# **Appendix C - Critical Care**



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

C3 - Critical Care - Service Change

# CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

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

	Week Daytime	Weekend Daytime	Week Oncall	Weekend Oncall	Total
Single Site Cover	5	10	19	10	44
Two Site Cover	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.

	Level 2 - elective	Level 2	Level 3		L2 transfe	ers to GGH	L3 transfe	ers 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 pos 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						

## Prince Philip Hospital (PPH) - admissions and transfer activity

The patients transferred during the 6-week period have been transferred safely with multidisciplinary 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 lechyd: 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: <u>Hyperlink to HDdUHB Well-being</u> <u>Objectives Annual Report 2018-2019</u>	9. All HDdUHB Well-being Objectives apply

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

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

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	s <sup>-</sup>	TANDAR	DS	RECO	MMEND	ATION
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Full Me
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%	339
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		00/	00/	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%	209
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		0.000			1000	
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%	09
3.2	Capacity Management	0%	30%	70%	25%	75%	09
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%	09
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 III 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%	09
					-		
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 III Pregnant (or Recently Pregnant) Woman	25%	0%	75%	17%	0%	83
4.11	Care of the Critically III Child in an Adult Critical Care Unit						
4.12	Standardised Care of the Critically III Patient	0%	30%	70%	10%	20%	70
5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS		001	-	001		
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 5.5	Critical Care Networks	0%	0%	100%	0%	0%	10
0.0	Critical Care Commissioning	0%	0%	100%			
6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS						-
		100/	0%	200/	0%	67%	22
61	Fire	10% 29%	0%	80% 71%	0% 56%	0%	33 22
6.1	Major Incidente			1 70	30%	U7/0	22
6.2	Major Incidents				4.09/	100/	70
	Major Incidents High Consequence Infectious Diseases: Initial Isolation and Management Surge and Business Continuity Planning	0%	0% 0%	100% 100%	10% 0%	10% 20%	70 <sup>°</sup> 80°

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Josewiczy w starting         Josewiczy w starting         Maxwell           1         Antina do nata do na	1.1	Levels of Critical Care			
1         2         3         6         9					
1         2         3         6         9	STANDARDS				
Anderson and a loss in		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	
Interm         Note         Advance           1         Control         Second           1         Control         Second         Second           1         Second				2=Fully met	
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Displace         Displace         Displace         Displace         Displace           1         Other and an put hold hubble programme fueld gramme fueld gra		None.		3=Not applicable to Unit	
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4     Data share share share show any way of share show any wa	2	The unit must participate in a National Audit Programme for Adult Critical Care.		2=Fully met	
1index managementindex managementindex managementindex managementINTERNATION<	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	
Constraint         Second	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 en Infection in Critical Care Quality Improvement Programme ICCQUP	Met / unmet	1=Partially met	
IntermediationKalchard and constraints and adda the shaded and matches and adda the shaded and adda t					
111	RECOMMENDATIONS				
1Substrate of a constraint of a const	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		
1aa	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	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	
B     B     Control     Contro     Contro <td>3</td> <td>Longer-term mortality should be collected on all patients admitted to critical care.</td> <td>met - collected on all patients, partially met - intermittant audit / review, not met - not reviewed</td> <td>1=Partially met</td> <td></td>	3	Longer-term mortality should be collected on all patients admitted to critical care.	met - collected on all patients, partially met - intermittant audit / review, not met - not reviewed	1=Partially met	
6       8       8       9       9       9         6	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		
Interview       Interview       Interview       Interview       Interview         1.1       Levid 2 nd 3 Physical Facilities       Levid 2 nd 3 Physical Facilities       Levid 2 nd 3 Physical Facilities         5TAUDROSC       Interview       Interview       SPANDARCE	5		National measure		
STANDARDS         Production           1         Galara factorization computed manaformadamica.	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	
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Instrume       Name       Name       Name       Name       Name       Name         Name	2	All new build units must comply with HBN 04-02.	met / not met / not applicable	3=Not applicable to Unit	
1Exiting units that do not comply should have a timeline do establish when national standards will be met.met. fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence of suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the metal set of progress and evidence of progress and progress and progress and evidence of pro	3	Medicines and fluid storage must comply with HBN 00-03.	met / not met		
1Exiting units that do not comply should have a timeline do establish when national standards will be met.met. fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence to suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence of suggest progress, partially met. timeline but no evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the met.Fineline and evidence of progress, not mathematication in the metal set of progress and evidence of progress and progress and progress and evidence of pro					
2       Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.       Intenies / Not applicable in standards inter         3       The unit should have enough beds and resources to obviate the need to transfer patients on other critical care units should have enough beds and resources to obviate the need to transfer patients on 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 and should be considered.       met, partially met, not met, not applicable       3=Not applicable to Unit         5       Critical care units should horoporties ufficient storage for medicines. (ICU designs also, need to account for how selected frees, slorage areas/rooms should be secure and appropriately temperature controled for all medicines. (ICU designs also, need to account for how selected frees, slorage areas/rooms should be considered into unitical care and should be considered into unitical care and should be considered into and transfer <0.5% of admissions, partially met, not met, not applicable	RECOMMENDATIONS				
Construction       Construction <th< td=""><td>1</td><td>Existing units that do not comply should have a timeline to establish when national standards will be met.</td><td>met - time line and evidence to suugest progress, partially met - timeline but no evidence of progress, not met - no timeline / not applicable if standards met</td><td>2=Fully met</td><td></td></th<>	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 suugest progress, partially met - timeline but no evidence of progress, not met - no timeline / not applicable if standards met	2=Fully met	
Column	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	
A diffuence interference on the process including the review of the building and facilities. Feedback should include any concerns       Interference on the process including methy me	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	
5       feeds. Storage areas/rooms should be secure and appropriately temperature controlled for all medicines. I/U designs also, need to account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not met, not applicable       Score account for how selected       met, partially met, not applicable       met, partially met, not applicabl	4		met, partially met, not met, not applicable	3=Not applicable to Unit	
6       It is recommended that critical care area shat have undergone recent new unit planning and building are contacted by those embarking on a new build to share       net, patially met, not met, not applicable       3=Not applicable to Unterplanning.         1       Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and digrity needs, and staff an outperplanning.       additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and digrity needs, and staff an outperplanning.       applicable to Unterplanning.       applicable to Unterplanning.         3       Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and digrity needs, and staff an outperplanning.       applicable to Unterplanning.       applicable to Unterplanning.         3       Additional factors that should be inspected as pat of the peer-review process, including the potential for long-stap patients to spend periods and splicable to unterplanning.       applicable to Unterplanning.       applicable to Unterplanning.         3       Additional factors that should be inspected as pat of the peer-review process, including the review of the building and facilities. Feedback should include any concerns on high plant any sippage to timeframes.       applicable to Unterplanning.       applicable to Unterplanning.         4       Additional factors that should be inspected as pat of the peer-review process, including the review of the building and facilities. Feedback should include any concerns on high pla	5	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	
7       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       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	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	
2 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.	7	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	met, partially met, not met, not applicable	1=Partially met	
9 Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners. National/regional measure	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	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	The CIS must comply with the set of common specifications, frameworks and implementation guides that support interoperability as specified with the NHS			
1	The core index compy win the set of common specina address in an events and imperimentation guides that support interoperability Toolkit. (https://digital.nhs.uk/services/interoperability-toolkit). (IS procurements and customisation must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system. This		3=Not applicable to Unit	
2	must include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineering, the CCIO (Chief Clinical Information Officer) and ICT specialists.	met, partially met, not met, not applicable	2=Fully met	
3	must not compromise patient salety in any way. There must be a process to ensure that suncient stan 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	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 cinical 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 pertunent 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	
COMMENDATIONS				
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 balicon pumps, extra-corpored 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 Audil Systems and Hospital Electronic Prescribing and Medication Administration (HEPMA) for electronic the store of the Cick System and the store of the	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	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 requried or can only be provided in a suboptimal medium, not met = no dashboard facility	0=Not met	
8	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		-		•
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	Consider Did Deservery
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 precise. All 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	Capital Bid Programme.
5	staff (medical, nursing, AHP and support staff) have complied with this provision. There indicate an instruction of the standard staff and the standard on interinstre care whose responsionines with incloude 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	recora. 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	Met / not met	2=Fully met	
7	personnel must have the appropriate skills and equipment to service the equipment used. 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	met - >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record.	2=Fully met	
	planned manuerance and replacement. There must be documented procedures for decontamination (cleaning, disinfection and sterilisation as appropriate, depending on equipment risk category and		2=Fully met	
9	sensitivity of devices). Appropriate sterile services must be provisioned so that national standards are followed for the re-sterilisation of endoscopes and reusable. Critical care units must be have appropriate systems in place to ensure an adequate supply of consumables.	met - >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record. 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 10	There must be robust mechanism for reporting adverse incidents resulting from the use of clinical equipment. Serious incidents involving clinical equipment may also	Wet = <2 incidents of delay to care or procedure in 12/12, partially met = 2-5 incidents, not met >5 incidents met - policy in place, partially met, no policy but can evidence, not met, no policy and / or no evidence	2=Fully met	
	need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).			

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 hosptial 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	met / not met	3=Not applicable to Unit
6	standards. There should be a clear escalation pathway from post-operative care to intensive care. 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	met / not met	3=Not applicable to Unit
7	Medicine. 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		3=Not applicable to Unit
11	ICNARC ARCIIC (Assessment of Risk in Cardiothoracic Intensive Care) programme - the national clinical audit for cardiothoracic critical care units. 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	met / not met	3=Not applicable to Unit
2	general (Level 3) critical care unit.		3=Not applicable to Unit
	Cardiac and thoracic surgery post-operative care is carried out in a dedicated environment with each component located in close proximity. 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	met = clear written protocol, partially met = occurs in practice but referer/accepter dependent, not met =	
3	facility as required.	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. 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	Statement	
5	period.	met / not met	3=Not applicable to Unit
6	Perfusion services should be readily available. Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an	met / not met	3=Not applicable to Unit
7	Carolionoracic anaestinesis and carolionoracic surgeons should be integrated into the multidisciplinary native or each carolionoracic critical care unit and take an active part in shaping services and analysing quality. Patient motify 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	Met / not met	3=Not applicable to Unit
	relevant chapters of GPICS.		

2	Neurocritical care units should have access to investigation facilities and appropriate cinical expertise for the following: a) diagnostic radiology (24-hour access to GT; access to MRH for ventilated subjects, and diagnostic angiography), b) access to bichemistry 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	
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 lattitude to NOT refer those clearly too frail for intervetnion)	3=Not applicable to Unit
5	As per NICE QS74, 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 lattitude to NOT refer those clearly too frail for intervetnion)	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
10	diagnostic/interventional specialities (neuroradiology and neurophysiology).		
10	diagnosciciniter version as spectatiles (neurorabiology and neurophysiology). When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.		
11		met / not met	3=Not applicable to Unit
11 RECOMMENDATIONS	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.	met / not met met = readily available at any point in pathway, partially met = available but not necessarily during critical care stay, not met = no psychology provision	
11 RECOMMENDATIONS 1	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.	met = readily available at any point in pathway, partially met = available but not necessarily during critical care stay,	
11 RECOMMENDATIONS 1 2	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus. Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care. 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,	3=Not applicable to Unit
11 RECOMMENDATIONS 1 2 3	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.           Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care.           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.           Multimodal monitoring of patients with neurological injury should be consistent with international consensus recommendations.           Early and formal involvement of the neurorhabilitation team as part of the multidisciplinary team should be sought to optimise outcomes and facilitate transitions of	met = readily available at any point in pathway, partially met = available but not necessarily during critical care stay, not met = no psychology provision 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 3=Not applicable to Unit 3=Not applicable to Unit 3=Not applicable to Unit
11 RECOMMENDATIONS 1 2 3 4	When calculating cerebral perfusion pressure in the management of traumatic brain injury, the arterial transducer should be placed (levelled) at the tragus.           Consultants providing out of hours care and advice should have regular timetabled sessions in neurocritical care.           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.           Multimodal monitoring of patients with neurological injury should be consistent with international consensus recommendations.           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 = readily available at any point in pathway, partially met = available but not necessarily during critical care stay, not met = no psychology provision 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 3=Not applicable to Unit 3=Not applicable to Unit 3=Not applicable to Unit
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Section 2	CRITICAL CARE SERVICES: WORKFORCE	Level description	Level	Comments
2.1	Medical Staffing			
STANDARDS	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	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	1=Partially met	Consultant carries bleep and in
	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 = anything else Met = daytime consultants work blocks of 3 or more days, with job planned handover time, partially met = blocks	-	
2	Consultant work patterns must deliver continuity of care.	of <3 days or days themselves divded 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. 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	Fully met = 7 days a week, partially met = 5 days per week	2=Fully met	
5	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. A consultant in Intensive Care Medicine must be immediately available 24/7. The consultant responsible for intensive care out of hours	Met / not met	2=Fully met	
7	must be able to attend within 30 minutes. A smail number or units that remain staned overnight by an anaesthetic consultant without daytime row sessions, by a necessity dictated	Met / not met	2=Fully met	Anaesthetist with a special inte
8	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	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	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 acheived	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
COMMENDATIONS				
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	
	The resident rota should be compliant with working time directives (i.e. Working Time Directive 2003)	met / not met	2=Fully met	
	The resident rota should be compliant with working time directives (i.e. Working Time Directive 2003) Registered Nursing Staff	met / not met	2=Fully met	
2		met / not met	2=Fully met	
2		met / not met met 98% of the time or not met	2=Fully met	
2 2.2 STANDARDS	Registered Nursing Staff			
2 2.2 STANDARDS 1	Registered Nursing Staff Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care. Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care. Each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service	met 98% of the time or not met	2=Fully met	X2 SNM's across the HB.
2 2.2 STANDARDS 1 2	Registered Nursing Staff           Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           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.           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 247 in critical care units. Units with fewer than six beds may consider having a supernumerary clinical coordinator to provide the supervisory role during pake activity periods. e.g. early shifts.	met 98% of the time or not met met 98% of the time or not met	2≃Fully met 2=Fully met	X2 SNM's across the HB.
2 2.2 STANDARDS 1 2 3	Registered Nursing Staff           Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           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 & Matron.           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 to provide the supervisory role during pake activity periods, e.g. early shifts.           Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory role during periods.e.g. ct.). 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 outpreak.	met 98% of the time or not met met 98% of the time or not met met / not met 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	2=Fully met 2=Fully met 2=Fully met	
2 2.2 STANDARDS 1 2 3 3 4	Registered Nursing Staff           Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           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 & Matron.           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 to provide the supervisory role during pake activity periods, e.g. early shifts.           Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory role during peak activity periods, e.g. carly shifts.           Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory role during peak activity. Periods, e.g. carly shifts.           Units mith refrained to be given during events such as infection outpreak.           Each critical care unit must have a dedicated Clinical Nurse Educator responsible for coordinating the deutation, training and CPD framework for intensive care nursing staff order care integrition.	met 98% of the time or not met met 98% of the time or not met met / not met met / not met 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 Met = unit >11 beds always has second supernumerary nurse available, Partially = available >60% shifts, not met	2=Fully met 2=Fully met 2=Fully met 1=Partially met	Not funded
2 2.2 STANDARDS 1 2 3 3 4 5	Registered Nursing Staff           Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           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.           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 to provide the supervisory role during peak activity periods. e.g. early shifts.           Units with greater than len beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to provide the supervisory role during peak activity periods. e.g. early shifts.           Units with greater than len beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to provide the supervisory role during peak senior registered nursing staff over and above the supervisory clinical coordination for the need of additional staff also needs to be given during events such as infection outbreak.           Each critical care unit must have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD	met 98% of the time or not met met 98% of the time or not met met / not met 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 Met = unit >11 beds always has second supernumerary nurse available, Partially = available >60% shifts, not met = unit has >11 beds and no additional nurse	2=Fully met 2=Fully met 2=Fully met 1=Partially met 3=Not applicable to Unit	Not funded N/A to ICU Bronglais
2 2.2 STANDARDS 1 2 3 3 4 5 5 6	Registered Nursing Staff           Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           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.           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.           Units with greater than ten beds must have additional supervisory role during peak activity periods, e.g. early shifts.           Units with greater than ten beds must have additional supervisory coldurator patient on the beds must you of the unit (e.g. multiple post/bays, single rooms). Consideration for the need of additional staff also needs to be given during events such as infection outbreak.           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.           All nursing staff appointed to intensive care musts be allocated a period of supernumerary practice to enable achievement of basic </td <td>met 98% of the time or not met met 98% of the time or not met met / not met met - not met is occasionally used in emergency to care for patient on &lt;5% shifts, not met = supernumerary nurse is required to care for their own patient &gt;5% shifts Met = unit &gt;11 beds always has second supernumerary nurse available, Partially = available &gt;60% shifts, not met = unit has &gt;11 beds and no additional nurse met - 1.0 per 75, partially met 1.0 per 100, unmet - no educator or less than 1.0 per 100 Met = always provided until competence achieved, partially = provided but may have own patient before full</td> <td>2=Fully met 2=Fully met 2=Fully met 1=Partially met 3=Not applicable to Unit 2=Fully met</td> <td>Not funded N/A to ICU Bronglais</td>	met 98% of the time or not met met 98% of the time or not met met / not met met - not met 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 Met = unit >11 beds always has second supernumerary nurse available, Partially = available >60% shifts, not met = unit has >11 beds and no additional nurse met - 1.0 per 75, partially met 1.0 per 100, unmet - no educator or less than 1.0 per 100 Met = always provided until competence achieved, partially = provided but may have own patient before full	2=Fully met 2=Fully met 2=Fully met 1=Partially met 3=Not applicable to Unit 2=Fully met	Not funded N/A to ICU Bronglais
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2 2.2 STANDARDS 1 2 3 3 4 5 5 6 6 7 8 8 9	Registered Nursing Staff           Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.           Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.           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.           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 to provide the supervisory role during peak activity periods, e.g. early shifts.           Uhits with greater than len beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to provide the supervisory role during peak activity periods, e.g. early shifts.           Uhits with greater than len beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to provide the supervisory role during peak activity periods, e.g. early shifts.           Uhits with greater than len beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to make additional supernumerary combib for coordination for the need of additional staff also needs to be given during events such as infection outbreak.           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 98% of the time or not met met 98% of the time or not met met / not met met / not met 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. Met = unit >11 beds always has second supernumerary nurse available, Partially = available >60% shifts, not met = unit has >11 beds and no additional nurse met - 1.0 per 75, partially met 1.0 per 100, unmet - no educator or less than 1.0 per 100 Met = always provided until competence achieved, partially = provided but may have own patient before full competencies completed, Not met = anything else met or not met Met = >95% of shifts, partially =90-95% shifts, not <90%	2=Fully met 2=Fully met 2=Fully met 1=Partially met 3=Not applicable to Unit 2=Fully met 2=Fully met 2=Fully met 0=Not met	Not funded N/A to ICU Bronglais 0.8 WTE for our unit 33% (less than 90%)
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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 course
4	Additional Clinical Nurse Educators will be required for larger units, i.e. 1.0 WTE for approximately 75 staff. Clinical Nurse Educators	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 relention 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	See above 2.2.6	2=Fully met	
2	coordinating the education and training and CPD framework for intensive care nursing staff and pre-registration students. All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to allow adequate time for registered	See above 2.2.7	2=Fully met	-
	nurses to develop basic skills and competencies assessed to ensure they can safely care for a critically ill patient. All registered nurses commencing in intensive care must be working towards Step 1 of the National Competency Framework for Adult			
3	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 patierm, 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 - inicudes 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.		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
ECOMMENDATIONS	Clinical Nurse Educators should be in possession of a post-registration award in intensive care and an appropriate postgraduate certificate	met / not met	1=Partially met	Partially, no post-graduate ce
	in education or equivalent. Nurse education programmes should follow the National Standards for Critical Care Education (2016) and include both clinical			r ardany, no post-graduate de
2	competence and assessment.	met / not met Met = funded/partially funded (may be from charitable sources) study leave up to 10 days per year available to all	2=Fully met	
3	Study leave should be provided for all members of the MDT for intensive care-related courses and conferences.	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.		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 = montly forum for full MDT, partially met = some provision but not monthly or not formalised, Not met = no mechanism	1=Partially met	Recently re-started
6		Met = trust provides electornic 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 availab
7	The critical care unit should provide access to online clinical resources from within the clinical area for all clinical staff.	Met = trust provides electornic access to appropriate ICM journals and resources, partially met = some access but		Access to on site library avail
8	All consultants should provide regular teaching and feedback to non-consultant grade doctors, nursing staff and allied health	clinicians believe notable omissions, Not met = no access	1=Partially met	Dr Ramesh, difficult intubation
	professionals. There should be a regular multidisciplinary educational programme, including simulation involving medical, nursing and allied health	Met = fully evidence simulation and MDT education programme, Partial = some MDT teaching provided but not		Di rramesn, unicult intubation
9	professional staff.	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	A FICM-associated ACCP with supervision from an ICM consultant falls within the definition of an intensive care resident and may provide			
1	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 Diptioma (PgDip) which meliciausly 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	These Advanced stage in textenence every in addic curca care pharmacy. 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 oharmacist for advice and referrals.	met / not met	0=Not met	
6	As a minimum, the pharmacist must have access to an Advanced Stage in excellence-level) intensive care pharmacist for advice and referrals. 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) revaildation.	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 mainta
4	Physiotherapy staffing must be adopted to provide the respiratory management and rehabilitation companyons of care, ensuring	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 o
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	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	met - 7 days per week, partially met 5 days per week,	1=Partially met	Physio attend on oncall basis (resp
8	plans should be updated accordingly. 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	
			1	
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 obvisiotherapis 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 tihis is purple? Scoping
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 carvice should have a clear local energtional policy and care standards for carvice provision which	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	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	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 hospit
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 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		met / not met	1=Partially met	
U	on service delivery, quality and effectiveness			
7	on service delivery, quality and effectiveness. 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	

1				
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.	<sup>9</sup> 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 referals 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	
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, partialy 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 handeover 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 referals 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
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 cove
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	
				<b>.</b>
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	met / not met	0=Not met	
	programmes that address the complex functional, cognitive and psychosocial needs of the patient cohort.			

