overseas. Option to bring them in as Senior Specialty doctors to then grow own into consultant level through CESR.

### Hywel Dda University Health Board Equality Impact Assessment (EqIA)

**Please note:**

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:-

Email: [Inclusion.hdd@wales.nhs.uk](mailto:Inclusion.hdd@wales.nhs.uk)

Tel: 01554 899055

## Form 1: Overview

1.	<b>What are you equality impact assessing?</b>	Admission to and management of patients in the four critical care departments across Hywel Dda University Health Board, which are based in: Bronglais General Hospital Glangwili General Hospital Prince Philip Hospital Withybush General Hospital
2.	<b>Brief Aims and Description</b>	The aim of this document is to ensure the safe and equitable care of any and all patients that require level 2 (high dependency) and level 3 (intensive care) treatment and interventions across Hywel Dda University Health Board.
3.	<b>Who is involved in undertaking this EqIA?</b>	Alex Walsby, Head of Nursing Diane Knight, Service Delivery Manager Nerys Davies, Senior Nurse Manager Abbi Daniel Thomas, Senior Nurse Manager Sarah Carmody, Service Manager
4.	<b>Is the Policy related to other policies/areas of work?</b>	Intensive Care Society <a href="https://ics.ac.uk/guidance.html">https://ics.ac.uk/guidance.html</a> Acutely ill adults in hospital <a href="https://www.nice.org.uk/guidance/cg50">https://www.nice.org.uk/guidance/cg50</a> Rehabilitation after critical illness in adults <a href="#">Overview</a>   <a href="#">Rehabilitation after critical illness in adults</a>   <a href="#">Guidance</a>   <a href="#">NICE</a> Intravenous fluid therapy in adults in hospital <a href="#">Overview</a>   <a href="#">Intravenous fluid therapy in adults in hospital</a>   <a href="#">Guidance</a>   <a href="#">NICE</a> Adult Critical Care <a href="https://gettingitrightfirsttime.co.uk/medical_specialties/adult-critical-care/">https://gettingitrightfirsttime.co.uk/medical_specialties/adult-critical-care/</a>
5.	<b>Who will be affected by the strategy / policy / plan / procedure / service?</b> (Consider staff as well as the population that the project / change may affect to different degrees)	Population of Hywel Dda University Health Board- patients and relatives Staff working within the Critical Care departments Staff aligned to critical care departments (therapies, radiology, microbiology etc) Colleagues referring patients into critical care services

6.	<b>What might help/hinder the success of the Policy?</b>	The EqIA reflects the current position and working processes of the existing critical care provision in the health board. Any alteration to the existing provision will require a review of the EqIA.
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## Form 2: Human Rights

**Human Rights:** The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	Yes	No
<b>Article 2 : The right to life</b>  <b>Example:</b> The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control	X	
<b>Article 3 : The right not be tortured or treated in an inhuman or degrading way</b>  <b>Example:</b> Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	X	
<b>Article 5 : The right to liberty</b>  <b>Example:</b> Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	X	
<b>Article 6 : The right to a fair trial</b>  <b>Example:</b> issues of patient choice, control, empowerment and independence	X	
<b>Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control</b>  <b>Example:</b> Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	X	
<b>Article 11 : The right to freedom of thought, conscience and religion</b>	X	

**Example:** The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers

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How will the strategy, policy, plan, procedure and/or service impact on:-	Positive	Negative	No impact	Potential positive and / or negative impacts	Opportunities for improvement / mitigation																																																																								
				Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.	If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also been included within the action plan.																																																																								
Age Is it likely to affect older and younger people in different ways or affect one age group and not another?			x	<div>Population Data</div> <table><tr><th>Year (data was collected)</th><th colspan="8">Hywel Dda University Health Board Population – 2021 Census</th></tr><tr><th>County</th><th colspan="2">Carmarthenshire</th><th colspan="2">Ceredigion</th><th colspan="2">Pembrokeshire</th><th colspan="2">Total</th></tr><tr><th>Measure</th><th>value</th><th>percent</th><th>value</th><th>percent</th><th>value</th><th>percent</th><th>value</th><th>Percent</th></tr><tr><th>Age</th><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Total: All usual residents</td><td>187,895</td><td>100</td><td>71,468</td><td>100</td><td>123,366</td><td>100</td><td>382,729</td><td>100.0</td></tr><tr><td>Aged 16 to 19 years</td><td>7,799</td><td>4.2</td><td>4,129</td><td>5.8</td><td>4,890</td><td>4</td><td>16,818</td><td>4.7</td></tr><tr><td>Aged 20 to 24 years</td><td>8,821</td><td>4.7</td><td>6,366</td><td>8.9</td><td>5,621</td><td>4.6</td><td>20,808</td><td>6.1</td></tr><tr><td>Aged 25 to 34 years</td><td>20,692</td><td>11</td><td>7,106</td><td>9.9</td><td>12,907</td><td>10.5</td><td>40,705</td><td>10.5</td></tr></table>	Year (data was collected)	Hywel Dda University Health Board Population – 2021 Census								County	Carmarthenshire		Ceredigion		Pembrokeshire		Total		Measure	value	percent	value	percent	value	percent	value	Percent	Age									Total: All usual residents	187,895	100	71,468	100	123,366	100	382,729	100.0	Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,890	4	16,818	4.7	Aged 20 to 24 years	8,821	4.7	6,366	8.9	5,621	4.6	20,808	6.1	Aged 25 to 34 years	20,692	11	7,106	9.9	12,907	10.5	40,705	10.5	
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Aged 35 to 49 years	31,801	16.9	10,145	14.2	19,459	15.8	61,405	15.6
Aged 50 to 64 years	40,905	21.8	15,256	21.3	27,335	22.2	83,496	21.8
Aged 65 to 74 years	24,605	13.1	9,942	13.9	17,444	14.1	51,991	13.7
Aged 75 to 84 years	15,246	8.1	6,095	8.5	10,855	8.8	32,196	8.5
Aged 85 years and over	5,615	3	2,348	3.3	4,044	3.3	12,007	3.2