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 with
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 pharmalogical stratergies. Not met	2=Fully met	
RECOMMENDATIONS	1			
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 facilities 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 care6 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 ortitical 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 avaiable	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 liness, 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, referrais of patients directly to psychological therapy services, or recommendations for GPs to make referrais to these services, or advice to patients directly to psychological therapy 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			
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				
RECOMMENDATIONS	The Critical Care Scientists should successfully complete an approved training programme, either via accredited specialist training or as			
1	part of the Scientist Training Program (STP) commissioned by the National School of Healthcare Science (NSHCS) and should be	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.	of 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 when they are not proficient.	re 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 Natio
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
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	recognised audit programme (such as ICNARC or SICSAG) and responsibility for the validation of these data. The Intensive Care Nation,	al met = full cover wiht leave cover, partially = less than recommended cover or no leave cover, not met = no al dedicated cover	1=Partially met	No Cover on AL
2.13	Smaller Remote and Rural Critical Care Units	Only relevent for small number of units. An autopopulate feature of not applicable would be useful		
STANDARDS	1			
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		met = 24/7 access to advice / 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-runy 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	with their regional network.	Statement		
3	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	-
	Where an intensive care pharmacist or healthcare professional, such as a physiotherapist or dietician, cannot be effectively delivered			

1	CRITICAL CARE SERVICES: PROCESS	Level description	Level	Comments
3.1	Admission, Discharge and Handover			
STANDARDS	The decision to admit to the critical care unit and the management plan must be discussed with the duty consultant in Intensive Care			
1	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				
STANDARDS	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care potents must be prioritised, such that patients remaining critical care support are admitted without delay (within four bours after decision to	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not		
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, 85-80% admitted within 4 hours, < 85% admitted within 4 hours or not data	2=Fully met	DTOC not met for rischarge
1	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/maging) and patients no longer requiring critical care are discharged within four hours. 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	data	-	DTOC not met for discharge
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1 2 3	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. 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 runse in charge of the critical care unit. Under no circumstances should clinical decisions be over-ridden by non-clinical operational management teams. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans.	data met / not met met / not met	1=Partially met 2=Fully met	
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1 2 3 4 5	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. The final decision outilisation or 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 learns. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans. 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. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios. Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duty intensive care betworks.	data met / not met met / not met met / not met met / not met	1=Partially met 2=Fully met 2=Fully met 2=Fully met	Consultant is not always involved in the decision - Site Manager
1 2 3 4 5 6	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. 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 learns. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans. 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. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scorarios. Regional intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duty to assist neighbouring critical care units. Regional pandemic escalation plans must include trigger levels for agreed critical care admission criteria and threshods for restriction of planed activity to assist neighbouring critical care units.	data met / not met	1=Partially met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	Consultant is not always involved in the decision - Site Manager
1 2 3 4 5 6 7	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. 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 joinly 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. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans. Hospital boards must demonstrate regular oversight of the use of critical care eatile. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to adaitor the virtue reas consultants and duty nurses in charge to coordinate the usage of intensive care beds across the network. Regional plans must include trigger levels for agreed critical care admission criteria and thresholds for restriction of planned activity to assist reglehouring critical care units.	data met / not met met / not met/met met / not met/met/met/met/met/met/met/met/met/met/	1=Partially met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 1=Partially met	Consultant is not always involved in the decision - Site Manager
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1 2 3 4 5 6 7 8 9 10 11	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. 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. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios. Regional Intensive Care Networks must have escalation during 'normal' operation and escalation during major incidents or pandemic scenarios. Regional Intensive care betworks must have an agreed policy on escalation of are and repatitation between escondary and tertiary units to include escalation nd in the solve care units. Regional Intensive Care Networks must have an agreed policy on escalation of care and repatitation between secondary and tertiary units to include escalation and in required, prioritisation of transfers over local elective activity. Regional Intensive Care Networks must have an agreed policy on escalation of are and rep	data met / not met / not met met / not met / not met/ not applicable met / not met / not applicable met / not met / not applicable Met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	1=Partially met       2=Fully met       2=Fully met       2=Fully met       1=Partially met       3=Not applicable to Unit       1=Partially met       2=Fully met	Consultant is not always involved in the decision - Site Manager
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1 2 3 4 5 6 6 7 8 8 9 9 10 11 11 8 RECOMMENDATIONS 1 2	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. 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-indeen by non-clinical operational management teams. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans. Critical care units must have documented escalation plans suitable for their hospital facilities and must audit and review the usage of these plans. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios. 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 critical care and musission criteria and thresholds for restriction of planen dactivity to assist neighbouring ortical care units in graded policy on escalation of care and repatiration between secondary and tertiary units to include escalation and in required, prioritisation of transfers over local elective activity. Regional Intensive Care Networks must have an agreed policy on escalation of care and repatiration between secondary and tertiary units to include escalation and intensive care on white admission of ransfers over local elective activity. Regularial intensive Care Networks must have an agreed policy on escalation fore are and	data met / not met not met / not applicable met / not met / not met >1% of admissions met / not met met = 1.35 or greater, partially 1.45-1:35	1=Partially met       2=Fully met       2=Fully met       2=Fully met       2=Fully met       1=Partially met       3=Not applicable to Unit       1=Partially met       2=Fully met       1=Partially met	Consultant is not always involved in the decision - Site Manager consultant to consultant discussion Mutual aid document HB escalation plan

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		
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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-frigger 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 deterioration 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 247.	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 hospital5. 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		xox
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%, partialy 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 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%, partilly 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, Synbiotix
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 ICCQIP).	met - supply data to ICCQIP ( or equivalent), partially met - locally monitored, not met - not regularly monitored mer - uccumented dany consultant microbiologist input at reast on - Or addit data against dost	1=Partially met	No Submitted VAP data
6	The principles of antibiotic stewardship must be adhered to in consultation with the microbiology team.	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 / 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	

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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 threafter.	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 plance / 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 neuroradiolocy.	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	policy in place = met, no policy = not met	2=Fully met	
3	responsible clinician according to local fail-safe policies. Urgent clinical chemistry and haematology advice should be available within 60 minutes from an appropriate specialist and a radiologist	met / not met	2=Fully met	HB policy
4	should be immediately contactable to support the management of acutely ill patients at all times. All point of care laboratory devices used to assist clinical decision making should be subject to appropriate quality assurance mechanisms,	met = fully centralised lab standard QA process in place with audit evidence, partially = some QA process		
5	agreed by laboratory and end users. Clear protocols for access to radiology services that are not available on site (e.g. interventional radiology, MRI in ventilated patients) should	with intermittent audit, unmet = no laboratory standard QA process	3=Not applicable to Unit	
	be available. Liaison psychiatry services should be available in all acute hospitals with a single point of referral. Emergency mental health referrals should			
6	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-assing treatment is necessary, or the patient is unconscious or otherwise incapable of being assessed.	met / not met	0=Not met	patients must be medically fiit 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	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	1=Partially met	
2	rehabilitation plan outlined by all relevant therapy professions as clinically indicated. Patients receiving rehabilitation must be offered therapy by the multi-professional learn 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 underlated according).	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	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2=Fully met	
4	completed. 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	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	0=Not met	
6	referrals to any necessary services can be made. 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	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	1=Partially met	
7	rehabilitation plan should occur as soon as feasible and appropriate. 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	
	roovery, the internation oncome by provided, at the latest, before discribinge from neaphair.			9
RECOMMENDATIONS				
1	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per mask: provision should be made for other therapy services to be provided as peeded 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	week; provision should be made for other therapy services to be provided as needed at weekends. Specialist rehabilitation co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to genue the second the provided and documentation as new provided out the provided as a provided on the terms of the provided on the provided o	met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doens't exist	0=Not met	respiratory care only due to capability
	ensure that assessments, referrals and documentation are completed and transferred to ongoing services and teams.			

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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	Initial cate: r during works required to determine the appropriate granuary or these. 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 on component of the formal handwards, functional, communication, social, spintae, inclusional and psychological. To facilitate the rehabilitation component of the formal handward or of care on discharge from critical care to a general ward, weekly multidisciplinary rehabilitation oward rounds should be led by a senior member of the critical care multi-professional team and result in an update to the rehabilitation opais. These should be set in conjunction with the platent and/or care where appropriate.	met / not met	0=Not met	
7	Docate to the feral manufacting data. These should be identified regularly and addressed in a consistent manner by the most appropriate Expectations of both patients and families should be identified regularly and addressed in a consistent manner by the most appropriate service members 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	To daminise the second se	met / not met	1=Partially met	
	and family.			Physios will fill out diaries
3.7	Intensive Care Follow Up			
0.1				
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		0=Not met	
	required for specific patients.			<u> </u>
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 discharce and at hospital discharce.	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 following 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 soreening 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- referaal 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 diring
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 familes, not met - not done	1-Faltially 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.		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	
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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		0=Not met	
3	for each patient is very beneficial and should be used if possible. Intensive care and ward staff should have training in what intensive care is like for patients and relatives and what challenges patients face	met / not met	0=Not met	
4	while in intensive care and during their rehabilitation. Asking former patients and relatives to help with this training is beneficial. 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 unconscicus 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	met / not met	2=Fully met	
5	relatives. 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 bareavement pathway supported by clinical psy
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 organizational priority. Units must manifer and requirely review matrice of staff well being as quality indicators (a.g.	met - quartlerly , partially met 1-2 yrs, unmet - not monitored or mroe 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. Schwarz) 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
	Inter and Intra and Hospital Transfer of Critically III Patients			
3.10				
3.10 STANDARDS	1			

	An any sinter any important and the subjects to undertake a safe to under and to many some limiting (solution a subject which may assure			
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	met / not met	2=Fully met	
-	daning a danset, sa quipmon asse lo parent danses mas conomico de recevan sarety standards, co regulariy servecu, and checked immediately before use.		2 1 010 1100	
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	
3		met / hot met	2-Fully met	
	Where patient transfers result in a change of team managing the patient during or following a transfer, an appropriate and documented		0.5.1	
4	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	
	record. 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.			
5	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.		2-Eully met	
ь		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	met / not met	2=Fully met	
	hospital. This must be agreed prior to the transfer being undertaken.			
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.	Percentge occuring within 48 hours of decision. Met > 85%, partailly met 75-85%, not met < 75% of the time or no data collected.	1=Partially met	
	Indist take place within 40 hours of referantio the receiving hospital.	ume of no data collected.		
RECOMMENDATIONS				
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	2=Fully met	
	The reason for any transfer should be documented in the patient's notes. This should include an assessment of potential benefits against	meet standard and no risk assessment	· ·	
2	risks. Transfer decisions should only be made by consultant intensive care team members, and this information should also be	met = documented 95%, partially met 80-95%, unmet <80% or no data or not a consultnat decision	2=Fully met	
-	documented.	The construct so w, parally the boost w, and construct so w of the data of the a construct	2 1 010 1100	
	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	met = checked with log and tagged, partially = daily check but not tagged or logged, unmet = no		
3	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	checking or significant deficiencies in kit available	2=Fully met	
	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.			Supported by operating theatre
	The patient's vital signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy		0.5.1	supported by operating incare
4	any physiological deterioration during the transfer.	met = audit evidence of obs or transfer forms, unmet = no evidence	2=Fully met	
	Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be			
5	scrutinised within a robust audit system, allowing eventful or substandard transfers to be investigated and lessons learnt to be shared	met = use of a network wide agreed form or electronic recording system, unmet = no standard system	2=Fully met	
	widely, as well as numbers and reasons for transfers. Where an adverse event occurs during a transfer, this should be reported and investigated using the healthcare organisation incident			
6	reporting system at the transferring unit. All learning should be widely shared.	met / not met	2=Fully met	
_	Every acute healthcare organisation should have a designated consultant and nurse who are responsible for maintaining standards of			
7	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	
-	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			
10	need for transfer. This discussion should be documented.	met = 95%, partially = 80-95%, unmet <80% documented	2=Fully met	
	There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area. The			
11	definition of 'delay' will vary according to the reason for the transfer. For patients being transferred from a specialist critical care unit to a	met / not met	2=Fully met	
	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		2 1 010 1100	
	of referral to the general critical care unit. Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who are			
10	at a high risk of harbouring such infections both during transfer and in the receiving hospital; their availability should be such that this does		0.5.1	
12	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	
	There should be a system for monitoring the quality of inter hospital transfers and governance arrangements which includes capture of	met - well established processes, data avaiable, partially met - reviewed, limited data available, not met.		
14	numbers, indication for transfer, incidents, deaved transfers and outcomes. Audit measures and learning should be widely shared.	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		
	protone and detende impact of unitations on the unitationing unit due to IUSS Of Key Statt.			
3.11	Care at the End of Life			
5.11				
STANDARDS				
1	Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and	met = 98% with clear documentation, partially = 95-98% documented but gaps found in documentation	2=Fully met	
	communicated to patients and their loved ones. The latter being of particular relevance if patients lack capacity (below).	on audit, unmet = <95% or major failings in what is documented	z=rully met	
	Decision making surrounding end of life care (EoLC) must be performed in accordance with relevant statutory requirements and			
2	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;	met / not met	2=Fully met	
	specifically Treatment and Care Towards the End of Life: Good Practice in Decision Making.			
3	Declaration of death by cardiorespiratory or neurological criteria must be done in accordance with professional guidance.	met / not met	2=Fully met	
3			z=rully met	
4	Consideration must be made as to whether organ and tissue donation can be offered to every dying patient, and where appropriate the	met = considered with audit data on referral rates reviewed quarterly, partially = considered but no audit	2=Fully met	
	specialist nurse-organ donation (SNOD) should be contacted. In order to identify dying patients and respond to changes in their condition, those at high risk of dying must have their condition regularly	data or <70% referral rate, unmet = not done	,	
5	reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.	Statement		
	and appropriate organization of the strength or and service and appropriate organization of the strength of th			
RECOMMENDATIONS				
	Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying. Best practice dictates			
1	that has close to the patient should also be informed.	met / not met	2=Fully met	

2	Decision making related to care at the end of file 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 dirikdians. Previous decisions should also be taken into account e.g. treatment escalation plans (TEP), ReSPECT	met / not met	2=Fully met	
3	(Recommended Summary Care Plan for Emergency Care and Treatment). At least two consultants, supported by serior 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 pallative 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 patient's surrogates (as defined by the MCA or equivalent) at the earlies 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 leams. 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 hourd/days of the enabling prompt symptom control. This includes therapeutic options for analgesia, dyspnesa, 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 handworer 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 detentiating 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	Statement		
-	does not have formal legal standing in Scotland, they are likely to be highly persuasive to the court).			

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		
0	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	Statement		
9	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.			
3	lack of agreement to a proposed course of action from those with an interest in the patient's weitare, a court application must be made.			<u></u>
9				1
RECOMMENDATIONS				1
RECOMMENDATIONS		met / not met	1=Partially met	Hospital concerns policy (from family)
RECOMMENDATIONS	A written departmental protocol for resolution of disagreements should be in place. Disagreements may be within the team, between different clinical leams or between team and family/friends. An ADRT that does not meet the oriteria 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.	met / not met Statement	1=Partially met	Hospital concerns policy (from family)
RECOMMENDATIONS 1 2 3	A written departmental protocol for resolution of disagreements should be in place. Disagreements may be within the team, between different clinical teams or between tam and family/firends. An ADRT that does not meet the oriteria to be formally legally binding should nevertheless be taken into account as part of the best		1=Partially met	Hospital concerns policy (from family)

Section 4 CRITICAL CARE SERVICES: CLINICAL CARE Level description

	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	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.	mer AbG machine on unit or winnin easy use, with a backup within 5 mins or unit or >1 machine, partiany – 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 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 hypercaphic 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	met / not met			
	out in NICE Guidance.				
4.2	Mandan Jawa Parlaman Manharita Manifetina and Lawa Tawa Hawa Manifetina American				
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					
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	
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	Units must hold mult-professional clinical governance meetings, including analysis of mortality and morbidity.	met / not met	1=Partially met	No M&M Meeting	
	Units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity. 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.		1=Partially met	No M&M Meeting Verbal discussion-no written documentation.	
	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory				
RECOMMENDATIONS	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. 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. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols.	met / not met met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved met protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols	1=Partially met		
RECOMMENDATIONS 1 2	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. 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 dielitian members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols. Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and	met / not met met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved	1=Partially met		
RECOMMENDATIONS 1 2 3	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or neurological co-morbidites. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure. 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 dieltian members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols. 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). The use of non-invasive ventilation (NV) as a bridge to spontaneous breathing should be considered in selective groups. Resources and skill in NVS ahould be available in all units managing patients with prolonged ventilatory needs.	met / not met met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved 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 1=Partially met 0=Not met		
RECOMMENDATIONS 1 2 3 4	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. Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing patients who weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietitian members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols. 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 (Charger 3.6). The use of non-invasive ventilation (NIV) as a bridge to spontaneous breathing should be considered in selective groups.	met / not met met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved 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 met / not met	1=Partially met 1=Partially met 0=Not met 2=Fully met		
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RECOMMENDATIONS           1           2           3           4           5           6	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or neurological co-morbidites. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure. 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 dietliam members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols. 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). The use of non-invasive ventilation (NV) as a bridge to spontaneous breathing should be considered in selective groups. Resources and skill in NV should be available in all units managing patients with prolonged ventilatory needs. Early discussion with regional domicilary 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 met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved 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 met / not met met / not met met / not met / NA if no regional weaning service	1=Partially met 1=Partially met 0=Not met 2=Fully met 2=Fully met		
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RECOMMENDATIONS 1 2 3 4 5 6 7	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. Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing patients whe weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietilian members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management, based on agreed protocols. 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 his document on rehabilitation (Chapter 3.6). The use of non-invasive ventilation (NV) as a bridge to spontaneous breathing should be considered in selecitive groups. Resources and skill in NV should be available in all units managing patients with protonged ventilatory needs. 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 canters should offer advice to referring units to assist with weaning. 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 met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved 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 met / not met met / not met met / not met / NA if no regional weaning service	1=Partially met 1=Partially met 0=Not met 2=Fully met 2=Fully met		

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	
ECOMMENDATIONS	5			
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	citrate anticoagulation should be available Mel/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	
STANDARDS				
1	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.	mer – clear guideline in place meeting trese chiena and addir 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	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	
COMMENDATIONS				
	6			
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	
1	Nutritional status and risk should be assessed on admission, and energy, protein and micronutrient needs determined by a	met / not met met / not met	2=Fully met 2=Fully met	
	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them.			
2	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to	met / not met	2=Fully met	
2 3	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them. 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 hypocabric nutrition may be safe	met / not met	2=Fully met	
2 3 4	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them. 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 hypocabric nutrition may be safe initially.	met / not met met / not met met / not met	2=Fully met 2=Fully met 2=Fully met	
2 3 4 5	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them. 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 2=Fully met 2=Fully met 2=Fully met	Will be part of WICIS
2 3 4 5 6	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them. 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. 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. Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines. Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly infusion rate of EN to optimise	met / not met	2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met	Will be part of WICIS No bridles across the HB
2 3 4 5 6 7	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them. 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. 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. Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines. 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	2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met 0=Not met	
2 3 4 5 6 7 8	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. 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. Nutritional intake targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remedy them. Efforts need not be made to cover full energy targets with EN or PN until clinical stability has been achieved. Delivering a calorie foad which exceeds energy expenditure appears harmful and should be avoided, whereas hypocatoric nutrition may be safe initially. 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. Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines. 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. There should be access to nasal bridles to secure NGTs in agitated patients and guidelines for their use and aftercare.	met / not met	2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met 0=Not met 0=Not met	

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		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 patierns.	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	2=Fully met		
4	Patients with ALF should have access to plasma exchange therapies. Praterns with ALF should have access to recrimingues used to assess intracramar pressure antizior cerebrar pendision, with	met / not met / not applicable	0=Not met		
5		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	infarction must be in place. 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 met / not met	2=Fully met 2=Fully met		
5	infarction must be in place. The intensive care team must facilitate the implementation of national standards, guidelines and pathways pertaining to the				
	Infarction must be in place. 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. The advanced management of patients with acute valvular insufficiency or acute heart failure secondary to valve disease must be	met / not met	2=Fully met		
	infarction must be in place. 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. 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		
6	Infarction must be in place. 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. 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 cardiothoracle surgical unit. 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	PICCO Implementation pending	
6 RECOMMENDATIONS	Infarction must be in place. 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. 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. 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 (in consultation with local/regional cardiology team). This may require transfer to anothere centre.	met / not met met / not met	2=Fully met 2=Fully met	PICCO Implementation pending	
6 RECOMMENDATIONS	Infarction must be in place. 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. 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. 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 met / not met met / not met	2=Fuly met 2=Fuly met 1=Partially met	PICCO Implementation pending	
6 RECOMMENDATIONS 1 2	Infarction must be in place. 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. 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. 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. An intra-aortic ballor pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.	met / not met met / not met met / not met met / not met	2=Fuly met 2=Fuly met 1=Partially met 0=Not met	PICCO Implementation pending	
6 RECOMMENDATIONS 1 2	Infarction must be in place. 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. 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. 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. An intra-aortic ballor pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.	met / not met met / not met met / not met met / not met	2=Fuly met 2=Fuly met 1=Partially met 0=Not met	PICCO Implementation pending	
6 RECOMMENDATIONS 1 2 3	Infarction must be in place. 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. 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. 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. An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre. 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 met / not met met / not met met / not met	2=Fuly met 2=Fuly met 1=Partially met 0=Not met	PICCO Implementation pending	
6 RECOMMENDATIONS 1 2 3	Infarction must be in place. 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. 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. 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. An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre. 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 met / not met met / not met met / not met	2=Fuly met 2=Fuly met 1=Partially met 0=Not met	PICCO Implementation pending	
6 RECOMMENDATIONS 1 2 3 3 4.7	Infarction must be in place. Infarction must be in place. 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. 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. 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. An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre. 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.  Echocardiography and Ultrasound	met / not met met / not met met / not met met / not met	2=Fuly met 2=Fuly met 1=Partially met 0=Not met	PICCO Implementation pending	
6 RECOMMENDATIONS 1 2 3 3 4.7 STANDARDS	Infarction must be in place. Infarction must be in place. 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. 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. 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. An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre. 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.  Echocardiography and Ultrasound	met / not met	2=Fuly met 2=Fuly met 1=Partially met 0=Not met	PICCO Implementation pending	
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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, curvilnear 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 echol/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/documented 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 emains 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	met / not met	2=Fully met	
	with technological advances.			
4.8	Neurological Support			
4.8	Neurological Support			
4.8 STANDARDS				
	Neurological Support 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	
STANDARDS	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. Adults who are unconscious after (out of hospital) cardia 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 - continuous EEG or processed EEG available on unit, not met, no EEG / Processed EEG available met / not met	0=Not met 2=Fully met	
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. 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. Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must			
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STANDARDS 1 2 3	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. 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. 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 partnershio of care.	met / not met	2=Fully met 2=Fully met	Cardiff
STANDARDS 1 2 3 4	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. 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. 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, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the linked spinal cord injury care following a primary intracerberal haemornhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral aftery infractor admitted to intensive must have access to a decompressive	met / not met met / not met	2=Fully met 2=Fully met 2=Fully met	Cardiff
STANDARDS           1           2           3           4           5	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. 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. Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the inked spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the inked 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. Previously fit adults, admitted to critical care following a primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral artery infraction admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of	met / not met met / not met met / not met	2=Fully met 2=Fully met 2=Fully met 2=Fully met	Cardifi
STANDARDS           1           2           3           4           5           6	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. 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. Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indiced spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indiced spinal cord or any any aspecialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indiced spinal cord or any any aspecial area primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral area printarciton admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Prognostication in hypoxic-ischaemic brain injury after resuscitation from cardiac arrest should follow the European Advisory	met / not met met - able to fully follow partially met - able to undertake some additional testing beyond CT, unmet - unable	2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	Cardff
STANDARDS           1           2           3           4           5           6	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. 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. Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indiced spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indiced spinal cord or any any aspecialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indiced spinal cord or any any aspecial area primary intracerebral haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral area printarciton admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Prognostication in hypoxic-ischaemic brain injury after resuscitation from cardiac arrest should follow the European Advisory	met / not met met - able to fully follow partially met - able to undertake some additional testing beyond CT, unmet - unable	2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	Cardff
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STANDARDS 1 1 2 3 4 5 6 7 RECOMMENDATIONS 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. 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. Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indixed spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the indixed spinal cord of surgical evacuation. Previously fit adults, admitted to critical care following a primary intracerebral haemonrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral artery infraction admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice. 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. 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=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	Cardiff
STANDARDS           1           2           3           4           5           6           7           RECOMMENDATIONS           1           2	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. Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infraction must be considered for coronary angiography with follow-on primary percutaneous coronary intervention if indicated. 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. Previously fit adults, admitted to critical care following a primary intracerbarity must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral artery infractor admitted to intensive must bare access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice. 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 should follow the European Advisory Statement on Neurological Prognostication in comatose survivors following cardiac arrest as per the Resuscitation Council (UK) guidelines. The management of faulents with prolonged disorders of consciousness should follow national guidance. Patients with perceived devastating brain injury should follow national and international best practice guidance.	met / not met	2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	Cardiff
STANDARDS           1           2           3           4           5           6           7           RECOMMENDATIONS           1           2           3	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. 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. 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, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the linked spinal cord injury care consultanti within four hours of disanosis to establish a partnership of care. Previously fit adults, admitted to critical care following a primary intracerberal haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral artery infraction admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be technical as per the Academy of Medical Royal College's Code of Practice. 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. Protocols should be available to deliver post-resuscitation care to comatose survivors following cardiac arrest as per the Resuscitation Council (UK) guidelines. The management of fraumatic brain injury should follow national and international best practice guidance. Management of fautents with prolonged disorders of consciousness should follow national guidance. Patients with perceived devastating brain injury should be admitted to the critical care unit to aid pr	met / not met	2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	Cardiff
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STANDARDS           1           2           3           4           5           6           7           RECOMMENDATIONS           1           2           3           4           5	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. Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infraction must be considered for coronary angiography with follow-on primary percutaneous coronary intervention if indicated. Following traumatic spinal cord injury, carefre consultant within four hours of diagnosis to establish a partnership of care. Previously fit adults, admitted to critical care following a primary intracerbary percutaneous coronary intervention if indicated. Adults under the age of 60 with middle cerebral artery infracriton admitted to intensive must be referred to specialist neurosurgical centres for consideration of surgical executation. Adults under the age of 60 with middle cerebral artery infracriton admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice. 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. The management of fraumatic brain injury should follow national and international best practice guidance. Management of patients with prolonged disorders of consciousness should follow national guidance. 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 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met 2=Fully met	
STANDARDS           1           2           3           4           5           6           7           RECOMMENDATIONS           1           2           3           4           5           6           7           8           1           2           3           4           5           6	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. 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. 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, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the linked spinal cord injury care consultant within four hours of disanosis to establish a patrementh of care. Previously fit adults, admitted to critical care following a primary intracerberal haemorrhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral artery infraction admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be to conducted as per the Academy of Medical Royal College's Code of Practice. 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. Management of ratematic brain injury should follow national and international best practice guidance. Patients with perceived devastating brain injury should follow national and international best practice guidance. Patients with perceived devastating brain injury should be admitted to the critical care unit to aid prognostication as per national guidance. Intracerebrain haemorrhage should be managed in accordance with international guidance with particular attent	met / not met	2=Fully met 2=Fully met	
STANDARDS           1           2           3           4           5           6           7           RECOMMENDATIONS           1           2           3           4           5           6           7           6           7           6           7           6           7           6           7	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. Adults who are unconscious after (out of hospital) cardiac arrest caused by suspected acute ST segment elevation myocardial infraction must be considered for coronary angiography with follow-on primary percutaneous coronary intervention if indicated. 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 care following a primary intracerberal haemornhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults andmitted to critical care following a primary intracerberal haemornhage, must be referred to specialist neurosurgical centres for consideration of surgical evacuation. Adults under the age of 60 with middle cerebral artery infracton admitted to intensive must have access to a decompressive craniectomy service at a specialist neurosciences centre. Declaration of death by neurological criteria must be conducted as per the Academy of Medical Royal College's Code of Practice. Prognostication in hypoxic-ischemic brain injury after resuscitation from cardiac arrest should follow the European Advisory Statement on Neurological Prognostication in comatose survivors of cardiac arrest. Management of ratumatic brain injury should follow national and international best practice guidance. Management of future brain injury should follow national and international best practice guidance. Patients with perceived devastating brain injury should be admitted to the critical care unit to aid prognostication as per national guidance. Intracerebrain haemorrhage should be managed in accordance with international guidance with particular attention to the reversal of anticoaguiation and acute control of blood pressure. The management of patie	met / not met	2=Fully met 2=Fully met	

		met - as per recomendation, partially met - less frequently than daily consultation, no telemedicine, unmet - difficult to access neurology advice	2=Fully met	
	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	
	Fever control to normothermia following traumatic brain injury, aneurysmal subarachnoid haemorrhage, ischaemic stroke, or haemorrhagic stroke may improve outcome.	a temperature controling device with a closed feedback loop must be available met / not met	2=Fully met	
	Appropriate patients with acute ischaemic stroke should be referred for mechanical thrombectomy in accordance with national commissioning policy.	met - referal pathway in place 24/7 partially met - referral pathway les than 24/7, unmet - no referral pathway	2=Fully met	
4.9	Burns			

Burns units only

STANDARDS

OTANDARDO			
	Staffing models must promote joint care between burn and critical care teams as this may improve safety and confer a significant survival benefit.		3=Not applicable to Unit
2	A burns theater 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
	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, o) 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

Care of the Critically III Pregnant (or Recently Pregnant) Woman

#### STANDARDS

4.10

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 peri- mortem 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 fails 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