Service demand is linked to an aging population, with the number of people aged 75 and over increasing by around 19% between 2009 and 2020. This trend is expected to continue. Between 2020 and 2032 across Wales the number of people aged 75 and over is forecast to grow by a further 27%. ([Source: Audit Wales 2023](#))

#### **Patient Data**

Patients are assessed on the appropriateness of admission to critical care depending on their clinical condition, including their medical history. Older patients are more likely to, but not definitively, have co-morbidities that could impact on viable treatment options available. Age is not considered a factor in determining ceilings of care, but age associated conditions might factor into the decision making.

#### **Staff data**

This information was not available for Critical Care

#### **Positive Impacts:**

All health board staff undertake equalities (including Safeguarding Adults, Safeguarding Children and Dementia Awareness) training relating specifically relating to age as part of mandatory competency training.

			<p>All health board staff undertake equalities training as part of mandatory competency training.</p> <p>There is a car transport service available for patients families to use.</p> <p>Hospital sites across the health board are located close to public transport routes and links.</p> <p>All sites will have accessible toilets either directly in the service area or nearby.</p> <p>Wheelchairs are widely available at hospital entrances to be used by patients family where required for those who have difficulty walking.</p> <p>When required, clinical staff will support the patients family acting as a chaperone for visiting.</p> <p>On each site, staff will have access to facilities to provide the patient with basic drinks and biscuits. Larger sites have access to meals.</p> <p><b>Negative Impact</b></p> <p>At this time no negative impact has been identified on age. This will be reviewed in line with any proposed service changes.</p>																					
<p><b>Disability</b> Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical</p>		x	<p><b>Population Data</b></p> <table border="1"> <thead> <tr> <th></th><th>Carmarthenshire</th><th>Ceredigion</th><th>Pembrokeshire</th><th>Total</th></tr> </thead> <tbody> <tr> <td>Disabled under the Equality Act: Day-to-day activities limited a lot</td><td>21255</td><td>6686</td><td>12522</td><td><b>40463</b></td></tr> <tr> <td>Disabled under the Equality Act: Day-to-day activities limited a little</td><td>21897</td><td>8951</td><td>14651</td><td><b>45499</b></td></tr> <tr> <td></td><td><b>43152</b></td><td><b>15637</b></td><td><b>27173</b></td><td></td></tr> </tbody> </table> <p><a href="#">How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)</a>  <a href="#">How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</a>  <a href="#">How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</a></p>		Carmarthenshire	Ceredigion	Pembrokeshire	Total	Disabled under the Equality Act: Day-to-day activities limited a lot	21255	6686	12522	<b>40463</b>	Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	<b>45499</b>		<b>43152</b>	<b>15637</b>	<b>27173</b>		
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conditions such as diabetes				<p><b>Patient data</b></p> <p>Patients are assessed on the appropriateness of admission to critical care depending on their clinical condition, including their medical history. There is potential that patients with disabilities may not respond to the high levels of interventions provided in critical care, or admission to care may not improve their clinical outcomes or quality of life. Therefore, disability is considered as part of the holistic patient assessment, but not in isolation.</p> <p><b>Positive Impacts:</b></p> <p>All health board staff undertake equalities (including Safeguarding Adults, Safeguarding Children and Dementia Awareness) training relating specifically relating to age as part of mandatory competency training.</p> <p>Adjustments may be necessary to allow for appropriate communication with patients / families. This could include support from occupational health for communication devices, liaison with Learning Disability services, support from sensory loss services.</p> <p>All hospital sites adhere to minimum accessibility standards.</p> <p>Wheelchairs are widely available at hospital entrances to be used by patients families who have difficulty walking.</p> <p>Hospital transport has cars to support patients family with different types of mobility concerns.</p> <p><b>Negative Impact</b></p> <p>At this time no negative impact has been identified on Disability. This will be reviewed in line with any proposed service changes.</p>											
<b>Gender Reassignment</b> Consider the potential impact			x	<p><b>Population Data</b></p> <table><tr><td><b>Year (data was collected)</b></td><td colspan="4"><b>Hywel Dda University Health Board Census Data - 2021</b></td></tr><tr><td><b>County</b></td><td>Carmarthenshire</td><td>Ceredigion</td><td>Pembrokeshire</td><td>Total</td></tr></table>	<b>Year (data was collected)</b>	<b>Hywel Dda University Health Board Census Data - 2021</b>				<b>County</b>	Carmarthenshire	Ceredigion	Pembrokeshire	Total	
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on individuals who either:  •Have undergone, intend to undergo or are currently undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.				<table><tr><th>Measure</th><th>value</th><th>percent</th><th>value</th><th>percent</th><th>value</th><th>percent</th><th>value</th><th>percent</th></tr><tr><td>Gender</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>All persons</td><td>187,897</td><td>100</td><td>71,475</td><td>100</td><td>123,360</td><td>100</td><td>382,732</td><td>100.0</td></tr><tr><td>Male</td><td>91,685</td><td>48.8</td><td>34,963</td><td>48.9</td><td>60,071</td><td>48.7</td><td>186,719</td><td>48.8</td></tr><tr><td>Female</td><td>96,212</td><td>51.2</td><td>36,512</td><td>51.1</td><td>63,289</td><td>51.3</td><td>196,013</td><td>51.2</td></tr><tr><td>Gender identity the same as sex registered at birth</td><td>144,924</td><td>93.2</td><td>55,874</td><td>91</td><td>95,794</td><td>93.4</td><td>296,592</td><td>92.5</td></tr><tr><td>Gender identity different from sex registered at birth but no specific identity given</td><td>210</td><td>0.1</td><td>84</td><td>0.1</td><td>121</td><td>0.1</td><td>415</td><td>0.1</td></tr><tr><td>Trans woman</td><td>93</td><td>0.1</td><td>73</td><td>0.1</td><td>58</td><td>0.1</td><td>224</td><td>0.1</td></tr><tr><td>Trans man</td><td>90</td><td>0.1</td><td>62</td><td>0.1</td><td>66</td><td>0.1</td><td>218</td><td>0.1</td></tr><tr><td>Non-binary</td><td>60</td><td>0</td><td>143</td><td>0.2</td><td>40</td><td>0</td><td>243</td><td>0.1</td></tr><tr><td>All other gender identities</td><td>38</td><td>0</td><td>66</td><td>0.1</td><td>32</td><td>0</td><td>136</td><td>0.0</td></tr></table>	Measure	value	percent	value	percent	value	percent	value	percent	Gender								All persons	187,897	100	71,475	100	123,360	100	382,732	100.0	Male	91,685	48.8	34,963	48.9	60,071	48.7	186,719	48.8	Female	96,212	51.2	36,512	51.1	63,289	51.3	196,013	51.2	Gender identity the same as sex registered at birth	144,924	93.2	55,874	91	95,794	93.4	296,592	92.5	Gender identity different from sex registered at birth but no specific identity given	210	0.1	84	0.1	121	0.1	415	0.1	Trans woman	93	0.1	73	0.1	58	0.1	224	0.1	Trans man	90	0.1	62	0.1	66	0.1	218	0.1	Non-binary	60	0	143	0.2	40	0	243	0.1	All other gender identities	38	0	66	0.1	32	0	136	0.0		
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<p><b>Marriage and Civil Partnership</b></p> <p>This also covers those who are not married or in a civil partnership.</p>		x	<p><b>Population Data</b></p> <table><tr><th>Year (data was collected)</th><th colspan="8">Hywel Dda University Health Board Census Data - 2021</th></tr><tr><th>County</th><th colspan="2">Carmarthenshire</th><th colspan="2">Ceredigion</th><th colspan="2">Pembrokeshire</th><th colspan="2">Total</th></tr><tr><th>Measure</th><th>value</th><th>percent</th><th>value</th><th>percent</th><th>value</th><th>percent</th><th>value</th><th>percent</th></tr><tr><th>Marital Status</th><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Total: All usual residents aged 16 and over</td><td>155,488</td><td>100</td><td>61,389</td><td>100</td><td>102,551</td><td>100</td><td>319,428</td><td>100.0</td></tr><tr><td>Never married and never registered a civil partnership</td><td>50,384</td><td>32.4</td><td>23,766</td><td>38.7</td><td>32,566</td><td>31.8</td><td>106,716</td><td>34.3</td></tr><tr><td>Married or in a registered civil partnership</td><td>73,529</td><td>47.3</td><td>26,468</td><td>43.1</td><td>48,487</td><td>47.3</td><td>148,484</td><td>45.9</td></tr><tr><td>Married</td><td>73,191</td><td>47.1</td><td>26,292</td><td>42.8</td><td>48,264</td><td>47.1</td><td>147,747</td><td>45.7</td></tr></table>	Year (data was collected)	Hywel Dda University Health Board Census Data - 2021								County	Carmarthenshire		Ceredigion		Pembrokeshire		Total		Measure	value	percent	value	percent	value	percent	value	percent	Marital Status									Total: All usual residents aged 16 and over	155,488	100	61,389	100	102,551	100	319,428	100.0	Never married and never registered a civil partnership	50,384	32.4	23,766	38.7	32,566	31.8	106,716	34.3	Married or in a registered civil partnership	73,529	47.3	26,468	43.1	48,487	47.3	148,484	45.9	Married	73,191	47.1	26,292	42.8	48,264	47.1	147,747	45.7	
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In a registered civil partnership	338	0.2	176	0.3	223	0.2	737	0.2
Separated, but still legally married or still legally in a civil partnership	3,157	2	1,029	1.7	2,210	2.2	6,396	2.0
Divorced or civil partnership dissolved	16,309	10.5	5,681	9.3	10,912	10.6	32,902	10.1
Widowed or surviving civil partnership partner	12,109	7.8	4,445	7.2	8,376	8.2	24,930	7.7