	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	
	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 III 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	met / not met	3=Not applicable to Unit			
	paediatric critical care. Medical staff with responsibility for the resuscitation and airway management of the critically ill child on an adult unit must have up					
5	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 III 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	met / not met	2=Fully met			
7	for the ICU (CAM-ICU) or the Intensive Care Delirium Screening Checklist (ICDSC). Indwelling intravascular catheters must be inspected daily for evidence of infection using a suitable scoring system e.g. Visual Individue Diffusion Canada (Individue) and a suitable scoring system e.g. Visual	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or	1=Partially met			
8	Infusion Phlebitis Score (Jackson 1998) to guide necessity for removal. The continued need for indwelling catheters (intravascular or urinary) must be considered daily.	compliance < 90%, un met = no guideline or compliance < 50% met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or	1=Partially met			
9	Monitoring of invasively ventilated patients must include continuous waveform capnography.	compliance < 90%, un met = no guideline or compliance < 50%	2=Fully met			
	monitoring of interview vortiliated patients most include continuous wavelotti capitography.					
10	Care bundles must be in place for Intubation Associated Pneumonia (IAP) prevention, Central Venous Catheter (CVC) insertion	mat / not mat	2-Eully mot			
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 cmH20 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) mainutrition, (which maybe a combination of cachexia (disease related) and mainutrition (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 5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS	Taxa Literariation		
		Level description	Lavel	Comme #56
8.1 STANABTS	Research and Development			
1	At individuals participating in RED activity must have completed Good Clinical Practice (GCP) training for research and keep this up	met / not met		
00000 Fab. 2000				
1	Ortical care units elouid nominate a lead for RMD activities who should coordinate activity and ensure it is carried out to UK Policy	met / not met or not applicable	2+Fully net	
2	Critical care units should participate in research retworks, which are organised at Local Clinical Research Network (LCHR) level Records the resistont Network Software (LCHR) retworks Research (NMR) Critical Care research retwork level	met / not met or not applicable	2+Fully not	
2		met / not met or not applicable	2+Fully met	
5		met i' not met or not applicable met i' not met or not applicable	2+Fully met	
		mut / not mut or not applicable	2+Fully met	
8.2	Audit and Quality improvement			
	Allow and Cased improvement			
STANDARDS	Critical care units must have a structured and planned divical audit programme to company practice to published standards. There			
1	Circlai care unte must have a disclored and planned circlai audi programme to compare practice to published standards. There must ha is interfant land for the scole incomment. Circlai care unte must addicate in a Network-Audi Programme for Adult Ortical Care, such as the Scottan Internative Care Society.	met / not met	1+Partially net	
	Audit forum riterfuldris or Intension Pana Mathemat Australia and Bearback Plasma (PMAE) incommenter Critical care units markethave a surveillance system in place for audit and feedback of neocomial infection, for example, catheter- aliante thereares and other folio of texamined infections, canonical to the antiback of neocomial infection, provide the surface and the surveil and the surface of the antiback of the antiback of the surface and the surface of the surface of the surface and the surface of the surfac	net / sol net		
3	also report the incidence of inclusion associated preventia. All write must participate in rational audit programmes for noncomial infections in intensive care, for example, Public Health England Erlectors in Critical Care Programme (CCOOP) and Sociation	met / not met	d-Mut set	
4	The second se	Discharges after 21.59 as persentage of at eligible advisiances - met <2% partially met, 2-6% not mercels	2+Fully met	
5	Difference on the functional regular feedback about the care that patients and relatives receive during their critical care admission is other to learn from and act on the feedback modered.	met - annual process, partially met, undertaken every 1-2 years, unmet, never done or less than 2 Veally	1-Padaly net	
RECOMMENDATIONS				
	Units should have nominated medical and numling leads for quality improvement and audit. Appropriate time should be made available in job plans for these dudes. Time to participate in audit and quality improvement programmes should also form part of the	met unmet	d-Nacional	
2	Hospitals should have a quality improvement (O) programme in place for each critical care unit in their organisation. The programme should aim to deliver sale, efficient, effective, patient centred, timely and equitable patient care, which is evidence based, and	met i unnet	1-Partially net	
3	should below recommend on the intercontent methodology. Staff should be encouraged and supported to train in quality improvement methodology and all projects should be multidisciplinary, recomming the reasests for a beam approach and the combinden of all staff proper.	mut / unmut	1-Padaly net	EQUP Programme available
4	Answer the component with neuronance methods and the component methods by a structure of the component method by a structure of the component methods by a structure o	mer + sobust data collection and feedback for both local and national audit, partially mer + sobust data collection and feedback for exclosed andrones not mer - no colour extenses for data collection or	0-National	
5	A value, our value, not the local on a statute and managements. Contract Loop Neuronal Networks were applied on the productional page events programme in place for the value in their jurisdiction. But instance when the taxat or a value of a statute of the value	met / not met / not applicable Net - eutent all data to: KNRRC / SICOAD data topic - entretic met - one-ro encounters	2 + ally stat	
	readmissions within 48 hours of discharge, as a potential indicator of resource pressures. It is recommended that units should also reasons a sub-discharges as their more to a mediatr of sub-ficient reasons as	mixing, not net - poor data compliance with IDMRC / SICIAG	are ally mill	
63	Clinical Gavernance			
STANDARDS	These reacts are accordingly realized considered and apply specific events of a react the deleted events of the			
1	These must be an appropriately trained consistent and service normal identified as leads for chical governance. The consultant must not be the distant lead or chical denoter for optical care. These must be an industry splice for reporting investigating, and learning from all padent takey incidents. Appropriate action praces must be formation in response to indicets. Use to action also from from (print og unit, a priodent Ased) in incidente in discover and the indicated in indicets. The state and also have from from (print og unit, a priodent Ased) in incidente in indicets in the indicets.	And / And Part	2.4 aly list	
	premis new wir new satellited in response to incidents. Understaud also learn from things that go well, a process described in excellence lasorities Units must hold regular structured multidecipinary dirical governance meetings, where they discuss wit motivity and incidence.			
3	Accords volts must have support executions multidiscipitary dinizit governance meetings, where they discuss out mobility and mortality, including all seams, critical includents and near instance. A wattern mode of address takes and tessors learned nour to key and using and mellitary and the discussion of address takes ingl control of bit iplass. These test discuss have not address of the discussion of the discussion of address takes ingl control of the discuss of the discussion of the folgouine feedbacks: must be discussed for any energy control of address of the quality of card delevers it, for example by the use of address address of the discussion of the discus	Inst - meets full standard with minimum of quarterly meetings, partially met - meets standard but less than quarterly, unmet - doesn't meet the standards	0-Marchael	
4	Regular feedback must be detailed from service users and staff about the quality of care delivered, for example by the use of safety interest and satellized "countrocomizes.		0+Nact and	
	Critical and statistical autocontrate Critical case with study participants in a non-tally review programme using appropriate methodology to maximize learning and commentants in case. Accounting autocontrate antices must be block observation sources and formation of the commentant of the statistical study of the statist	met + mostality review process that includes all deaths in X2J. / out met	d-National Tablety and	
,	At ands was manine a risk register that is registery reviewed and updated by both servic managenia and device cell. The out must have processes to ensure clinical cell at waves, in a triangly being, of any serving point their obtained and register and inclusion leaving the complete transformed and processes, existences imports, pathetic cellsence and complexity and search cell services and an another device the service of the cells of the service of the second search and search as all to another pathetic and the second second second search and the second s	mit - in place, quarterly reverse, partially met, in place less than quarterly reverse, unnet - not in place	2-Fuly not	
'	are contrasting to many or many responses and processing incomes open in particular contains and composition, and the area and to add to any particular important information to inform partient care (for example information about medications and unit policied) advances many particular information to inform partient care (for example information about medications and unit policied) advances many particular information to inform partient care (for example information about medications and unit policied) advances of the second	east / not east		
	abilities random Staff with these to conduct reviews of patient safety incidents, not cause analysis and appreciative enguly must be taked in the management of these processes so that the seleces are conducted anxiatively and constructively. Similarly, effective quality incomments monitors with the school is units incomments related to the seleces.	mat / not mat	2+Fuly net	
	necessaries cancels control and a scalar la variable control incompanies antibioticity. Scalar with restrictions and control and registrational to restrice proceedings to the scalar processing, central lines and cherrication income and scalar lines and cherrication in the scalar processing scalar lines and cherrication in the scalar processing scalar lines in the scalar processing scalar lines in the scalar processing scalar lines in the scalar sca	and i not out	2+Fully net	Critical care LocidiP in place
	internation transfer, procedurar verification, a safety briefing and time out, and a sign out and debrefing. An example of this process			
50	Critical care units must comply with reviews and visits by national organisations, (for example the COC in England).	met / not met	2+Fully met	
RECOMMENDATIONS				
1	Intervalse care worlf should aver with other divided teams in the tongoat with regard to joint learning from monitolity and monitolity minus and second team instantial second teachesis of const. This should be applied to be applied to the second this should regard the second teachesis of constraints and other seconds of existing to many that the set complexes with sets produce. These existence sources should be transmitted in to comprehensive totally agreed guidelines or Standard Amendministry.	met - done quarterly, partially met, done annually, not met, not done - use comments box	d-Max and	
2	Units should regularly review publices from professional organizations and other accross of evidence to ensure that the unit complex with best practice. These evidence sources should be translated into comprehensive locally agreed guidelines or Standard documents of the sources.	met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed	1-Partialy net	
3	The unit should identify key performance indicators (KPIs) that describe outcomes of their service. Such KPIs may be generic and		d-Nucleat	
4	Soft should be recognized as the key resource in interview care. A fully engaged, and restructed with trained and with ted workforce is essential to allow incidence in clinical care to fouries. Staff sickness cases, turnown rates and information from appraisal, staff	Met + all staff wellkeing criteria stated are nonitored, partially net + same criteria are monitored, not	1-Partially net	
5	Service And Ser	men existent of closes and memory memory and the program to share best practice and Q(1) not met	1-Partialy net	
-	agencies, including intensive care networks. The external responsibility for the oversight of governance annangements varies	nen e una partupar el renera nen propue se suare sen prassar ana que ren ren		
	The unit should be able to demonstrate that it is continuously working to improve patient care using recognized quality improvement technicum networks for increasional real-statement and	metri Unit have undertaken at least one local patient centric Otprogram in previous 12 months / unmet		
6 84	Critical Care Networks	metre Unit have undertaken at least one local padient centric Of program in previous 12 months r unmet		
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Section 6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS	Level description	Land	As a second s
Section 6	URITICAL CARE SERVICES: EMERGENCI PREPAREUNESS	Level description	Level	Comments
6.1	Fire			
STANDARDS				
1		Met or unmet	2=Fully met	
2	Each unit must have a specific fire execution 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 the state of the second	Met or unmet	2=Fully met	
	to continue working. Action cards summarising the evacuation procedure should be displayed within the unit, ideally next to fire call opints, so that they can be referred to in an emergency. Recommendations for the safe use of oxygen cylinders must be adhered to at all times and include: the safe use of oxygen cylinder			
3	bed brackets, b) the safe storage of oxygen cylinders and c) following the recommended sequence of events when turning on an oxygen cylinder. Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring		2=Fully met	
4	and mice comp, whice cannot be particular to read registronic registrong due increases manual or management of earling and cutatins. 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 : givintifies et routes, b) site day, sit sheets or other vecusation aids for all bed spaces		2=Fully met	
5	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	this most have a major incident plan in place which allows for the transfer in of multiple critical care patients from a neighbouring hostiality critical care unit should it need to carr out an emercency execution. Any problem with oxygen cylindes and associated equipment must be reported immediately to both the medical gas supplier and	Met / unmet Met / unmet	2=Fully met	Major Incident plans in place, along with Business Continuity plans. Activity
	the Medicines and Healthcare products Regulatory Authority (MHRA). All staff must undergo regular training in fire prevention and fire procedures, to include training in-situ in the specific clinical areas in which thou which all stoff must force of the location of the order outline their sum unit and how to appret them. In the location			
8	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 piceline 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. Local unit evacuation policies must be drawn up, with consideration for: a) other locations within the hospital where critical care	met = > 90% of staff compliant , partially met > 75%,, not met < 75%	2=Fully met	
10	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	Met / unmet	0=Not met	Departmental fire plans currently being updated to include guidance from the
	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			
RECOMMENDATIONS				
RECOMMENDATIONS	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		1=Partially met	Fire evacuation plan discusses Liaison with hospital fire response team.Patie
2	be harmed by a transfer: if evacuation occurs too late, then patients and staff may be harmed by fire and smoke. Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be	Met - tested annually , partially met tested daytime only and / or less than annually, unmet, not tested	1 1=Partially met	rite evacuation part discusses claison with hopital life response team rate
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	in the last 2 years Met - system available / unmet - no system in place to do this	2=Fully met	Included in Fire Plan
3	Management (TRIM) system is a screening tool used in the military and more recently used successfully in healthcare which could be considered. Critical care networks should develop systems to support planning for, and management of, a major incident in one critical care unit	mos - oyusun avanaure r unmes - nu system in prace to do uns	- · · · · · · · · · · · · · · · · · · ·	
4		met / not met / not applicable	3=Not applicable to Unit	Local BCP and Major Incident plans apply
				-
6.2	Maior Incidents			
STANDARDS	All hospitals designated receiving hospitals with Level 3 critical care capability must be prepared to double their normal Level 3	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments		
1	ventilated capacity and to maintain this for up to 96 hours. All nominated supporting hospitals with Level 3 critical care capability must be prepared to double their normal capacity for Level 3	box here ) unmet - no clans in clace to meet this standard Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments	0=Not met 0=Not met	innadequaute logistics to double capacity Inadequate logistics to double capacity
3		box here ) unmet - no plans in place to meet this standard Met / unmet	2=Fully met	
4	within Critical Care Operational Deliverv Network areas and bevond.	Met / unmet	2=Fully met	Patients will be taken to Theatres/Recovery or the day surgery unit dependin
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	adequate rest and psychological support for staff. Action cards must be available for use on activation of plan and must include information and communication routes that are to be	met / unmet met / unmet	2=Fully met 2=Fully met	Business Continuity plans in place.Dedicated Pschologist working in Critical Action Cards included in major incident and fire plans
	used.			
RECOMMENDATIONS	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response			
1	(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.			
3	Intensive care service staff should participate in the local and regional multidisciplinary exercises including 'table top' and 'live'	met / unmet met / unmet - within the last 2 vears	0=Not met	
3	Intensive care service staff should participate in the local and regional multidisciplinary services including table top' and "lev" averises to further rathe local and resolut alians and communication route heterean consistions and networks intensive care leads should work with their EPRR team to facilitate exercises in the execution of very dependent patients from any part of their hospital. This should include practical use of all shrets, and other patient handing adds, as well as rehearing the	met / unmet - within the last 2 years met / unmet - within the last 2 years met / unmet - within the last 2 years	0=Not met	
3 4 5	Intensive care service staff should participate in the local and regional multidisciptinary exercises including table top' and "twe exercises to hatter refer local and redomination notes between constraintions and heaterds. Intensive care leads should work with their EPRR team to facilitate exercises in the evolucitor of very dependent platents from any part of their hospital. This should include practical use of all sheets, and other platent handing acts, and we are releaning the decision making and forward planning resulted by the sheet to a controlled stated environment. The should include them forward planning resulted by and this table to succord a controlled stated environment. The planned to send forward forward planning resulted by and the concertaint hold grade and network. The prevent to send	met / unmet - within the last 2 years		Would participate as designated in local major incident response
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#### Introduction

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 comoleted in collaboration with members of Inis 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 memb 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, 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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Intensive Care Society

### 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	ST	FANDAR	DS	RECO	MMEND	ΑΤΙΟ
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Fu M
1	CRITICAL CARE SERVICES: STRUCTURE				1		
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		13%	13%	75%	0%	0%	10
1.6 1.7	Cardiothoracic Critical Care Neurocritical Care	0%	0%	0%	0% 0%	0% 0%	0
1.7		070	078	070	070	070	
2	CRITICAL CARE SERVICE: WORKFORCE		4000	0.00/	00/		
2.1 2.2	Medical Staffing Registered Nursing Staff	0%	40% 9%	60% 73%	0%	0% 0%	10
2.2	Workforce, Induction & Training of Medical and Nursing Staff	0%	9% 27%	73%	20% 18%	0% 64%	0
2.4	Advanced Critical Care Practitioners	078	21 /0	1370		0470	
2.5	Pharmacists	38%	25%	25%	60%	20%	2
2.6	Physiotherapists	25%	25%	50%	73%	18%	Q
2.7	Dieticians	0%	25%	75%	33%	33%	3
2.8	Speech and Language Therapists	0%	50%	0%	63%	38%	0
2.9	Occupational Therapists	33%	33%	33%	100%	0%	(
2.10	Psychologists	0%	0%	100%	0%	42%	5
2.11	Healthcare Scientists Specialising in Critical Care						
2.12	Support Staff	10%	30%	60%	0%	60%	4
2.13	Smaller Remote and Rural Critical Care Units						
0							
3 3.1	CRITICAL CARE SERVICES: PROCESS Admissions, Discharge and Handover	18%	27%	55%	0%	0%	(
3.2	Capacity Management	14%	29%	57%	20%	40%	4
3.3	Critical Care Outreach and Rapid Response Systems	0%	0%	100%	0%	29%	5
3.4	Infection Control	0%	17%	50%	0%	17%	8
3.5		0%	17%			14%	
3.6	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology		14%	83%	14%	14%	5
3.7	Rehabilitation Intensive Care Follow Up	29% 50%	50%	57% 0%	29% 91%	9%	4
3.8			14%		30%	9% 10%	-
3.8	The Patient and Relative Perspective	29% 0%	0%	57% 100%	0%	0%	6 10
3.10	Staff Support Inter and Intra Hospital Transfer of Critically III Patients	0%	13%	88%	8%	8%	8
3.11	Care at the End of Life	0%	0%	100%	11%	11%	7
3.12	Organ Donation	0%	0%	100%	0%	29%	7
3.12	Legal Aspects of Capacity and Decision Making	100%	0%	0%	0%	100%	(
4	CRITICAL CARE SERVICES: CLINICAL CARE						
4.1	Respiratory Support	0%	10%	90%	75%	0%	2
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	50%	50%	57%	14%	2
4.3	Renal Support	0%	0%	100%	0%	0%	8
4.4	Gastrointestinal Support and Nutrition	0%	60%	40%	30%	0%	7
4.5	Liver Support				22%	22%	5
4.6	Cardiovascular Support	50%	33%	17%	67%	0%	3
4.7	Echocardiography and Ultrasound	73%	0%	27%	89%	0%	1
4.8	Neurological Support	14%	0%	86%	31%	0%	6
4.9	Burns						
4.10	Care of the Critically III Pregnant (or Recently Pregnant) Woman	14%	14%	71%	40%	20%	4
4.11	Care of the Critically III Child in an Adult Critical Care Unit	0001	001	0000		001	
4.12	Standardised Care of the Critically III Patient	20%	0%	80%	20%	0%	8
5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS			<u> </u>			
5.1	Research and Development	0%	0%	100%	0%	0%	1(
5.2	Audit and Quality Improvement	60%	0%	40%	33%	50%	1
5.3	Clinical Governance	20%	20%	50%	50%	50%	(
5.4	Critical Care Networks	0%	0%	100%	0%	0%	1
5.5	Critical Care Commissioning	0%	0%	100%			
6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS		<b> </b>	├───			-
-	Fire	10%	20%	50%	33%	67%	(
6.1		29%	43%	29%	56%	0%	2
6.1 6.2	Major Incidents			2070	0070	070	2
6.2	Major Incidents High Consequence Infectious Diseases: Initial Isolation and Management					10%	7
	Major Incidents High Consequence Infectious Diseases: Initial Isolation and Management Surge and Business Continuity Planning	0%	0% 0%	100% 50%	<mark>10%</mark> 0%	10% 20%	7 8

Section 1	ARMAN DALER ARNIARA AVEILARUT"		
	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		
1.2	Outcomes		
STANDARDS			
	Critical care units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.	met - comprehensive programe with muliprofessional involvement, partially - programme but limited multiprofessional involvement, not met - no review	1=Partially met
	The unit must participate in a National Audit Programme for Adult Critical Care. Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and improvements in care.	See section 1.1 met / not met	2+Fully met
	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 ICCOIP	Met / unmet	1=Partially met
RECOMMENDATIONS	The UK intensive care community should encourage and develop a validated methodology to review referrals to intensive care and evaluate decision making and	National measure	
	subsecuent outcomes relating to intensive care admission and refursal. 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 cellings 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 - intermittant audit / review, not met - not reviewed	1-Partially met
	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. Citical care units should consider systematic assessment of patient and family experiences and demonstrate how these are used to guide improvement.	National measure met - quarterly assessment, partially met - 1-2 yearly, not met - not done	1-Partially met
5	оппановно чляд апода сонаков узненяве визикаляти и ракет вна веля офекенская вно чененакам пом владе вно чися и дола пергочениен.	ник - чим сылу выявлялисти, рак сылу тиск - тос усвану, тиск тиск - тиск сонта.	
1.3	Level 2 and 3 Physical Facilities		
STANDARDS			
	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			
	Existing units that do not comply should have a timeline to establish when national standards will be met.	met - time line and evidence to suugest 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	2+Fully 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 <0.8% 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. Critical care units should incorporate sufficient storage for medicines (including refrigerated and controlled drugs), IV Iliuids (including renal replacement) and	met, partially met, not met, not applicable	3-Not applicable to Unit
5	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 neer the patient's bedaties. 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	met, partially met, not met, not applicable	2-Fully met
-	experiences and learning. Additional factors that should be considered include potential noise and natural light levels, colour and decoration schemes, privacy and dignity needs, and staff	met, partially met, not met, not applicable	3=Not applicable to Unit 1=Partially met
8	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. Citical 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	met, partially met, not met, not applicable met - peer reviewed, feedback included, partially met - peer review, no feedback, not met - no peer review	2=Fully met
9	or highlight any slocage to timeframes. Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners.	met - peer reviewed, teedback included, partially met - peer review, no teedback, not met - no peer review National/regional measure	
		1	<u>l</u>
1.4	Clinical Information Systems*  1ff 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. (https://doital.nhs.uk/services/interoperability-toolkit). CIS procurements and customisation must involve a mitidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system.		2+Fully met
2	This must include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineering , the CCIO (Chief Clinical Information Officeri and ICT seecialists. The CIS must have a rigrorous business continuity access (BCA) plan and resilience system so that critical patient information remains available and system	met, partially met, not met, not applicable	2+Fully met
3	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	1=Partially met
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 or ward rounds and on an <i>dh</i> no 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.	2-Fully met
	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 organization in partnership with the vender company. Due consideration should be given to how this training will be provided to new starters and locum		2-Fully met
	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	
RECOMMENDATIONS			
	Critical care units should consider using a CIS.	met / not met	2-Fully met
2	Clinical care units anotal outside daning a Co. 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, tempenature management devices, intra-aortic balloon pumps, extra-corporeal life support (ECLS) devices, blood gas	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	0-Not met
-	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	using them monthly to link them)	
3	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	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	1-Partially met
4	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. Investigation ordering should be fully integrated and recorded, and include electronic prescribing of drugs and fluids and ordering of laboratory and radiology removes	partially met – clinical tastf have to log into 1 additional system regularly, not met + staff have to access >1 additional system to obtain routene information required for patient accessment. Partially met – clinical tastf have to log into 1 additional system regularly, not met + staff have to access >1	0-Not met
5	services. 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.	additional system to obtain routine information required for patient assessment. Met – captures all required data, Unmet – unable to capture any information regarded as essential to review patient	1=Partially 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, parially met – either alerts or worklists not provided comprehensively, unmet – unable to provide worklists or does not provide alerts (could probably do with colition)	0-Not met
7	There should be a functionality within the database to alert, within a short limeframe, lack of compliance with care bundles and specifically for physiological abnormalities that are undestable or life threatening. These alerts should be via dashboards displayed clearly within the unit and also via text or email to strainthornes or notecarb-nee devices carried be habitives tail.	spitting) Met = alerts provided in real time in format required by unit, partially met = some alerts but not all those required as a some which exercised in a subscription tension on the solution of family based family.	0-Not met
8	smarthones or noteoad-vue devices carried by healthcare staff. The CIS should include cusmisable transferidischarge summary, pulling key information from diagnoses, intensive care management, clinical notes, labs and medication.	or can only be provided in a suboptimal medium, not met - no dashboard facility 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	1=Partially met
-	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. The system should provide caeacity to evolve sochisticated electronic decision support systems, to facilitate patient safety and quality. The CIS should be caeable	met = single log in provided computer operating system already logged in, not met = user has to enter ID more than once to access Met = versatile system where users have been able to create decision support algorithms as required, partially	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 = 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. There must be a programme in place for the routine replacement of capital equipment.	met / not met met / not met	2-Fully met 0-Not met
	All staff must be appropriately trained and completent and familiar with the use of equipment. Up-to-date training records must be maintained to demonstrate that all staff medical, nurpring, AVP and support staff have complete with this protection. There must use a numerical response operation of the staff of the staff operation of the staff	met ->85% trained staff for all equipment, partially 75-85% trained staff all equipment, not met < 75% or no clea record.	<sup>f</sup> 2=Fully met
5	There induce an intended weagnated dependent units after on many data was required and intended weagnated and replacement of equipment on the critical care unit in collaboration with the electro-biomedical engineering (EBME) provider and the organisation is overaching 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	Met / not met	0-Not met
-	personnel must have the appropriate skills and equipment to service the equipment used. 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	Met / not met met - >85% equipment, partially 75-85% all equipment, not met < 75% or no clear record.	2-Fully met
8	planned maintenance and replacement. There must be documented procedures for decontamination (cleaning, disinfection and sterilisation as appropriate, depending on equipment risk category and sensibility of devices). Appropriate sterile services must be provisioned so that national standards are followed for the re-sterilization of endoscopes and reusable.	met - x85% equipment partially 75-85% all equipment online - 75% or no clear second	2-Fully met
9	Critical care units must be have appropriate systems in place to ensure an adequate supply of consumables.	met ->85% soupment, partially 75-85% all equipment, not met <75% or no clear record. 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 Madicines and Healthcare Products Regulator / Agency (MHRA). The MHRA may situes adder yates partialing to medical devices, as may obvice manufacturers from time to time. There must be designated role and robust	met - policy in place, partially met, no policy but can evidence, not met, no policy and / or no evidence met - 100 % alerts received and acted upon, partially met 85-100% received, not met - no robust mechanisms or	2-Fully met
	mechanism for ensuring that such alerts are cascaded to staff and acted upon as appropriate. Sufficient equipment must be available to meet the service demand to enable treatment provision (basic and specialist monitoring, ventilation, renal replacement	not able to evidence	The factority read
12	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 surce demand. Magnetic resonance imaging (MRI) compatible equipment must be provided for use where mechanically ventilated patients are to undergo MRI investigation. These	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	must be clearly labelled and staff must be adequately trained. Where advanced monitoring techniques are used (e.g. diagnostic electroencephalography, cardiac output monitors, intracranial pressure/other invasive		2-Fully met
14	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 accorocitate. Immediate access to point of care blood gas analysis and glucose/ketone analysis on a 247 basis must be provided.	Met = all advanced techniques reported within 6 hours of event (inc verbal and provisional reports). Partially 6- 24h, Not met = greater than 24h delay     Met / not met	2=Fully met
	Immediate access to point of care blood gas analysis and glucose/ketone analysis on a 247 basis must be provided. 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 cass of injury to either gainetins of staff from potentially untailing equipment, and the supplies should provide adequate training to ensure correct use. The EBNE	Met / not met met / not met	2=Fully met 1=Partially met
	or injury to emer parents or start from potentiary untaminar equipment, and the supplier should provide adequate training to ensure correct use. The Estime provider should facilitate this process by testing the equipment for safety as well as evaluating servicing and maintenance implications.		
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. The availation of disponentic ultraneous devices the standard by the likely nation providers and staff emergine. As you least, there must be immediate	Net = art L3 areas or the mospharuse same memory remainants r portable vermanors r KK++ memoring 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 ultrascund equipment should be guided by the likely patient population and staff expertise. At very least, there must be immediate access to sufficient ultrascund equipment to ensure that intravascular calheters can be placed safely and in a timely manner, even in emercent circumstances.	met / not met	2=Fully met