In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner. [How life has changed in Carmarthenshire: Census 2021 \(ons.gov.uk\)](#)

In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner. [How life has changed in Ceredigion: Census 2021 \(ons.gov.uk\)](#)

In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner. [How life has changed in Pembrokeshire: Census 2021 \(ons.gov.uk\)](#)

#### **Patient Data**

Marriage and civil partnerships are of no impact when considering admission to and treatment in, critical care departments.

			<p><b>Staff Data</b></p> <p><b>Positive Impacts:</b> All health board staff undertake equalities training as part of mandatory competency training.</p> <p>In 2020, 52.74% of staff in the Health Board were married, 1.44% were in a civil partnership, 31.37% were single, with 9.44% reporting being divorced, separated or widowed, and 5.01% not recorded on ESR. <a href="#">H DUHB EQUALITIES DUTIES REPORTING - Staff In Post (nhs.wales)</a></p> <p><b>Negative Impact</b></p> <p>At this time no negative impact has been identified on Marriage and Civil Partnership. This will be reviewed in line with any proposed service changes.</p>	
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**Form 3 Gathering of Evidence and Assessment of Potential Impact**

<p><b>Pregnancy and Maternity</b></p> <p>Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.</p>		<p>x</p> <p>In 2021, there were 29,007 births registered across Wales.</p> <p><a href="#">Maternity and birth statistics: 2021   GOV.WALES</a></p> <p><b>Patient Data</b></p> <p>Pregnant parents or those on maternity would not be a factor on admission to, and treatment in, critical care departments if clinically indicated.</p> <p><b>Staff Data</b></p> <ul style="list-style-type: none"><li>The Health Board has clear policies to address any pregnancy and maternity related highlighted risks, and Workforce and Occupational Health teams who can support with specific concerns.</li></ul> <p><b>Negative Impact</b></p> <p>Where a patient is pregnant this may change the course of treatment that would normally be considered may not be an option.</p>	<p><b>Mitigation</b></p> <p>Support and input would be sought from relevant specialist teams, e.g. maternity, obstetrics etc.</p>																											
<p><b>Race/Ethnicity or Nationality</b></p> <p>People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers,</p>		<p>x</p> <p><b>Population Data</b></p> <table><tr><td><b>Year (data was collected)</b></td><td colspan="8"><b>Hywel Dda University Health Board Census Data - 2021</b></td></tr><tr><td><b>County</b></td><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Totals</td></tr><tr><td><b>Measure</b></td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr></table>	<b>Year (data was collected)</b>	<b>Hywel Dda University Health Board Census Data - 2021</b>								<b>County</b>	Carmarthenshire		Ceredigion		Pembrokeshire		Totals		<b>Measure</b>	value	percent	value	percent	value	percent	value	percent	
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<b>Measure</b>	value	percent	value	percent	value	percent	value	percent																						

asylum seekers and migrant workers.