1.6	Cardiothoracic Critical Care		
1.0	*Not applicable to non Cardiothoracio Critical Care		
TANDARDS			
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of	met / not met	3=Not applicable to Unit
2	GPICS. Each cardiothoracic critical care unit must have designated lead consultant with training in cardiothoracic intensive care. This should be recognised in their job plan	met / not met	3-Not applicable to Unit
3	and they should be involved in multidisciplinary service planning and governance within the unit 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	met / not met	3=Not applicable to Unit
5	resident team must be trained in Cardiac Surgery Advanced Life Support (CALS) and be capable of emergency chest re-opening 247. Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complies with	met / not met	3=Not applicable to Unit
6	national standards. There should be a clear escalation pathway from post-operative care to intensive care. 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	met / not met	3=Not applicable to Unit
7	Care Medicine. 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	met / not met	3-Not applicable to Unit
11	the ICNARC ARCIIC (Assessment of Risk in Cardiothoracic Intensive Care) programme - the national clinical audit for cardiothoracic critical care units. Transthoracic and transpesophageal echocardiography must be immediately available.	met / not met	3=Not applicable to Unit
MMENDATIONS			
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	met / not met	3-Not applicable to Unit
2	general (Level 3) critical care unit. 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	met = clear written protocol, partially met = occurs in practice but referen/accepter dependent, not met =	3=Not applicable to Unit
4	care facility as required. ACCPs, with adequate training and appropriate support, can provide a safe, sustainable alternative to medical staff in the cardiothoracic critical care unit.	escalation does not/cannot occur 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	met / not met	3-Not applicable to Unit
6	period. Perfusion services should be readily available.	met / not met	3=Not applicable to Unit
-	Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an		
7	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*		
1.7			
	Neurocritical Care*		
1.7 TANDARDS	Neurocritical Care* "NOT Applicable if non neurocritical care		
	Neurocritical Care* "NOT Applicable if non neurocritical care Consultants, nursing, resident medical, healthcare professional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in	Mar / not met	9-Met applicable to Linit
TANDARDS	Neurocitical Care* *NOT Applicable if non neurocitical care Consultants, nursing, resident medical, healthcare podessional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in	Met / not met met - all available, partially - some available	3-Mar applicable to Unit 3-Mar applicable to Unit
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TANDARDS           1           2           3           4           5	Neurocritical Care* "NOT Applicable if non neurocritical care Consultants, nuising, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in the information datasense of DPUS." Consultants, nuising, resident medical, healthcare professional and appropriate circlaid spectra for the following, of approximate cardiology (24-box access to Consultants, nuising, resident medical, healthcare professional and appropriate circlaid spectra for the following, of approximate cardiology (24-box access to Consultants, nuising, resident medical, healthcare professional and appropriate circlaid spectra for the following, of approximate cardiology (24-box access to Consume the disputsion of the disputsion appropriate), bacreas to becomenzy and incordious 24-box EEC monitoring is a for an encomplexity (CS) spectra for allowing a head injury at any time must have access to specialist tratement from neuroactions card back. A per NEC 0574, dipples patients must have assessment for is-patient rehabilitation if one cognitive, emotional, behaviourd or physical difficultes presist for more than 2 hours.	met - all available, partially - some available kully met - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met - all patients appropriate for encolation discussed, not met (must allow local clinicians professional latitude bNO rote the dose dose to local all' clinication), met / rot met met - have access humdhatily once ready for discharge from acute center, partially met – have access but	3-Not applicable to Unit 5-Not applicable to Unit 5-Not applicable to Unit 5-Not applicable to Unit
TANDARDS           1           2           3           4           5           6	Neurocritical Cere* "NOT Appricable if non neurocritical care Consultants, nutsing, resident medical, healthcare professionial and pharmacy stalling numbers and work patterns must athere to the same standards outlined in the attention charters of GPACS. Consultants, nutsing, resident medical, healthcare profession in advectory patterns and work patterns must athere to the same standards outlined in the attention charters of GPACS. Consultants, must advect to the standards and appropriate directly approximate the total standards and the standards and appropriate the total standards and the standards and the standards and most to the standards and the standards and most total to the standards and most total and the standards and most total standards and most total and the standards and most total and total and the standards and most total and the standards and most total and the standards and most total and total and the standards and most total and total and the standards and the standards and most total and total and the standards and most total and t	met - all available, partially - some available May net - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is MOT refer to eac dearly to fail or intervention) is MOT refer to eac dearly to fail or intervention; met - toward a cores immediately once ready for discharge from acuse center, partially met - have access but find-hange datas - skin core. Java dear we no access or dearly - 4 weeks to access news relead.	3-Not applicable to Unit 3-Not applicable to Unit 3-Not applicable to Unit 3-Not applicable to Unit 3-Not applicable to Unit
TANDARDS           1           2           3           4           5           6           7	Neuroscritical Care*     NOT Applicable if non neuroscritical care     Not Applicable if non neuroscritical care     Consubarts, nusting, readent medical, healthcare professional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in the detection chapter of GPDG.     Consubarts, nusting, readent medical, healthcare professional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in the detection chapter of GPDG.     Consubarts, nusting, readent medical, healthcare professional and patromicities and appropriate circulal separations for the following: all diagnostic medicingy (24-hour access to C1: access to MR to venillate duplets, and diagnostic angiography), b) access to biochemistry and indicability services to autique centrompical facilities and appropriate circular approaches down and musting increases pharmacy (25: monitore).     All cases requiring inmodately lifesching neuroimage head implicit and indicability are store interpreted.     All cases requiring immediately lifesching neuroimage head implicit and there access to specialist retembers of the initial availability of neurocritical care tools.     All cases requiring immediately lifesching and texter head head implicit and there access to specialist neuroimage and musting increases the activity of previous affinitudes persist for frame that a Clasging care tradebalance in the access to specialist neuroimage and the access to specialist neuroimage and the access to specialist neuroimage and the access.     Neuroimage and the access to special theory in the advallability of neuroimage and theory and the access to specialist neuroimage and the access to specialist neuroimage and the access to specialist neuroimage and the access.     Neuroimage and the access to specialist neuroimage andintegraphical difficulting persist of the neat the access to spec	mit - sil available, partailly - some available kup ear - formally agreed and audited pathways in place, pathally met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is NOT refer to ace clearly too fail or intervition). Met / ont met met - how access immediately once ready for discharge from access center, partially met - have access tool charge datas - skin - 200 -	3-Not applicable to Unit 3-Not applicable to Unit
TANDARDS           1           2           3           4           5           6           7           8	Neuroritical Care*  Consuberts neuring resident medial; healthcare potencianal and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in a dispute analyzing interpotencian balance and approximation of CPCS.  Provide the contrast should have access to investigation balance and approximate initial separate for the following: a dispute initial balance and approximate initial separate for the following: a dispute initial balance and approximate initial separate for the following: a dispute initial balance and approximate initial separate for the following: a dispute initial balance and approximate initial separate for the following: a dispute initial balance and approximate initial separate initial balance and provide the staff sectored to a subject and balance and approximate initial sectores to contrast one of the staff sectored initial balance and approximate initial sectores to initial sectores to balance and provide and initial balance and examples in the staff sectored in the staff	mit - sil available, partailly - some available kup ear - formally agreed and audited pathways in place, pathally met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is NOT refer to ace clearly too fail or intervition). Met / ont met met - how access immediately once ready for discharge from access center, partially met - have access tool charge datas - skin - 200 -	3-Not applicable to that 3-Not applicable to that
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TANDARDS 1 2 3 4 4 5 6 6 7 8 9 10 11 11 2 3 1 2 3	Not Applicable if non neuroritical Care*     Not Applicable if non neuroritical care Consultants, nutsing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards collined in the interact advance of CPUS. Consultants, nutsing, resident medical, healthcare professional and appropriate diricial events for the following is disputed catelogy (2A-box access to Consultants, nutsing, resident medical, healthcare professional and appropriate diricial events for the following is disputed catelogy (2A-box access to Consultants, nutsing, resident medical, healthcare professional and appropriate diricial events for the following is disputed catelogy (2A-box access to Consultants, nutsing, resident medical, baseling and appropriate diricial events for the following is disputed and page (2A), is access to becamery and incredency provides to environmediate (3E-0). A case response to a scale (COS) score of 16 following is head signary at any time must have access to sepaciate treatment from neurocellocia care basel. A particle VEC 0374, eligible patternts must have assessment for in-patient rebabilitation 1 new cospition, emotional, behaviourd or physical difficulties pareited for many than 2 hours. A defer NEC 0374, eligible patternts must have access to paciated treatment from neurocellocia care. Neurocitical care must have resources to support regional resolution or in line with NEC IPG 544. Determine that be careed for by a null-professional interactive of advanting speciaties (neurological patients with subarachroad treatment). Consultating periods of the local advance care tare with period additional proteinary in meaning on circlewing a meaning on circlewing and the sequence available. Care of circlewing in production directions and advance must be advanced to advanting speciaties (neurological patients with subarachroad treatments. Care of circlewing in production advance advance of the sequence of the sequence advance advance the sequence of the	met         all available, partially - some available           met         all available, partially - some available           met         all parties appropriate for expandition discussed, not met (must allow local clinicitions professional tatitude to NOT refer to eac dearly to fail or termination)           met         all parties appropriate for expandition discussed, not met (must allow local clinicitions professional tatitude table) to the to eac dearly to fail or termination)           met         approximative for expandition discussed, not met (must allow local clinicitions professional tatitude table) approximative for expandition discussed, not met (must allow local clinicitions professional tatitude to NOT refer these dearly too fail for intervention)           met         and and approximable for expandition discussed, not met (must allow local clinicities professional tatitude to NOT refer these dearly too fail for intervention)           met         /not met           met         not met           met         not met           met         not met	S-Not applicable to Unit S-Not applicable to Unit
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Section 2	CRITICAL CARE SERVICES: WORKFORCE	Level description	Level	Comments
2.1	Medical Staffing			
	incurce country			
STANDARDS				
1	Patients' care must be led by a consultant in Intensive Care Medicine, who is defined as " a consultant who is a Felow/Associate Fellow or eligible to become a Feliow/Associate Fellow of the Faculty of Intensive Care Medicine. A consultant in Intensive Care Medicine will have dayime Direct Clinical Care Programmed Activities in Intensive Care Medicine identified in their job plan. These programmed	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	2=Fully met	
2	win nave cayime Direct Clinical Care Programme Activities in intensive Care Medicine Identified in their job part. These programmed activities will be exclusively in ICM and the Consultant will not be responsible for a second speciality at the same time." Consultant work patterns must deliver continuity of care.	met = anything else Met = daytime consultants work blocks of 3 or more days, with job planned handover time, partially met = blocks	2=Fully met	
3	The daytime consultant to patient ratio must not normally exceed a range between 1:8 and 1:12.	of <3 days or days themselves divided but with clear handover, not met = anything else Fully met = 7 days a week, partially met = 5 days per week	1=Partially 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	1=Partially 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. A consultant in Intensive Care Medicine must be immediately available 24/7. The consultant responsible for intensive care out of hours	Met / not met	2=Fully met	
7	A consultant in metric care weckare into be inimicately available 247. The obligation responsible of interview date work in our simulates. A single able to attend within 30 minutes. A single instruction of unitable that format single up an antestineto consultant without adjunte (care session), buy a necessary uncared by the unit's size and remolenses, must also have a consultant in findencie care Medicine available for advice 247, effect by local	Met / not met	2=Fully 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 round must have daily input nom musting, microbiology, pharmacy and physionerapy and regular input nom detence, 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 acheived	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	1=Partially met	Vacancies
	1			
ECOMMENDATIONS	The consultant rota should seek to avoid excessive periods (> 24 hours) of direct patient consultant responsibility.	met / not met	2=Fully met	
2	The consultant rota should seek to avoid excessive periods (> 24 hours) of direct patient consultant responsibility. The resident rota should be compliant with working time directives (i.e. Working Time Directive 2003)	met / not met met / not met	2=Fully met	
	······································			
2.2	Registered Nursing Staff			
STANDARDS	Earled Bastlands must have a participant superfactor of the statement of the data of the statement of the stat	need RDM of the Kine of net met	2=Fully met	
2	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 met 98% of the time or not met	2=Fully met	
3	Level 2 parents must neve a registered in the parent rate of a minimum of 1.2 to derive unex care. 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 Ba Matron.	met of or an a mine of her 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	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	2=Fully met	Not funded.
	supernumerary clinical coordinator to provide the supervisory role during peak activity periods, e.g. early shifts. Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory	to care for their own patient >5% shifts		
5	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 oliven 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	2=Fully met	Not funded.
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	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	nursing staff. All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to enable achievement of basic	Met = always provided until competence achieved, partially = provided but may have own patient before full	2=Fully met	
8	specialist competence. A minimum of 50% of registered nursing staff must be in possession of a post-registration award in Critical Care Nursing.	competencies completed. Not met = anvthing else met or not met	0=Not 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	
10	Where direct care is augmented using support staff (including unregistered nursing roles), appropriate training and competence assessm	met or not met	1=Partially 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	
COMMENDATIONS				
1	Step 1 of National Competencies for Adult Critical Care Nurses should commence when a nurse with no previous experience of the	met / not met	2=Fully met	
2	specialty begins working in Intensive Care Medicine. 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 swarded 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 cours
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	See above	2=Fully met	
	and be in possession of a post-registration teaching gualification.			
5	Registered nurses supplied through an agency to work in intensive care should provide evidence of appropriate experience and	met / not met	3=Not applicable to Unit	
5	competence to care for critically ill patients. The Best Practice Principles to Apply When Considering Moving Critical Care Nursing Staff to a Different and Unfamiliar Clinical Care	met / not met	3=Not applicable to Unit	
6	competence to carls for critically ill patients. The Bast Protection Principles & Apply When Considering Moving Critical Care Narsing Staff to a Different and Unfamiliar Clinical Care The Bast Protection Staff Principles & Apply When Considering Moving Critical Care Narsing Staff to a Different and Unfamiliar Clinical Care and the Staff Sta	met / not met met - policy in place, partially met - no policy but followed, not met - no policy and not followed	3=Not applicable to Unit 2=Fully met	
	competence to care for critically ill patients. 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 moreia, recruimert and retention should be considered, particularly when this is recurrent. Executive Directors of Nursing			Discuss with Sandra
6	competence to care for critical it patients. The Best Practice The Destination of the Des	met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	Discuss with Sandra
6	competence to care for critically it gaterits. The Best Practice Troingets 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 affects on staff moraline, incruitment and reterion should be considered, paircicularly when this is recurrent. Executive Directors of Mursing should the require steps to minimise this. Superminently risk cardinal coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive	met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	Discuss with Sandra
6	competence to care for critical it patients. The Best Practice The Destination of the Des	met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	Discuss with Sandra
6 7 23	competence to care for riterally it patients. The back Practice houses to Apply then Considentian Moving Critical Care Hauring Satif as a Different and Utdentile Circuit Care the back Practice houses to Apply then Considentian Moving House Interaction and Provide the Interaction and Practice Interaction and Interaction and Interactive Interaction Interaction and Practice Interactive Interaction Interactive Interacti	met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	Discuss with Sandra
6 7 23	competence to care for critical plasters. The Best Practice The Best Practice The Destination of the Destin	met - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met	2=Fully met	Discuss with Sandra
6 7 2.3 STANDARDS 1 2 3	competence to care for related in Datasets. The Sear Pacific Provides to Argel When Considenting Moving Critical Care Hauring Salf as a Different and Utdenting Circle Care The Sear Pacific Provides to Argel When Considenting Moving Critical Care Hauring Salf as a Different and Utdenting Circle Care and Salf Based Salf Care Salf and Salf as a data and an annual competencies in addition to their post-registration award in intensive salf and their registration award in intensive Care Moving Salf as a Different Salf as a Different Salf as a Salf Care Salf Provide Salf Argel Salf and Salf Salf Salf Salf Salf Salf Salf Salf	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.1-recommendation	2-Fully met OuNot met 2-Fully met 2-Fully met 2-Fully met	Discuss with Sandra
6 7 23 STANDARDS 1 2 3 3 4	competence to care for ritically it baters. The back Practice models is Apply them Considering Moving Critical Care Nations Suff as Different and Understand Critical Care to back Practice Moving is a Apply them Considering Moving Critical Care Nations Suff as Different and Understand Critical Care to back Practice Moving Apply Critical Care Nations Competencies in addition to their post-registration award in intensive enters and moving. Featurement and releasion back and the Competencies in addition to their post-registration award in intensive enters and enter and enter and enter on the Apply Critical Care Apply Criti	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.7 See above 22.1-recommendation See above 22.8	2-Fully met 0-Not met 2-Fully met 2-Fully met 2-Fully met 2-Fully met	Discuss with Sandra
6 7 2.3 STANDARDS 1 2 3	competence to care for ritically it baters. The back Practice The back Practice Theory and theory and the back Practice Theory and the back Practice Theory and theory and the back Practice Theory and t	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.1-recommendation	2-Fully met OuNot met 2-Fully met 2-Fully met 2-Fully met	Discuss with Sandra
6 7 23 5TANDARDS 1 2 3 3 4 5	competence to care for critical plasters. The basel Practice The Basel Practice Transformer and the Instance Control of the State Practice Transformer and the Instance Control of the State Practice Transformer and relevant and the Instate Control of the State Practice Transformer and relevant and the Instate Control of the State Practice Transformer and relevant and the Instate Control of the State Practice Transformer and relevant and the Instate Control of the State Practice Transformer and relevant and the Instate Control of the State Practice Transformer and relevant and the Instate Control of the State Practice Transformer and relevant and the Instate Control of Instate Control On Instate Control of Instate Control	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.7 See above 22.7 See above 22.1 See above 22.1 See above 22.11	2-Fully met 0-Not met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Portially met	Discuss with Sandra
6 7 23 STANDARDS 1 2 3 3 4	competence to care for ritical plasters. The basel Practice Provides to Apply When Considering Moving Critical Care Nations Staff and Different Andreama and Different Andreama and Different Andreama and Different Andreama and	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.7 See above 22.1-recommendation See above 22.8	2-Fully met 0-Not met 2-Fully met 2-Fully met 2-Fully met 2-Fully met	Discuts with Sandra
6 7 2.3 5 5 4 5	competence to care for critical plasters. The bask Practice The Bask Practice The Determined Technologies as Apply them Considering Moving Critical Care Nating Saff to a Determined to International Care and Bask Practice Technologies as Apply Them Considering Moving Critical Care Nating Saff to a Determined Technology The Critical Care and Apply Critical Care and	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.7 See above 22.7 See above 22.1 See above 22.1 See above 22.11	2-Fully met 0-Not met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Portially met	Discuss with Sandra
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6 7 2.3 5TANDARDS 1 2 3 3 4 5 6 6	competence to care for ritically it baters. The best Precision Provides to Apply When Considering Moving Critical Care Naturing Staff to a Different and Underhald Careful Car	met - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met  See above 2.2.6  See above 2.2.7  See above 2.2.7  See above 2.2.8  See above 2.2.8  See above 2.2.11  met - infoudes all elements, partially met - some elements, not met - no identifiable written programme.	2-Fully met 0-Not met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met	Discuss with Sandra
6 7 2.3 5 5 3 4 5 6 6 7	competence to care for ritically a bateria. The best Precision Provides to Apply them Considering Moving Critical Care Nature Staff to Different and Understand Critical Care Nature Staff to Different and Understand Apple Staff to Different Apple	net - policy in place, partially met - no policy but followed, not met - no policy and not followed met / not met See above 22.6 See above 22.7 See above 22.1- recommendation See above 22.8 See above 22.11 met - infoudes all elements, partially met - some elements, not met - no identifiable writen programme. met - mets all elements, partially met - some elements met, not met - no identifiable writen programme.	2-Fully met G-Not met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Partiality met 1-Partiality met	Discuss with Sandra
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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	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. Other alliated hearmacide was particle a patient to idea on the process of hear the minimum competencies to allow them to do no.	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 State II must have access to an Advanced State II (accellence-level) intensive care ohermacist for advice and referrids. As a minimum, the pharmacist must attend aday multidisciplinary ward rounds on exectings (excluding pothic holdsys). Attend = dips	met / not met	0=Not met	
6	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.	2=Fully met	
/	There must be sufficient patient-facing pharmacy technical staff to provide supporting roles.	met / un met	0=Not met	
RECOMMENDATIONS	1			
1	To maintain the continuity of the service during annual leave, sick leave and training leave, additional appropriate resources will be	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no	1=Partially met	
2	required (20% minimum is recommended).	cover or on call type cover only	0=Not met	
3	Intensive care pharmacists should undergo an independent, recognised process to verify competence level. Senior specialist intensive care pharmacist support should, preferably, be provided within the organisation but may be provided from a	met / not met met / not met / not applicable	2=Fully met	
	critical care network or on a regional basis. A peer-to-peer practitioner visit should occur at least once a year to ensure training issues are identified and to help maintain the			
5	competence of small teams and sole workers. This supports General Pharmaceutical Council (GPhC) revaildation. Where a team of intensive care pharmacists is in place, there should be a structured range of expertise, from trainee to Fellow level.	met -yearly, partially met 1-3 yearly, not met - not done or > 3 yearly	0=Not met	
6		met / not met	0=Not met	
6	Intensive care pharmacists are encouraged to become active independent prescribers.	Statement		
2.6	Physiotherapists			
CTANDADC -	1			
STANDARDS	Physiotheraniste must participate in populy piling for interanded dentities making and discussion of about the second dentities and discussion of the second dentities and discussion of the second dentities are second dentities and discussion of the second dentities are second dentities and discussion of the second dentities are second dentities are second dentities and discussion of the second dentities are second are se			
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 capapcity withing the service
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 oovernance and quality assurance.	met / not met	1=Partially met	Limted ability to produce adequate
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 stalling 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	Most standards met 5 days but sign
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	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	
7	Intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation coals. 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	met - 7 days per week, partially met 5 days per week,	0=Not met	Unable to consistently provide pres-
	Incluency appropriate to each strengy in order to there the crinical need and rehabilitation plan for an information participation of the plans should be updated accordingly. Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team(s) following discharge from intensive			
8	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
	1			
RECOMMENDATIONS	The service provision should be based upon the overall patient case-mix taking into account acuity, dependency and complexity of the			
1	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	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	1WTE Funded as establishment
	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	0.5 per tour level 3 beds		
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 pres-
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 Agenda for Change (AIC) bands applicable to the local service. This should reflect relevant national competency and professional development frameworks. A local training and development	met / not met	0=Not met	
4	Competency/capability frameworks should be in place encompassing all Agenda for Change (AIC) bands applicable to the local service. This should reflect relevant nations competency and professional development frameworks. A local training and development programme should exist to alion with these frameworks. Clear ords specifications should exist for intensive care physiotherapits who have reached the level of Advanced Practice according to Clear ords specifications should exist for intensive care physiotherapits who have reached the level of Advanced Practice according to Clear ords specifications should exist for intensive care physiotherapits who have reached the level of Advanced Practice according to Clear ords specifications should exist for intensive care physiotherapits who have reached the level of Advanced Practice according to Clear ords specifications should exist for intensive care physiotherapits who have reached the level of Advanced Practice according to Clear Clear Clea		0=Not met 0=Not met	
	Competency/capability frameworks should be in place encompassing all Agends for Change (AIC) bands applicable to the local service. This should reflect viewn national competency and professional development frameworks. A local training and development aronamme should exist to alion with these frameworks. Clear rede specifications should exist for interieve care physiothempasts who have reached the level of Advanced Practice according to the Health Education Encland Tramework.	met / not met	0=Not met	
5	Competency/capability frameworks should be in place encompassing all Agends for Charge (AKD bands applicable to the local service. This should reflect underest radiational competency and prolessional development Tamarenova A. A local radiating and development Tamarenova. A local radiating and development Clear role specifications should east for intensive care physiothempatis who have reached the level of Advanced Practice according to the Health Schuldming service should have a schular local operational policy and core standards for service provision which Tam intensis care physiothempary service should have a schular local careful development the intensis care physiothempary service, who when the core data careful and a schular local careful development for intensis care physiothempary service, where appropriative, as pard of the MCD, should have robust and evidence-based chiral the intensis care physiothempary service, where appropriative, as pard of the MCD, should have robust and evidence-based chiral the intensis care physiothempary service. Schular have in schular have for service provision which the intensis care physiothempary service, where appropriative, as pard of the MCD, should have robust and evidence-based chiral the intensis care physiothempary service. Schular have for schular have	met / not met met / not met	0=Not met 0=Not met	
5	Competency/capability frameworks should be in place encompassing all Agends for Drange (ARD bands applicable to the local service. This should reflect indexing a competing and predisorable development Thansenia A. Root Tarinia and development Thansenia and the service provides and the service of the should reflect the service and the service and the service and the service and the service provides and the service provides which the service care physiotherapy service should have a clear local certainal policy and core standards for service provides which the interest care physiotherapy service should have a clear local certainal policy and core standards for service provides which the interest care physiotherapy service and which and cold variation and operations and special transmission interventions including which modification of a standards and service and the service service service service service in the service to the service service and physiotherapy service are where appropriate, as part of the MDT, should there induce interventions including which modification or determinism including and minimized and physiotherapy services are service and physiotherapy service are and the service physiotherapy service area.	met / not met	0=Not met	
5	Competency/capability frameworks should be in place encompassing all Agends for Change (AKD bands applicable to the local service this should relate where mit assing competency and professional development Tamawork. A local training and development placements should relate to allow with their frameworks. The straining of the	met / not met met / not met	0=Not met 0=Not met	Due to capacity unable to attend ma
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-	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 wearing 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, partialy met - adhoc availability, not met - no service	0=Not met	SLT are developing a FEES service. It
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	Met (included in standardised handeover process) or not met	1=Partially met	SLT are developing a FEES service, I
8	transferred from intensive care to another unit or ward. 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 considencies.	met > 90% of referals 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 \$
	nur und opiniteit dur receing orientetere.		l	we have not nau referrais asking for a
2.9	Occupational Therapists			
STANDARDS				
1	Critical care units must have access to occupational therapy services 5 days a week during working hours. Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and	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 s
2	Indicate the second sec	See 2.6.7	0=Not met	Occupational therapy not part of MDT
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	
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	for more complex patients who have h
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 pharmalogical stratergies. Not met	2=Fully met	
RECOMMENDATIONS	Psychologists should ensure that delirium is accurately assessed by nurses using a validated instrument, and that when delirium is			
1	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 care6 using a validated measure such as the Intensive Care Psychological Assessment Tool. If It a patient is screened as being at risk of future psychological morbidity, psychological support should be offered by psychologists or	met = >75% suitable patients assessed, partially 50-75%,not <50% (or no audit data)	1=Partially met	
5	In a patient is sofeline as being a risk of indue psychological molitolity, psychological support should be direct by psychologists of other appropriately trained staff (e.g. nurses or psychology trainees) to give patients the opportunity to express their needs and feetings, and to have those feelinos validated and normalised.	met/not met	2=Fully 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	met = 75% assesseed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met =	1=Partially met	
	individualised structured rehabilitation programme that is formally documented and handed over at the time of transfer to general wards.	not assessed		
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. Psychologists should contribute to the information (verbal and written) patients and relatives receive to help them continue their personal	met/not met	1=Partially met	
8	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	met = always available at FU clinic, partially = available by referral, not met = not avaialble	3=Not applicable to Unit	
10	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,	Met = all elements, partially = some, not = none (could be split)	2=Fully met	
	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	mer – an cierricite, parsuny – donne, ner – none (cours de april)		
	also need bereavement succont if their family member dies in the critical care unit. 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			
11	raging polytoking polytoking approximation of the second o	Met = all elements, partially = some, not = none (could be split)	2=Fully met	
	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. Employers have a duty of care to support staff working in a stressful environment such as intensive care, where burnout is highly			
12	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	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1=Partially met	
	To develop this coordinated service for patients, families, and staff, critical care units should employ a service HCPC-registered			
13	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/hot met	2=Fully met	
2.11	Healthcare Scientists Specialising in Critical Care			
STANDARDS				
STANDARDS 1	Critical Care Scientists must comply with the professional standards of behaviour and practice set out in Good Scientific Practice (SSP).	method met	3=Not applicable to Unit	
	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 Standardstation (150) standard (2287/2016).	methot met	3=Not applicable to Unit 3=Not applicable to Unit	
STANDARDS 1	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 Standardstation (TS) standard 12297/2014). The Health and Care Protessions Council (HCPC) must meet the Standard of Proficiency and comply with the Standards 1267/2014. Performance and Ethics.	methot met met – are registered and comply / not met		
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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		met = 7/7, partially 5/7, not = no dedicated staff	2=Fully met	
5	Each similar vale area should have a data creme or dedicated lime anotes in a sunable memory to an introduce emity to a nationally recognised audit programme (such as ICNARC or SICSAG) and responsibility for the validation of these data. The Intensive Care	met = full cover wiht 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 relevent 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	with their regional network.	Statement		
3	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 device and support remote and rung training houses in critical care.	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit	