Ethnicity								
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Other ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

In Wales, 93.8% of the population identified as White, 2.9% as Asian, 0.9% as Black, 1.6% identified as 'Mixed or multiple ethnic groups' and 0.9% as 'Other ethnic group'.  
<https://www.gov.wales/ethnic-group-national-identity-language-and-religion-wales-census-2021-html>

In Hywel Dda, 86.22% of staff identified as White, 0.91% as Black or Black British, 3.92% as Asian or Asian British, 0.48% as Mixed, 1.40% as 'Any other ethnic group' and 7.07% did not

		<p>record their ethnicity on ESR. It is unlikely the staff ethnicity, race or nationality will impact or be impacted by these changes in the service.</p> <p><a href="#">H DUHB EQU</a></p> <p><b>Positive Impacts:</b> All health board staff undertake equalities (Equalities, Diversity and Human Rights) training relating specifically relating to gender identity as part of mandatory competency training.</p> <p>Race, ethnicity or nationality is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated.</p> <p><b>Negative Impact:</b> Where a patient or their family are non English or Welsh speaker may be unable to communicate to staff.</p>	<p><b>Mitigation</b></p> <p>The Healthboard has access to a translation service for patients who are unable to communicate in English or Welsh.</p> <p>Adjustments may be necessary to allow for appropriate communication with patients / families, for which, translation services are available and accessible.</p>
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**Religion or Belief (or non-belief)**  
The term 'religion' includes a religious or philosophical belief.

x **Population Data**

Year (data was collected)	Hywel Dda University Health Board Census Data - 2021							
County	Carmarthenshire		Ceredigion		Pembrokeshire		Totals	
Measure	value	percent	value	percent	value	percent	value	percent
Religion								
Total: All usual residents	187,899	100	71,476	100	123,363	100	382,738	100.0
No religion	83,409	44.4	30,749	43	52,998	43	167,156	43.5
Christian	89,378	47.6	33,409	46.7	60,174	48.8	182,961	47.7
Buddhist	557	0.3	378	0.5	462	0.4	1,397	0.4
Hindu	419	0.2	158	0.2	161	0.1	738	0.2
Jewish	103	0.1	75	0.1	58	0	236	0.1
Muslim	1,026	0.5	515	0.7	587	0.5	2,128	0.6
Sikh	177	0.1	35	0	32	0	244	0.0
Other religion	1,127	0.6	677	0.9	746	0.6	2,550	0.7
Not answered	11,703	6.2	5,480	7.7	8,145	6.6	25,328	6.8

In Carmarthenshire, 44.4% of people declared not having a religion, 47.6% are Christian and 6.2% did not answer; 1.2% were Buddhist, Hindu, Jewish, Muslim or Sikh and 0.6% replied with 'other'. <https://www.ons.gov.uk/visualisations/censusareachanges/W06000010/>

In Ceredigion, 43% of people declared not having a religion, 46.7% are Christian and 7.7% did not answer; 1.5% were either Buddhist, Hindu, Jewish or Muslim and 0.9% replied with 'other'. [How life has changed in Ceredigion: Census 2021 \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/howlifeincredigionhaschangedcensus2021/2021-03-18)

In Pembrokeshire, 43% of people declared not having a religion, 48.8% are Christian and 6.6% did not answer; 1% were either Buddhist, Hindu or Muslim and 0.6% replied with 'other'. [How life has changed in Pembrokeshire: Census 2021 \(ons.gov.uk\)](#)

#### Patient data

Religion or belief is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated. However, when the service is aware of a person's religion or beliefs, adjustments to the care are made. Every patient is treated in an individual basis according to their needs.

#### Staff data

In Hywel Dda, 39.94% of staff reported being Christian, 11.06% atheist, 19.01% did not disclose their religion and 19.92% did not record their religion on ESR. The remaining 10.07% recorded other religions.

[H DUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](#)

Religion	Headcount
Atheism	1,281
Christianity	4,627
I do not wish to disclose my religion/belief	2,202
Other	1,168
Not Recorded on ESR	2,308
<b>Grand Total</b>	<b>15,586</b>

#### Positive Impacts:

- All health board staff undertake equalities training (including Equality, Diversity and Human Rights) as part of mandatory competency training.
- Any staff or patient needs related to their religion or beliefs would be accommodated following an assessment of what is required and included on the patients notes.
- Provision of protected prayer space/time or belief room on request
- The Health Board has a Jehovah's Witness specific consent form which can be used if necessary.

			<p><b>Positive Impacts:</b> All health board staff undertake equalities (Equalities, Diversity and Human Rights) training relating specifically relating to gender identity as part of mandatory competency training.</p> <p><b>Negative Impact:</b></p> <p>A non-English or Welsh speaker may be unable to communicate to staff.</p>	<p><b>Mitigation</b></p> <p>The Health Board has access to a translation service for patients who are unable to communicate in English or Welsh, and Health Board leaflets are available in different languages.</p> <p>The <a href="#">specialist pharmacy service</a> can support when managing situations where a patient is known to be unable to be administered specific drugs</p>
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<b>Sex</b> Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?			x	<b>Population data</b>	

			Year (data was collected)	Hywel Dda University Health Board Census Data - 2021							
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			<table><tr><td>All other gender identities</td><td>38</td><td>0</td><td>66</td><td>0.1</td><td>32</td><td>0</td><td>136</td><td>0.0</td></tr></table>	All other gender identities	38	0	66	0.1	32	0	136	0.0				
			All other gender identities	38	0	66	0.1	32	0	136	0.0					
			Patient data													
			Sex is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated.													
Staff Data																
			As of 2020, 77.7% of staff in Hywel Dda were female and 22.3% were male. It is unlikely staff sex will affect or be affected by these changes in the service.													
			<a href="#">H DUHB EQUALITIES DUTIES REPORTING - Staff In Post (nhs.wales)</a>													
			<table><tr><td>Gender</td><td>Headcount</td></tr><tr><td>Female</td><td>45</td></tr><tr><td>Male</td><td>39</td></tr><tr><td>Grand Total</td><td>74</td></tr></table>						Gender	Headcount	Female	45	Male	39	Grand Total	74
			Gender	Headcount												
Female	45															
Male	39															
Grand Total	74															
Positive Impact:																
			<ul style="list-style-type: none"><li>• All health board staff undertake equalities training (including Equality, Diversity and Human Rights) as part of mandatory competency training.</li><li>• There are male and female staff in the service and where possible, if a patient requests a specific gender of staff for their review, this will be provided.</li></ul>													
			Negative Impact:													
			At this time there is no negative impact has been identified under the characteristic of sex. This will be reviewed in line with any proposed service changes.													
Sexual Orientation Whether a person's sexual attraction is towards their own sex,		x	Population data													

the opposite sex or to both sexes.

Year (data was collected)	Hywel Dda University Health Board Census Data - 2021							
County	Carmarthenshire		Ceredigion		Pembrokeshire		Totals	
Measure	value	percent	value	percent	value	percent	value	percent
Sexual Orientation								
Total: All usual residents aged 16 years and over	155,486	100	61,391	100	102,551	100	319,428	100.0
Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
Bisexual	1,500	1	1,617	2.6	1,050	1	4,167	1.5
Pansexual	202	0.1	225	0.4	149	0.1	576	0.2
Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0	49	0.1	12	0	84	0.0
All other sexual orientations	19	0	16	0	7	0	42	0.0

#### Patient data

Sexual orientation is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated.

#### Staff Data

In Hywel Dda, 65.27% of staff reported being straight, 1.06% reported being gay or lesbian, 0.03% undecided, 0.46% bisexual, with 20.07% not recorded, 13.08% refused to answer, and 0.03% 'Other sexual orientation not listed'.

## [HDUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](https://nhs.uk/equality-duties-reporting/)

Sexual Orientation – All Staff	Headcount
Heterosexual or Straight	7,562
Not stated (person asked but declined to provide a response)	1,516
Other	183
Not Recorded on ESR	2,325
<b>Grand Total</b>	<b>11,586</b>

### Positive Impact

All health board staff undertake equality training (including Equality, Diversity and Human Rights) as part of mandatory competency training.

### Negative Impact:

At this time there is no negative impact has been identified under the characteristic of sexual orientation. This will be reviewed in line with any proposed service changes.

### Armed Forces

Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It

### Population data

	Carmarthenshire	Ceredigion	Pembrokeshire	Totals
Previously served in the UK regular armed forces	5610	1851	4654	<b>12115</b>
Previously served in UK reserve armed forces	1334	537	930	<b>2801</b>
Previously served in both regular and reserve UK armed forces	336	137	248	<b>721</b>
	<b>7280</b>	<b>2525</b>	<b>5832</b>	<b>15637</b>

<p>could be through ‘unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.’</p> <p>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: <a href="#">Armed-Forces-Covenant-duty-statutory-guidance</a></p>		<p><b>Patient Data</b></p> <p>No impact. Armed Forces are not relevant to the decision to admit into critical care, and would not affect treatment options.</p> <p><b>Negative Impact:</b></p> <p>At this time there is no negative impact has been identified under the characteristic of armed forces. This will be reviewed in line with any proposed service changes.</p>																												
<p><b>Socio-economic Deprivation</b></p> <p>Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access</p>	X	<p><b>Population Data</b></p> <p>Information to inform on Socio-economic deprivation is hard to obtain. However, economic activity information is available on the 2021 census. We are aware that there are areas within the health board footprint of considerable deprivation. The below table notes economic activity within the health board footprint</p> <table><tr><th>Year (data was collected)</th><th colspan="8">Hywel Dda University Health Board Census Data - 2021</th></tr><tr><th>County</th><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Totals</td></tr><tr><th>Measure</th><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr></table>	Year (data was collected)	Hywel Dda University Health Board Census Data - 2021								County	Carmarthenshire		Ceredigion		Pembrokeshire		Totals		Measure	value	percent	value	percent	value	percent	value	percent	
Year (data was collected)	Hywel Dda University Health Board Census Data - 2021																													
County	Carmarthenshire		Ceredigion		Pembrokeshire		Totals																							
Measure	value	percent	value	percent	value	percent	value	percent																						

services and facilities.  
Food / fuel poverty and  
personal or household  
debt should also be  
considered.