24	CRITICAL CARE SERVICES: PROCESS	Level description	Level	Commente
		Level description	Eevei	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 = >98%, 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 = >96%, partial = >90%, not <90% or no data	1=Partially met	
4	Patients must have a clear and documented treatment escalation plan. Patients must be reviewed, in person, by a consultant in Intensive Care Medicine as urgently as the clinical state dictates and always	Met >95%, partial 80-95%, not <80 or no audit evidence	2=Fully met	
5	Transfer to other critical care units for non-clinical reasons must be avoided where possible.	95% of the time - Met, <95% or no data - not met met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2=Fully met 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	2=Fully met	
9	Discharge from critical care to a general ward must occur within four hours of the decision and must occur between 07:00hrs and 21:59hrs.	met = >80%, partially = 60-80%, not <60%	0=Not met	
10	There must be a standardised handower procedure for medical, nursing and AMP staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation prescription. Patients undergring specialitic care must be reparitated to a healthcare organisation closer to their home when clinically appropriate to	met / not met	2=Fully met 0=Not met	
11	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	U=Not met	
RECOMMENDATIONS				
	None			
3.2	Capacity Management			
STANDARDS	1			
017407400	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	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not		
1	admit and completion of essential resuscitation/imaging) and patients no longer requiring critical care are discharged within four hours.	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 duty of the duty of the duty of the duty nurse in charge of the critical care unit. Under no circumstances should clinical duty of the duty of the duty of the duty nurse in charge of the critical care unit.	met / not met	2=Fully met	
3	need; rests jointly with the duty consultant and the duty nurse in charge of the critical arear unit. Under no circumstances should dinical decisions be coverided by to non-clinical coexistinal management teams. 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	0=Not met	
5	Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic	met / not met	2=Fully met	Consultant to Consultant discussions
6	scenarios. Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to	met / not met	1=Partially met	
7	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 Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units	met / not met / not applicable	3-Not applicable to Unit	HB Escalation Plan and Mutual Aid Document
9	to include escalation and, if required, prioritisation of transfers over local elective activity. Regional Intensive Care Networks must ensure that a system to record capacity across the network is in use, and that this is updated	met / not met / not applicable met / not met / not applicable	3=Not applicable to Unit 3=Not applicable to Unit	
10	regularly. Transfer to other critical care units for non-clinical reasons must be avoided where possible.	met / not met / not applicable Met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions	2=Fully met	
RECOMMENDATIONS	A			
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 emergence, admissions before accession elevies 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	2=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=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 oblamed 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	met / not met	2-Fully met	
	process. All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical detectoration in all non-menoant adult patients over 16 years. The National Farly Warning Score (NEWS-2) is the recommended for call			HB Policy and Critical Care Outreach
2	aterioration in all non-programs 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 stall operate the same language across the patient pathway and enhances the benefits of an early varming system. As part of a multi-trigger system, other triggers such as urine cuptur case kistory injury effic, succe for come and patient/case Call for Corcern, bund be considered as they will enhance the	met / not met	2=Fully met	
	accession of the deteriorating patient.			
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 corroetence, interventional therapies and senior		2 Fully and	
1	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 and Critical Care Outreach
1	should detail what is required from staff in terms of observational frequency, skills and competence, interventional therapies and senior inclusing involvement. It should define the speed and upgroup of response, fieldulary of active scatiation (b) for ensure that and paperprint and organization should an upper state of the speed and upgroup of response. Fieldulary of active scatiation (b) from the speed and the speed and upper state and the speed and upper state of the speed and upper state and organization should an uppedient income cars from appropriately trained critical cars nutreech, regid response or equivalent from the speed and uppedient the speed and upper should have an upper should be assessment of orce and additional the speed and uppedient the speed and uppedient and the speed and uppediency based assessment of orce and additional the speed and uppedient the speed and uppedient the speed and uppediency based and the speed and uppediency based and additional the speed and uppedient the speed and uppedient the speed and the speed and uppediency based and speed and uppediency based and the speed and the speed and uppediency based and the spee		2-Fully met	HB Policy and Critical Care Outreach
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4	Acutely ill patients must have access to diagnostic radiology services at all times including timely access to a radiologist. All imaging investigations must be reported within an agreed timeframe relevant to the investigation by someone appropriately trained. All	met / not met	2-Fully met	
6	re inalgrig intelsigatus into to reporte winit a agreto interant reveal to une intesugator of solitorie appropriaties traines traines. Imaging intelsigations need to be accompanied by a formal, permanently recorded report covering the entitistiet There must be seven-day availability of radiology services, appropriate to the specialities being cared for, to allow timely truestigation of crictually il patients. This would need for example, ultrasound and Crictarring to the specialities being cared for, to allow timely truestigation of crictually il patients. This would need for example, ultrasound and Crictarring to a depsi diagnosis and source control; and in	met = full service 7/7, partially = 7/7 service but some elements not always available (eg 7/7 reporting	2=Fully met	
, , , , , , , , , , , , , , , , , , ,	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.	but interventional service only daytimes), unmet = <7/7 service		Occasionally there have been times where radiological intervention has not be
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	
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. Ukgent clinical chemistry and hatematology advice should be available within 60 minutes from an appropriate specialist and a radiologist	policy in place - met, no policy - not met met / not met	2+Fully met	HB Policy
4	should be immediately contactable to support the management of acutely ill patients at all times. 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	HB Policy
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 coeration 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, inrespective 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-savino treatment is necessary, or the objective is uncertainty in catable of beino assessed.	met / not met	0+Not met	Patiente must he madically fit for crizir team arrestment
8	In the manual international of insections of the manual of international of source and the source of contractions. Liaison professionals should be available to advise on issues around menial 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	I MARTA INDE AN INSEART IS DE STUELISEN BERGETENS.
3.6	Rehabilitation			
	1			
STANDARDS	The rehabilitation needs of all patients must be assessed within four days of admission to intensive care (or on discharge if sconer) and a	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2-Fully met	
2	rehabilitation olan outlined by all relevant herapy professions as clinically indicated. 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	> 80% of patients - met, 75-80% pamaily met, < 75% ( of no data ) unmet all rehab needs met 7 days a week = met, all rehab needs met 5 days per week = partially met, rehab	1+Partially met	
3	plans should be updated accordingly. All patients must be screened for delirium at least daily, and when changes or fluctuations in behaviour occur; in the event of a positive	needs not met consistently = unmet	2-Fully met	
3	delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors correleted. 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 > 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2=Fully 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,	> 85% of patients - met, 75-85% partially met, < 75% ( or no data ) unmet	0-Not met	
6	additional refemals to any necessary services can be made. Adults at risk of poor quality recovery must have an individualised rehabilitation plan documented in their formal handover of care when transferred from cricial care to a general ward. All members of the care team must be aware of this. Patient involvement in setting this	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2+Fully met	
7	transferred from critical care to a general ward. All members of the care team must be aware of this. Patient involvement in setting this inhibitation table should occur as son as feasible and associations. 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 > 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2+Fully met	
	recovery. Inits information should be provided, at the latest, before discharge from hospital.	man a second provide the second for the rend A guilled		
RECOMMENDATIONS	Disariothermore reactions about consists are accessed and intervention for back words are intervented to intervented in the second			
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. Specialist rehabilitation co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to	met 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doens't exist	1=Partially met 0=Not met	
	ensure that assessments, referrals and documentation are completed and transferred to ongoing services and teams. The role of therapy support workers or rehabilitation are interactive bound be considered as part of the rehabilitation team; there may	nest - second and registering restary, partially may - has unler roles, unmet - doens t exist		
3	be un-professional or multi-professional in nature and recruited from nutrising or allied health backgrounds. These may enable enhanced delivery and increased efficiency of enhances and encode the state of the enhances of the delivered following dechange from critical care. Further work is recurred to determine the acconcritient pradical of these relets. Rehabilitation cutomes should be monitored and progression made using autocome measures appropriate for the stage of recovery.	Statement met - rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially -		
4	individual therapy, and dependent on local resources (including personnel, equipment, and finance). The rehabilitation plan that forms part of the handover of care on discharge from critical care should address all relevant domains for	met - renaio progression monitoring assessments in piace inclatter reaving ICU (eg CPA1), partially - on icu oliv.unmet - no progression monitoring met / not met	2+Fully met	Check with Monon and Tom
6	individual patients including, but not restricted to, physical, functional, communication, social, spiritual, nutritional and psychological. To facilitate the rehabilitation component of the formal handover of care on discharge form or informatical care not spectral word, weekly multidisciplinary rehabilitation ward rounds should be fed by a service member of the critical care nuti-professional team and result in an	met / not met	0=Not met	
7	update to the rehabilitation poals. These should be set in conjunction with the patient and/or carer where appropriate. Expectations of both patients and families should be identified regularly and addressed in a consistent manner by the most appropriate serior member of the team, all patient and family communication should be centrally documented to ensure that it can be accessed	met / not met	2+Fully met	
	easily by all team members. For bink-risk/complex natients, canturing the experience for the patient and family in a manner that they can reflect upon and engage			
8	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	Patients with higher risk of morbidity related to critical illness must be given information about ongoing rehabilitation goals in the			
1	community. Patients discharged from the critical care unit must have access to an intensive care follow-up programme, which can include review of	met = all patients provided with rehab goals, partially = selected patients, unmet = none	1=Partially met	
2	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	
05001-1012				
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	
1 2	and again on discharge from hospital. Primary care should also be informed through the discharge summary. 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. A minimum 2030 minute follow-up appointment should be offered hos to three months after hospital discharge if appropriate the follow-up of the structure of the structured and support to the structure of the structure of appropriate the structure of the structur	met = all patients, partially = selected patients, unmet = none	0-Not met	
1 2 3	and again on discharge from hospital. Primary care abuid also be informed finvogit the discharge summary. The followup programme shuid ensure the dielery of structured and supported self-directed trabilitation to all patients at critical care discharge and at hospital discharge. Animum 20.30 minet followup appointment shuid be offend ho to three months after hospital discharge if appropriate. The follow- up team shuid include an informise care consultant, intensive care nurse, cinical psychologist, physiothempist, dietician and consultant literature acrosofts be the indukta galent's needs.	met = all patients, partially = selected patients, unmet = none met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none	0=Not met	
1 2	and again of discharge from hospital. Privary care should also be informed fritogath the discharge summary. The follow-programmer hould ensure the disking of attortund and appointed self-restered hospital discharge if appropriate. The follow- formation and a morphal decharge. An immum 2030 mmore holdow appointment should be effered two to three months after toopital discharge if appropriate. The follow- top issue should include an interiory appointment should be effered two to three months after toopital discharge if appropriate. The follow- top issue should include an interiory and constraint, interior are music, clinical proteindaget, direction and Section of patient follows policity and beaution of longed or styp in the more than three topics or increased risk tog is following anaphylase, zoostrautum intense care). Self-selection of patient should also be extended.	met – all patients, partially – salected patients, unmet – none met – all appropriate patients, partially – selected patients limited by capacity not need, unmet – none met / not met	0-Not met	
1 2 3 4	and again of discharge from hoppid. Privacy care should also be informed through the discharge summary. The follow-programmer hould enture the discharge of a should and any poperties all-infected invalidation all plantisms at initial care discharge and a hospida discharge, consistent should be differed two in them nortical discharge and any posterior discharge and the initial discharge and the initial discharge and the initial discharge and the consolitorial discharge and the initial discharge and the initial discharge and the initial discharge and the consolitorial discharge and the initial discharge and the initial discharge and the initial discharge and the discharge and the initial discharge and the initial discharge and the initial discharge and the initial discharge and the discharge and the initial discharge and the initial discharge and the initial discharge and the initial discharge and the discharge and the initial discharge and the initial dinitia	met = all patients, partially = selected patients, unmet = none met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none	0=Not met 0=Not met 0=Not met	
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1 2 3 4 5	and again on thebrage from hongial. Privacy can alload alload be informed through the discharge summary. The follow or programmer sould ensure the below of a tokunute and any poperties all-interest in the discharge summary. The follow or programmer sould ensure the below of a tokunute and any poperties all-interest in the discharge summary. The summary of the summary in the summary in the summary is an experiment. The summary of the summary of the summary of the summary of the summary is an experiment.	met = all patients, partially = selected patients, unmet = none met = all appropriate patients, partially = selected patients limited by capacity not need, unmet = none met / not met met / not met	0-Not met 0-Not met 0-Not met 0-Not met	
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	Staff well-being is an organisational priority. Units must monitor and regularly review metrics of staff well-being as quality indicators (e.g.			
5	cial wendeng is an organisational priority. Ones must multion and regulary review metrics of stall wendening as quary moleators (e.g. sickness rates). All staff must have opportunities for personal development reviews including annual appraisals.	met - quartlerly , partially met 1-2 yrs, unmet - not monitored or mroe than 2 yearly intervals 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	Not specifically to 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		Not specifically to this title - but regular meetings to encourage feedback.
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
RECOMMENDATI	All staff engaged in a managerial or leadership role should have access to appropriate mentoring and/or coaching services to support	met / not met	2-Fully met	
2	them in their role. 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	met / not met	2-Fully met	
6	This includes routine dinical practice (e.g. multidisciplinary rounds, mortality and mobility meetings), as well as specific reflective events (e.g. Schwartz Centre Rounds, debriefins following medical emergencies). 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				
3.10	Inter and Intra and Hospital Transfer of Critically III 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	met / not met	2=Fully met	
5	record. 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 bogsital. 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.	Percentge occuring within 48 hours of decision. Met > 85%, partailly met 75-85%, not met < 75% of the time or no data collected.	1-Partially met	
RECOMMENDATI	NS			
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	meet standard and no risk assessment met = documented 95%, partially met 80-95%, unmet <80% or no data or not a consultnat decision	2-Fully met	
-	documented An adequately stocked and regularly checked, dedicated transfer bag should be available for use during all patient transfers. This bag			
3	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 maintaind) or, if sealed with a tag, then a daily check that the seal is unbroken. The transfer bag must be restoched between uses to avoid delays when it is needed. Staff carrying out patient transfers should be familiar	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	with bao layout and content. The patient's vital signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy	met = aurit evidence of obs or transfer forms unmet = no evidence	2-Fully met	Supported by Operating Theatre
5	any physiological deterioration during the transfer. Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be	met = audit evidence of obs or transfer forms, unmet = no evidence met = use of a network wide agreed form or electronic recording system, unmet = no standard system	2=Fully met	
	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. Where an adverse event occurs during a transfer, this should be reported and investigated using the healthcare organisation incident			
6	reporting system at the transferring unit. All learning should be widely shared. Every acute healthcare organisation should have a designated consultant and nurse who are responsible for maintaining standards of	met / not met met - both, partially met - one, not met - none	2=Fully met 1=Partially met	
8	transfer of critical care patients, guideline production, training, governance, audit and reporting. 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 the completion of specialist care, a delayed transfer is one that has not been undertaken 48 hours after	met / not met	2=Fully met	
	the time of referral to the general critical care unit. Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who			
12	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 ambutance 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, deleved transfers and automers. Audit measures and learning thould be widely shared.	met - well established processes, data avaiable, partially met - reviewed, limited data available, not met. rarely undertaken or not at all	0-Not met	
15	There should be standardized network wide transfer documentation and training programmes.	met = both / partially met = one or the other / not met = neither		
	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and			
16	Consideration should be given to the formation of specialist transfer learne, 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		
16 3.11	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 the ystaff. Care at the End of Life	Statement		
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3.11 STANDARDS	prevent the absence impair of transfers on the transferring unit due to loss of key staff.  Care at the End of Life  Decision making summunding care at the end of [iii, including the rationale for any decisions, must be documented clearly and communicated to patients and their lond once. The latter being of patients lack capacity (block).  Decision making summunding of all is care (EAC) must be prénomed in accordance with referent latter and become making summunding and at le care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter accordance and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent latter may intervent and become making auronauting and of life care (EAC) must be prénomed in accordance with referent accordance de life care (EAC) must be prénomed in accordance with referent accordance de life care (EAC) must be prénomed in accordance with referent accordance de life care (EAC) must be prénomed in accordance with referent accordance de life care (EAC) must be prénomed in accordance with referent accordance de life care (EAC) must be prénomed in accordance with referent accordance de life care (EAC) must be prénomed in accordance with		2=Fully met 2=Fully met	
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	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				
	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		
0	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	commuted obsidements about dest interests benefit, me treating crimican must not act uniateraity. 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				
	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
-	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 & Waters)/Court of Session (Scotland). NHS Resolution or the Civil Mediation Council provide access to individual mediators or recognized noruns.	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 discute about best interests between the medical team and family.	Statement		