For a comprehensive  
guide to the Socio  
Economic Duty in Wales  
and supporting resource  
please see:  
<https://gov.wales/more-equal-wales-socio-economic-duty>

Economic Factor								
Total: All usual residents aged 16 years and over	155,487	100	61,392	100	102,551	100	319,430	100.0
Economically active (excluding full-time students)	83,262	53.5	29,845	48.6	54,182	52.8	167,289	51.6
In employment	79,927	51.4	28,718	46.8	51,697	50.4	160,342	49.5
Unemployed	3,335	2.1	1,127	1.8	2,485	2.4	6,947	2.1
Economically active and a full-time student	2,612	1.7	2,119	3.5	1,352	1.3	6,083	2.2
In employment	2,025	1.3	1,401	2.3	1,068	1	4,494	1.5
Unemployed	587	0.4	718	1.2	284	0.3	1,589	0.6
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.2
Retired	43,170	27.8	16,997	27.7	30,306	29.6	90,473	28.4
Student	6,422	4.1	6,150	10	3,544	3.5	16,116	5.9
Looking after home or family	6,296	4	2,119	3.5	4,755	4.6	13,170	4.0
Long-term sick or disabled	9,710	6.2	2,730	4.4	5,632	5.5	18,072	5.4
Other	4,015	2.6	1,432	2.3	2,780	2.7	8,227	2.5

			<p>In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'Least deprived' or as second 'least deprived' in Wales. There is a number of areas identified as being nearer 'most deprived', which seem to be concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly. (Welsh Index of Multiple Deprivation 2019). <a href="#">Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)</a></p> <p><b>Patient data</b></p> <p>Socio-economic deprivation is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated.</p> <p>There may be some impact on the families of patients who are likely to have longer admissions to hospitals which may affect them with travel costs, parking costs, cost of food and drink while visiting which maybe for prolonger periods, ability to work.</p> <p><b>Staff Information</b></p> <p>There is currently no data available on socio-economic status for staff.</p> <p>Staff's socio-economic status should not impact or be impacted by changes in the service, as any expenses incurred as part of travelling and education are reimbursed by the Health Board.</p> <p><b>Negative Impact</b></p> <p>Hywel Dda University Health Board covers a very large geographical area, which may impact service users families and staff when trying to access certain parts of the service that might only be delivered from sites which are not immediately local.</p>	<p><b>Mitigation</b></p> <p>The Health Board has adopted savings schemes for staff to use, such as the Hapi app benefits for everyday discounts, the</p>
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				<p>Leasing Car Scheme and Pool Car scheme, amongst many others.</p> <p>Hywel Dda strives to deliver care closer to home whenever possible, which helps in reducing the amount of time the patients spend travelling, or unpaid work time the patients or their carers/family members need to take off to attend hospital care.</p>
<b>Welsh Language</b> Please note opportunities for persons to use the Welsh language and treating the Welsh language no less	x	<b>Population Data</b>  According to Welsh Census 2022 data, it is estimated that 29.5% of people aged three or older were able to speak Welsh. This figure equates to around 900,600 people.  The Health Board adopted the Welsh Language Standards in 2019 across all directorates including Mental Health & Learning Disabilities Services. Following on from this a Welsh Language Services Report is produced annually.		<b>Mitigation</b>

favourably than the English language.		<p><b>Positive Impact</b></p> <p>In March 2021 the Bilingual Skills Policy was introduced across the health board. The main aims of the policy are as follows:</p> <ul style="list-style-type: none"> <li>· To increase the use of Welsh within the workplace.</li> <li>· To enable everyone who receives or uses our services to do so through the medium of Welsh or English, according to personal choice, and to encourage other users and providers to use and promote the Welsh Language within the health sector.</li> <li>· To ensure staff are able to enact their right to receive services through the medium of Welsh within our internal administrative systems.</li> </ul> <p>The health board uses its ESR system to capture Welsh Language information with 92% now showing an identified Welsh skill set. The skills set ranges from 0-5 with 0 being no welsh language skills to 5 being fluent orally and written. Staff members identified at Level 3 and above can provide bilingual services to patients and carers.</p> <p>All service users and patients are offered a proactive service offer of Welsh language, which is recorded.</p> <p>The health board has developed a range of Welsh Language learning opportunities for all staff to learn and develop their skills, and time is given from work to attend. Since the Pandemic, these opportunities have been made available online which has seen an increase in uptake.</p> <p><b>Negative Impact</b></p> <p>Patients who would like to converse in Welsh may have to communicate in English.</p>	<p><b>Mitigation</b></p> <p>Welsh language standards applied to all health board staff</p> <p>Patient information available in</p>
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				<p>English and Welsh</p> <p>Welsh language speaking staff are available</p> <p>The Health board has access to a translation service for patients who are unable to communicate in English or Welsh. With planned appointments, prior knowledge a translator will already be available.</p>
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#### Form 4: Examine the Information Gathered So Far

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1.	Do you have adequate information to make a fully informed decision on any potential impact?	Yes
2.	Should you proceed with the Policy whilst the EqIA is ongoing?	This EqIA reflects the current service provisions.
3.	Does the information collected relate to all protected characteristics?	Yes
4.	What additional information (if any) is required?	None
5.	How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).	N/A

### Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

<b>Protected Characteristic</b>	<b>Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)</b>	<b>Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)</b>	<b>Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)</b>
<b>Age</b>	1	0	0
<b>Disability</b>	1	0	0
<b>Sex</b>	1	0	0
<b>Gender Reassignment</b>	1	0	0
<b>Human Rights</b>	1	0	0
<b>Marriage and Civil Partnership</b>	1	0	0
<b>Pregnancy and Maternity</b>	1	0	0
<b>Race/Ethnicity or Nationality</b>	1	0	0
<b>Religion or Belief</b>	1	0	0
<b>Sexual Orientation</b>	1	0	0

<b>Socio-economic Deprivation</b>	2	-2	-4
<b>Welsh Language</b>	1	-1	-1

<b>Scoring Chart A: Evidence Available</b>	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

<b>Scoring Chart B: Potential Impact</b>	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

<b>Scoring Chart C: Impact</b>	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

### Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

<b>Will the Policy be adopted?</b>	N/A- the EqIA reflects the current provision of critical care services
<b>If No please give reasons and any alternative action(s) agreed.</b>	N/A

<b>Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?</b>	No, however critical care services are subject to the Clinical Services Plan programme
<b>What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?</b>	Admission data is routinely collected and monitored.
<b>When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?</b>	The data is subject to analysis and scrutiny as part of the Clinical Services Plan programme.
<b>Where positive impact has been identified for one or more groups please explain how this will be maximised?</b>	N/A

<p><b>Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this.</b></p> <p><b>If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.</b></p>	<p>The most significant negative impact score is for socio-economic deprivation and is based on assumed and anecdotal information. This score will vary for individual patients and families based on their deprivation status and the clinical status of the patient which will influence the duration of time spent in critical care and as an inpatient in hospital. Support will be offered, where possible, to relatives to adjust visiting times to suit with transport arrangements (e.g. if they are reliant on lifts to reduce public transport costs) and signposting will be given for financial support from local and county support services.</p> <p>The second, potential negative impact relates to Welsh language. Where possible at least one Welsh speaking nurse is rostered onto each shift, however with a smaller pool of nurses in the smaller units this can be more challenging to achieve. Historically there has been a reliance on temporary workforce which provide no guarantee of Welsh speaking. Welsh speakers from other staff groups can be asked to support, for example, Allied Health Professionals. In rare and extreme circumstances, translation services are available.</p>
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#### Form 7 Action Plan

<b>Actions</b> (required to address any potential negative impact identified or any gaps in data)	<b>Assigned to</b>	<b>Target Review Date</b>	<b>Completion Date</b>	<b>Comments / Update</b>
<b>Reviewing of staff training compliance levels to ensure that all training is up to date.</b>	Service Line Managers	Annually	Rolling annual review as part of PADR review	




<b>EqlA Completed by:</b>	<b>Name</b>	Ben Rogers & Rian Furlong
	<b>Title</b>	Transformation Programme Office
	<b>Team / Division</b>	Strategy & Planning
	<b>Contact details</b>	<a href="mailto:Ben.Rogers@wales.nhs.uk">Ben.Rogers@wales.nhs.uk</a> <a href="mailto:Rian.Furlong@Wales.nhs.uk">Rian.Furlong@Wales.nhs.uk</a>
	<b>Date</b>	04MAR24
<b>EqlA Authorised by:</b>	<b>Name</b>	Diane Knight & Alex Walsby
	<b>Title</b>	SDM & Nursing Lead
	<b>Team / Division</b>	Critical Care Service
	<b>Contact details</b>	<a href="mailto:Diane.knight2@wales.nhs.uk">Diane.knight2@wales.nhs.uk</a> <a href="mailto:alex.walsby@wales.nhs.uk">alex.walsby@wales.nhs.uk</a>
	<b>Date</b>	04MAR24
<b>Seen by Diversity &amp; Inclusion Team:</b>	<b>Name</b>	Eiddan Harries
	<b>Title</b>	Diversity and Inclusion Manager
	<b>Team</b>	Partnerships, Diversity & Inclusion
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	<b>Date</b>	06.03.2024