Section 4	CRITICAL CARE SERVICES: CLINICAL CARE	Level description	Level	Armonte
	CRITICAL CARE SERVICES: CLINICAL CARE	Level description	Level	Comments
4.1	Respiratory Support			
STANDARDS	1			
1	Units must have access to sufficient modern invasive and non-invasive ventilators which will support pressure/volume controlled	met / not met	2=Fully met	
2	ventilation, titration of inspired oxygen concentration, support spontaneous ventilation and allow application of PEEP. Pulse oximetry, capnography, ECG, blood pressure monitoring and ventilator alarms must be used for all ventilated patients whose	met / not met met / not met	2=Fully met	
3	trachea is intubated. An accurate height must be measured on admission for every patient requiring invasive mechanical ventilation to calculate predicted		2=Fully met	
4	body weight (PBW) and corresponding target tidal volume to allow protective ventilation (6mi/kg PBW in those with ARDS or at risk of ARDS). Units must have evidence-based, written guidelines covering the use of non-invasive ventilation, the management of ARDS,	met / not met met - guidelines for al and review date within last 3 years , partially met - one or more guidelines missing or not reviewed within the last 3 years, not met - imited outlines and/ or okter than 3 years	1=Partially met	
5	revertion of ventilator-associated ensumoia and weaning from ventilation (including the use of sectation). Referral pathways for patients with severe but potentially reversible acute hypoxaemic respiratory failure must be in place with Redional Entra-concoreal Membrane Oxvienstion-acaable (ECMO) Centres.	reviewed within the last 3 years. not met - limited guidlines and / or older than 3 years 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.	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 guidlines and / or older than 3 years	2=Fully met	
9	Non-invasive ventilation must be considered and available for patients with acute hypercapric respiratory failure. High flow nasal oxygen must be available for the management of patients with acute hypoxaemic respiratory failure.	met / not met met / not met	2=Fully met	
	ang ana amin'ny genanana amin'ny faritr'o ana ang ana ana ana ana ana ana ana ana			
RECOMMENDATIONS				
1	Tidal volume (mikg 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. Units should have standardized systems to monitor VAP rates and antibiotic resistance patterns.	met / not met met / not met	0=Not met	
4	There is insufficient evidence at present to inform other many and interaction texture parameter parameters and the second	met / not met	0+Not met	
	NICE Guidance			
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services			
	-			
STANDARDS	l en 19 mile mathema energe la constant barro mathefan and annine arb deservante mathe in stere to establem indu			
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 Revisional Control	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			
RECOMMENDATIONS 1	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant respiratory or		0=Not met	
	neurological co-morbidities. Patients with slowly deteriorating neurological conditions are at particular risk of weaning failure. Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing	met / not met		
2	patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and detitian members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation management,	met = ful MDT routinely used, partial = 1-2 MDT professions not routinely involved met protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols in	1=Partially met	
3	based on agreed protocols. Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and	met protocols in place and audited, partially met = protocols in place but not audited, not met = no protocols in place/hot reviewed in last 2 years met / not met	0=Not met	
5	resources to provide these services as described in the section of this document on rehabilitation (Chapter 3.6). The use of non-invasive ventilation (NIV) as a bridge to spontaneous breathing should be considered in selective groups. Resources	met / not met met / not met	0=Not met 2=Fully met	
6	and skill in NIV should be available in all units manacino catlents with croknosed ventilatory needs. Early discussion with regional domicilary ventilation services should occur in any patient with chronic neuromuscular impairment, and in those requiring more than 21 days of ventilation. Regional warning centres should offer advice to referring units to assist with	met / not met / NA If no regional wearing service	0=Not met	
7	weaning. The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation centres and	met / not met / NA if no regional wearing service	2=Fully met	
	protocols should be in place to aid these decisions.			
4.3	Renal Support			
STANDARDS	1			
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 oxideline.	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 dystunction.	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	met / not met	2=Fully met	
2	creatinine values as per Kidney Diseases Improving Global Outcomes (KDIGO) recommendations and the NICE guideline. Where Ife-threatening complications of AKI occur, such as intractable hyperkalaemia, RRT should be started emergently unless a	met / not met	2=Fully met	
3	dencifien has been made on the exclusive theranu Patients with end-stage renal failure who are not in a renal unit/dalysis 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 root met	2=Fully met	
4	Continuous and intermittent RRT should be considered as complementary therapies for AKI. The choice of therapy should be based	met / hot met	2=Fully met	
5	on patient status, expertise of the clinical staff and availability of machines. 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	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 detection to use anticoagulation to maintain circuit patency and the choice of anticoagulant should be based on the potential risks and benefits in an individual advant the securities of the advant due and the advant adv	citrate anticoagulation should be available Met/unnet	2=Fully met	
	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.			
7	Bicarbonate, rather than lactate should be used as a buffer in dialysate and replacement fluid for acute RRT. Drug dosing may need adjusting whenever RRT is started or the RRT prescription is altered. Close collaboration with an intensive	met / Partially met = daily prescription chart but compliance not audited / not met met / not met	2=Fully met	
9	care charmacits with suitable experience in AKI and the effects of RRT is essential. Patients treated with acute RRT should receive standard enteral nutrition as long as there are no significant electrolyte abnormalities or fluid overlaad enfractory to RRT.	met / not met	2.41 Gly max	
10	In historeinbatternation to RKT. 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 accrossible 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	
_	Intensive care services must have a nutrition support guideline with institutional strategies to promote nutrition delivery and to overcome EN insiderance. It is suggested that it should include, a) Measures to minimise the risk of EN aspiration, b) Crisnia for the use of provineing medications, c) Crisnia for mass-planal feeding, d) Crisnia for use of parenteral nutritions. C) Consistent times for	met = clear quideline in place meeting these criteria, partial = quideline in place with some omissions or >3v		
2	stopping and restarting EN around anaesthetic, surgical or bedside procedures and f) A protocol for initiation of nutrition without waiting for a distitian's plan	met – clear guideline in place meeting these criteria partial – guideline in place with some omissions or >3y since review, unnet – 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 = 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. Intensive care services must have access to a range of enteral nutrition products to include: 3) Low electrolyte, b) High protein, c)	met = all elements Isted, partial = TPN available but limited range, unmet = not available or a single standard bag only available	1=Partially met	Limited range
5	mensive care services must have access to a range or enterial number products to include: a) Low encoding of 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 detitian 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 and dat within three daws	met / not met	2=Fully met	
3	Care to old use the many reset data. Numiformal instance targets should be set and compared daily with actual intake. Deficits should be monitored and steps taken to remody 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 hypocaboric nutrition may be asked 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 2=Fully met	
			Local March 1995	
6	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines. Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly infusion rate of EN to optimise delivery	met / not met		Wil be part of WICIS
	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidelines.	met / not met met / not met met / not met	0=Not met	Will be part of WICIS No brides in HB
7	Feeding plans should be adjusted for those with a BMI > 30 kg/m2 according to international guidalines. Volume-based or 'catch up' feeding should be used to allow nursing staff to adjust the hourly inflution rate of EN to optimise delivery after interruption.	met / not met	0=Not met	
7	Paeding plans should be adjusted for those with a BMI > 30 kg/m3 according to international guidelines. Volume-based or visited up feeding should be used to allow nursing staff to adjust the howly indusion rate of EN to optimise delivery adjustment and the international. There should be been so in the should be included in the international guidelines for their use and aftercare. Nutrition support targets should be included in the interbalitation of ortically ilguidents.	met / not met	0=Not met 0=Not met	
7 8 9	Reading given school to adjuste for those with a BM > 30 bigind according to interminitional guidateses. Volume based or visit on If feating school to load or unaring staff to adjust the housy shaks rate of EN to optimise delawy after interpretations. There school the access to instal facilities to access NGTs in agaited gaited school guidates for their use and altercare. Natifition support targets should be included in the installation of critically ill patients.	nel rot met met rot met met rot met met rot met	0=Not met 0=Not met 2=Fully met	No brides in HB
7 8 9	Paeding plans should be adjusted for those with a BMI > 30 kg/m3 according to international guidelines. Volume-based or visited up feeding should be used to allow nursing staff to adjust the howly indusion rate of EN to optimise delivery adjustment and the international. There should be been so in the should be included in the international guidelines for their use and aftercare. Nutrition support targets should be included in the interbalitation of ortically ilguidents.	nel rot met met rot met met rot met met rot met	0=Not met 0=Not met 2=Fully met	No brides in HB
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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 excerience 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 orean succent 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 auided in consultation with a local cardiologist and the specialist cardiothoracic surgical unit.	met / not met	O+Not met
	1		
RECOMMENDATIONS	A validated method for advanced haemodynamic assessment with a skilled operator in both the practical use of the device and		
2	interpreting the data it provides should be available at all times. An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to	met / not met met / not met	2=Fully met 0=Not met
3	another centre. Local protocols in the use of vasoactive drugs should be in place, although there is little evidence to support the use of any single	met / not met	0+Not met
5	agent in practice.	THE FIRE THE	
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 oovernance 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 rowide a competencies ultrasound service.	met= immediate availability (ie on unit) of ultrasound machine for vascular access and rapid access of machine for focused echolung ultrasound / partially = not all elements eg only 1 machine on a large unit / not all probe hore/ not met	2=Fully met
6	nnovide a nomenhensive utrassured service Infection control measures must be adhered to at all times.	tunes/ not met met/ not met	2+Fully met
7	The disinfection and storage of transcesophageal 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	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, urmet = images not safely archived in PACS	0+Not met
9	machine storace caeacity is not a secure method. Whenever scars are performed to inform clinical decision making, a structured report must be generated and stored in the patient record.	not twivened or reviewed but non-centralised storano. ummet = imaxes not safety archived in PACS met = structured report and audited, with > 90% compliance, partially met reported but not structured, not audited or < 90% comeliance . not met = < 50% reported/documented 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	quarty improvement, water, and peer review accurred and occar 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)	0=Not met
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 0=Not met
5	Individuals who scan and report independently should keep a personal logbook of their images and reports. Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to more	met / not met met / not met	0=Not met
6	advanced accreditation. Images and reports should be uploaded logether to the same archive used by the host institution's cardiology or radiology department, as appropriate. Reports should identify the focused mature 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. Consideration should be given to the development of Muly qualified physiologists with dedicated intensive care commitment and	met / unmet	0+Not met
8	Consideration should be given to the development or using quarter physiologists with indicated interver care commenter and experience under joint supervision to deliver echocardiography services within intensive care. Regular replacement of utrasound equipment is required to ensure it remains up to date. Normal guidance states that electrical	met / not met / not applicable	O+Not met
9	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	Adult patients with refractory convulsive status epilepticus must be admitted to critical care and have EEG monitoring established; the		
1	primary endpoint of treatment being the suppression of epileotic 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
2	infanction must be considered for coronary angiography with follow-on primary percutaneous coronary intervention if indicated. Following traumatic spinal cord injury, a specialist neurosurgical or spinal surgeon at the major trauma centre or trauma unit must contact the linker strain cord injury centre oneoxicat within four lowice of diaponeis to estable an automethic of care	met / not met	2=Fully met 2=Fully met
3	infraction must be considered for coronary angiography with follow-on primary percutaneous. coronary intervention / indicated. Following traumatic spinal cord injury, a specialist neuronalization for those of angio the statistical and intervention of trauma unit must constant the linked social cord injury center constanti within four hours of davarosis to testabiliha andmethatin of care. Previously its dashs, admitted to critical care following a primary infraceretinal hemorithage, must be referred to specialist manuscupical centers for consideration of angical evaluation.		2=Fuly met
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3           4           6           7           RECOMMENDATIONS           1           2           3           4           5           6           7           8           9           10           11           12           3           4           5           7           4.9           1           2           3           4.9           5           7           8           9           10           12           3           4.9           5           7           8           7           8           9           1           2           3           4           5           6           7           4           5           6           6           7           8      <	indexidential the considered for corrows angiography with these on primery percentances corows preteredential reductions. Fieldwash punctures ground cord knys, a special data corossing all anging throughout the time primer and the original reductions. Fieldwash punctures ground correlation and primer and the correlation are the original reduction. Fieldwash punctures ground correlation and primer and the corossing and anging through the primer and the corossing and a strength correlation and the corossing and a strength correlation and primer and the corossing and a strength correlation and the corossing and a strength correlation and the corossing and a strength correlation and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the corossing and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the strength correlation and the corossing and anging and the strength corossing and the strength corossing and the strength corossing and anging and the strength corossing and anging and the strength corossing and the strength co	mail / can mail	3-4 June        3-4 June <t< td=""></t<>
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1Note of the section of th	5		met / not met	2=Fully met
1Constrained any	6	Women who require care that falls outside Enhanced Maternal Care (EMC) must be referred as soon as possible to the general	met / not met	3-Not applicable to Unit
1RealRealRealRealConstructionRealRealReal1RealRealRealReal1RealRealRealReal1RealRealRealReal2RealRealRealReal3RealRealRealReal3RealRealRealReal4RealRealRealReal3RealRealRealReal4RealRealRealReal4RealRealRealReal5RealRealRealReal6RealRealRealReal7RealRealRealReal8RealRealRealReal8RealRealRealReal9RealRealRealReal10RealRealRealReal11RealRealRealReal12RealRealRealReal13RealRealRealReal14RealRealRealReal15RealRealRealReal16RealRealRealReal16RealRealRealReal16RealRealRealReal17RealRealRealReal18RealReal<	7		mat / not mat	0-Not met
Note of the second of the s		Critically ill pregnant or recently pregnant women who updergo intra- or inter-facility transfer must be transferred in accordance with		
Mathematical and a start of	8	standards equivalent to the Intensive Care Society's Guidelines for the transport of the critically il adult	met / not met	2=Fully met
Mathematical and a start of				
Image: state of the state o	RECOMMENDATIONS			
1MainMainMainMain1MainMainMain </td <td>1</td> <td>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 surga-regional critical care unit with experience in MCC.</td> <td>met / not met</td> <td>2=Fully met</td>	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 surga-regional critical care unit with experience in MCC.	met / not met	2=Fully met
164006400640011000100010001000<	2	Physical contact between a mother and her baby should be maintained during post-natal critical illness, even if the mother is		2. Et du met
Image: space		psychological rehabilitation after critical care or in bereavement counseling	THEFT THE THEFT	
111 <th< td=""><td>3</td><td>includes input from a clinician with experience in critical care follow-up.</td><td>met / not met</td><td>0=Not met</td></th<>	3	includes input from a clinician with experience in critical care follow-up.	met / not met	0=Not met
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nnn <th< td=""><td>5</td><td>Healthcare professionals looking after critically ill women should undergo regular, cross-specialty, multidisciplinary team training, to</td><td>met / not met</td><td>1=Partially met</td></th<>	5	Healthcare professionals looking after critically ill women should undergo regular, cross-specialty, multidisciplinary team training, to	met / not met	1=Partially met
111 <th< td=""><td>6</td><td>Simulation-based learning should be considered to assist healthcare professionals to develop the technical and non-technical skills</td><td>met / not met</td><td>0-Not met</td></th<>	6	Simulation-based learning should be considered to assist healthcare professionals to develop the technical and non-technical skills	met / not met	0-Not met
1Note and any	7			3-Not applicable to Unit
110mm ma ma ma ma ma ma 		Obstetric units delivering EMC or level 2 critical care should be members of a regional MCC network which itself should have a		2. Met energiesels to Heit
1       1		formal relationship with the local Critical Care Operational Delivery Network and Strategic Clinical Networks.		
Unspace1Construction of the second of the	9	Intensive Care Society Audit Group and used to improve local performance.	met / not met	3-Not applicable to Unit
Unspace1Construction of the second of the				
164848964849408484940848494016484940648494064849401 <td>4.11</td> <td>Care of the Critically III Child in an Adult Critical Care Unit</td> <td></td> <td></td>	4.11	Care of the Critically III Child in an Adult Critical Care Unit		
164848964849408484940848494016484940648494064849401 <td></td> <td></td> <td></td> <td></td>				
164848964849408484940848494016484940648494064849401 <td>STANDARDS</td> <td></td> <td></td> <td></td>	STANDARDS			
		Critically il 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	met / not met	3-Not applicable to Linit
JMainMainMainMain1MainMainMainMain2MainMainMainMain4MainMainMainMain4MainMainMainMain4MainMainMainMain4MainMainMainMain4MainMainMainMain4MainMainMainMain5MainMainMainMain6MainMainMainMain7MainMainMainMain7MainMainMainMain7MainMainMainMain7MainMainMainMain7MainMainMainMain7MainMainMainMain8MainMainMainMain7MainMainMainMain7MainMainMainMain8MainMainMainMain7MainMainMainMain7MainMainMainMain8MainMainMainMain9MainMainMainMain9MainMainMainMain9MainMainMainMain9MainMainMainMain9MainMainMain </td <td></td> <td>when there is an expected short duration of critical care e.g. an older child with overdose or alcohol excess. Admission must be decrument and arread by the local consultant in Integrity Care Medicine. local consultant paed atrician and the</td> <td></td> <td></td>		when there is an expected short duration of critical care e.g. an older child with overdose or alcohol excess. Admission must be decrument and arread by the local consultant in Integrity Care Medicine. local consultant paed atrician and the		
aaa	-	consultant in needlatrin Intensive Care Medicine (this may be the tenional needlatrin transport team consultant) A compated lead intensive care consultant and lead purce in the adult critical care unit must be represented for intensive care		
1NoteNote3Markan and management in the start and material of		policies, procedures and training related to the care of children.		
1Mathematical and any	4	paediatric critical care.	met / not met	3+Not applicable to Unit
number of the stand and the	5	date competencies in advanced paediatric life support and advanced airway management. This medical cover may be provided by	met / not met	3-Not applicable to Unit
		anaesthetists or consultants in Intensive Care Medicine according to local arrangements. Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer of critically ill children and the provision of		2 Nationalizable to Link
1SealestSealestSealest3SealestSealestSealestSealest4SealestSealestSealest5SealestSealestSealest5SealestSealestSealest6SealestSealestSealest6SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest8SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9 </td <td>6</td> <td>paediatric critical care must be available.</td> <td>met / not met</td> <td>3=Not applicable to Unit</td>	6	paediatric critical care must be available.	met / not met	3=Not applicable to Unit
1SealestSealestSealest3SealestSealestSealestSealest4SealestSealestSealest5SealestSealestSealest5SealestSealestSealest6SealestSealestSealest6SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest7SealestSealestSealest8SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9SealestSealestSealest9 </td <td>7</td> <td>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.</td> <td>met / not met</td> <td>3=Not applicable to Unit</td>	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
Image: Problem in the strengt problem				
1       мала ма	8	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
Interview         Interview         Interview         Interview         Interview           1         Angebrank unde sonder aus dara fram to segort son of a data.         Angebrank under sonder aus data fram to segort son of a data.         Angebrank under sonder aus data fram to segort son of a data.         Angebrank under sonder aus data fram to segort son of a data.         Angebrank under sonder aus data fram to segort son of a data.         Angebrank under sonder aus data fram to segort son of a data.         Angebrank under sonder aus	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
1Andrame and an anomaly and any	10	There must be 24-hour access for parents/carers to visit their child.	met / not met	3=Not applicable to Unit
1Andrame and an anomaly and any				
2       8       8       9	RECOMMENDATIONS			
2       8       8       9				2 Met and adds to Unit
demonstration         main and marked ma				
Also         Rescale of the Control of the Contro				
Bit Number of the second bit for out-of-the decision of the second bit out-of-the decision of the second bit for out-of-the decision	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
Bit Number of the second bit for out-of-the decision of the second bit out-of-the decision of the second bit for out-of-the decision				
1Performance and water and wate	4.12	Standardised Care of the Critically II Patient		
1Performance and water and wate				
1Performance and water and wate	STANDARDS			
1MarkaMarkaMarkaMarka2Backet and			met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance <	2 Februari
Bit Mode         Bit Mode         Bit Mode         Bit Mode         Bit Mode           3         Window framework window dawade wind			90%. un met = no quideline or compliance < 50% met = quideline and audit data to show compliance > 90% partially met = quideline but no audit or compliance <	
4         6	-	with ARDS must receive a tidal volume of less than or equal to 6 milko PBW.	90%. un met = no duideline or compliance < 50%	
Image: Constraint of the second registery of the second		Ventilated patients must have respiratory function evaluated daily and undergo spontaneous breathing trials where appropriate.	met / not met - no SBTs	
Image: Control of the stream of the	4	Sedation must be individualised to patient needs and the appropriateness of a sedation hold considered daily.	met / not met	2+Fully met
Interfact         Interfactor	5			
1Media prosuble calculate single		All patients must be assessed regularly for evidence of pain, with analgesia optimised to minimise sedation requirements.	met / not met	2=Fully met
Hales for Labora 1990, Labora 1990, and seconds for retrond.         PD/L match and addites all completes 4990, and the mark addites and addites addit	6	All patients must be screened daily for evidence of delirium using a validated method such as the Confusion Assessment Method for		
Image: Control (Control (Contro) (Control (Control (Contro) (Control (Control (Control (Control (		All patients must be screened daily for evidence of delirium using a validated method such as the Confusion Assessment Method for the ICU ICAM-ICU or the Internate Care Delirium Screening Checklast ICDSCI. Indeeling Intervasianal architeters armut be inspected failly for evidence of Interiorus autable scoring system e.g. Visual	met / not met met = aukleline and auklt data to show compliance :> 90%, partially met = aukleline but no auklt or compliance <	2+Fully met
10     Sense nuble nables	7	A patients must be screened staffs for evidence of defaunt using a validated nethod such as the Confusion Assessment Method for the CLU CAM-MCU on the interance Can Defaunts Screener Oncektral (CDSC). Indeeling intravascular catheters must be inspected daily for evidence of infection using a suitable scoring system e.g. Visual influidon Thebits for cal Lackons (TBS) to guide recessity for removal.	met / not met met / not met met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90%, su met = no guideline a compliance < 50%. met = guideline audit data to show compliance > 90%, partially met = guideline but no audit or compliance <-	2+Fuly met
no     partner     partner     partner     partner       1     partner     partner     partner       2     partner     partner     partner       3     partner     partner     partner       3     partner     partner     partner       3     partner     partner     partner       4     partner     partner     partner       4     partner     partner     partner       5     partner     partner     partner       6     partner     partner     partner       6     partner     partner     partner       7     partner     partner     partner       6     partner     partner     partner       7     partner     partner     partner       7     partner     partner     partner       8     partner     partner     partner       9     partner     partner     <	7	Al pointer much a convent daily to endorso of defairs mutigs a validation ferebit candon is the Contractor Assessment Method for defail (CMAALCI) and the bitmates Canao Defaire Secretion CAssesSin (CDES). Televisiting internascular candreter much interpreted daily for velocime of referition using a validate scoring system e.g. Visual Hinkano Petkallis Social (CMA) daily daily candon consist for removal. The continued need for indeelling catheters (intravascular or univary) must be considered daily.	net / not met met - packelme and auch data to show compliance > 90%, partially met - guideline but no auch or compliance - 50%, un met - an packelme and compliance - 50%, and and and the show compliance - met - guideline and auch data to show compliance - 90%, partially met - guideline but no auch or compliance - show compliance - and auch and a show compliance - 90%, partially met - guideline but no auch or compliance - show compliance - and auch auch and auch and auch auch and auch auch auch and auch auch auch auch auch auch auch auch	2-Fidy met 2-Fidy met 2-Fidy met
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Section 5	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS	Level description	Level	Comments
5.1	Research and Development			
STANDARDS	All individuals participating in R&D activity must have completed Good Clinical Practice (GCP) training for research and keep this up			
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 standards. Critical care units should participate in research networks, which are organised at Local Clinical Research Network (LCRN) level	met / not met or not applicable	2=Fully met	
2 3	through the regional National Institute of Healthcare Research (NIHR) Critical Care research network lead. All research studies should be registered on the UK Critical Care Research Portfolio whenever they fulfil eligibility criteria.	met / not met or not applicable 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 noncing research. for example through posters, leafliets, or within generic intervative care information resources Critical care units participating in research should have clear procedures for approaching patients, families and SDMs in a manner	met / not met or not applicable	2=Fully met	
5	Critical care units pandipaning in research studio naré clear picobautes ou approaching parents, names and soms in a mainter hat minimises tests, but provides adequate information in a timé y manner. Critical care units pandipaning in multiple research studies should have clear co-enrolment policies based on the UK co-enrolment quideline.	met / not met or not applicable met / not met or not applicable	2=Fully met 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. Critical care units must participate in a National Audit Programme for Adult Critical Care, such as the Scottish Intensive Care Society	met / not met met / not met	2=Fully met	
	Audit Group (SICSAG) or Intensive Care National Audit and Research Centre (ICNARC) programmes. Critical care units must have a surveillance system in place for audit and feedback of nosocomial infection, for example, catheter- related bacterateria and other blood stream infections renorded to the patiental exchere where anolicable. Critical care units should			
3	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 (ICCQIP) and Scottish nosocomial infections in ICO audit coroamme.	met / not met	0-Not met	
4	Ortical care units must measure night-time discharges in order to encourage and support local improvement to reduce night-time intensive care discharges. Ortical care units must obtain regular feedback about the care that patients and relatives receive during their critical care admission	Discharges after 21:59 as percentage of all eligible admisisons - met <2% partially met, 2-4% not met>4% met - annual process, partially met, undertaken every 1-2 years, unmet, never done or less than 2	0=Not met	Data not reviewed
	In order to learn from and act on the feedback received.	yearly		
RECOMMENDATIONS	Units should have nominated medical and nursing leads for quality improvement and audit. Appropriate time should be made			
1	Units should have nominated medical and nursing leads for guality improvement and audit. Appropriate time should be made walitable in job ans for these duries. Time to participation is nuclit and quality improvement programmes should also form part of the ob along of all intensive care staff (medical, nursing, nohamacists, healthcare ordersionals and anciliary staff). Horontals should have a nuality improvement (non programme in obser for adard, chicid care nu time in their constraints). The nonrammer	met/ unmet	0-Not met	
2	Hospitals should have a quality improvement (Q) programme in place for each critical care unit in their organization. The programme should aim to deliver safe, reficienci, therefore, patient-criterical, finely and equilable patient care, which is evidence based, and should follow meconized quality improvement methodologo. Start should be encouraged and supported to train in quality improvement methodology and all projects should be multidisciplinary.	met / unmet	1=Partially met	EQUIP recomme weiteble
3 4	recognising the necessity for a team approach and the contribution of all staff groups. Audits should be linked to QI programmes. Units should have robust data-collection systems in place that support the collection of schicky and number data for lead and national with recommendent	met / unmet met - rooust data collection and reedback for both local and national audit, pantally met - rooust data collection and feedback for national audit only, not met - no robust systems for data collection or	1=Partially met 0=Not met	EQUIP programme available
5	acevery and quary data for local and national autoi programmes. 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. All interial care units must massure and record their dislaved discharuse, our of hourd scharbares. non-finitian transfers and	met / not met / not applicable	2=Fully met	
6	All cincia care units must measure and report mer dealyse discnarge, out of nours discnarges, non-dimical 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 / SICSAG data tools, patially met - one or more data submissions missing , not met - poor data compliance with ICNARC / SICSAG	1=Partially met	DTOC figures captured by IRIS. 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 train to the detailed by divised divised divised of activity of the senior of t	met / not met	1=Partially met	Medical support under discussion
2	not be the clinical lead or clinical director for critical care. There must be a robust system in place for reporting, investigating, and learning from all patients 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	met / not met	2=Fully met	
3	excellence recorrino. 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 mely and reliable method for discussionation of shared learning should be in place. There should be clear structures in place for	met - meets full standard with minimum of quarterly meetings, partially met - meets standard but less	0=Not met	
4	disseminating findings to staff, and deficiencies in care should lead to measurable change. Regular feedback must be obtained from service users and staff about the quality of care delivered, for example by the use of safety	than quarterly, unmet - doesn't meet the standards met - undertake critical care led staff safety and relative surveys at least once a year, partially met is	0=Not met	
5	surveys and relatives' questionnaires. Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and mprovements in care. Appropriate actions must be taken whenever preventable factors are found.	less frequently or only one group surveyed. Not met = no patient or staff survey 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. The unit must have processes to ensure clinical staff are aware, in a timely fashion, of key learning points from national safety alerts	met - in place, quarterly review, partially met, in place less than quarterly review, unmet - not in place	1-Partially met	
7	and local learning (for example from patient stafety incidents, excellence reports, patient concents 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. Staff who have to conduct reviews of patient stafety incidents, not cause analysis and appreciative enquiry must be trained in the Staff who have to conduct reviews of patient stafety incidents, not cause analysis and appreciative enquiry must be trained in the	met / not met	2-Fully met	
8	management of these processes so that the reviews are conducted sensitively 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, contral line and chest drain insertion and lumbar puncture). They must also have safe standards for the handover of information for patients going to have mussive procedures in other departments. These standards should include documentation of invasive procedures, handovers and	met / not met	2-Fully met	Critical Care LocSSIP in place
10	Information transfer, procedural verification, a safety briefing and time out, and a sign out and debriefing. An example of this process is the NHS Enaland Safety standards for invasive procedures. Critical care units must comply with reviews and visits by national organisations, (for example the CQC in England).	met / not met	2=Fully met	
	anna an ann ann an ann a bhairtean an ann a' ann an a gunannaí (ar ann da an airtean an Gunah.			
RECOMMENDATIONS				
1	Intensive care staff should work with other clinical teams in the hospital with respect to joint learning from morbidity and mortality		0-Not met	
1 2	Intensive care staff should work with other clinical teams in the hospital with respect to joint learning from morbidity and mortality netwer and ensuring best practice around handovers of care. Uhits should regulatly review guidelines from professional organizations and other sources of evidence to ensure that the unit complex with best practic. These evidence sources should be translated into comprehence locally agreed evidence to answer that the unit	met - done quarterly, partially met, done annually, not met, not done - use comments box met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed	0-Not met 1-Partially met	
1	Teview and ensuring best practice around handows of care. Units should regularly inverse guidations providesional argumanisations 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 Creating Proceedings. The unit should identify key performance indicators (PPD) that describe outcomes of their service. Such KPIs may be generic and commons to ment units, using a comprehensition takes an offent match outcomes concernance ancean access the service.	met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed	0=Not met 1=Partially met 0=Not met	
1	Index and ensuring best practice animal handboard at our.	met - annuel review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed met / not met Me - all suff wellbare orients atsied are monitored, partially met - some orients are monitored, not	1-Partially met	
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RECOMMENDATIONS			
	These recommendations may not be applicable to those units outside of England and Wales		
1	Collection of all 34 fields in CCMDS is recommended. This should be done by dedicated trained personnel.	met / not met	3-Not applicable to Unit
2	There should be clinical oversight of the CCMDS data entry/data submission to ensure accuracy of data.	met / not met	3-Not applicable to Unit
		met / not met	3-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	3=Not applicable to Unit
5	A lead commissioner should be identified with a commissioning forum for each critical care service.	met / not met	3-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	
	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 venillatory support, intravenous therapies and invasive monitoring for patients			
2	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	Met or unmet	1=Partially met	Departmental fire plans currently being updated to include guidance from the As
3	can be referred to in an emergency. Recommendators 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	Met / unmet	2-Fully met	
	brackes, b) the same sociage of oxygen cylinders and c) tolowing the recommended sequence of events when surring on an oxygen cylinder. Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring and			
4	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	Met / unmet	2=Fully met	Major Incident plans in place, along with Business Continuity plans. Activity 18 n
7	critical care unit should it need to carry out an emergency evacuation. Any problem with oxygen cylinders and associated equipment must be reported immediately to both the medical gas supplier and the Modelinear model Mediatrice Republices and the Modeline Control Mediate Republices and the Modelinear modelinear solution by (MMER).	Met / unmet	2=Fully met	
	Medicines and Heathcare products Regulatory Authority (MHRA). All staff must undergo regular training in fire provention and fire procedures, to include training in-situ in the specific clinical areas in which they work. All staff must how all the location of the call points within their own unit and how to operate them, b) the location of fire		1=Partially met	Fire Training is mandatory, arranging unti specific training
8	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 pas 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
	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			
10	unwell patients being evacuated first and the most unwell patients fact; o) possible co-existing power and/or explores theory failure; f) use of transport verifiators and hand ventilation if needed, g) temporary discontinuation of renal replacement therapy; and h) transfer of bosptial notes expecially if electronic patient monitoring is in use. In a major fine, it is possible that serial evacuations will be required with a	Met / unmet	0+Not met	Departmental fire plans currently being updated to include guidance from the As
	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.			
ECOMMENDATIONS				
1	Evacuation policies should include liaison with the Brozes (Operational), Silver (Tacica) and Godd (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 tate then noticets and staff may be harmed by line and ornivia.		1=Partially met	Fire evacuation plan discusses Liaison with hospital fire response team.Patient
2	Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be nonclised	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 Co
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)	Met - system available / unmet - no system in place to do this	1=Partially met	Included in Fire Plan
	system is a screening tool used in the military and more recently used successfully in healthcare which could be considered.	and a second sec		
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 accommode all critically ill patients in this type of situation. A retrieval team approach, with staff from neighbouring units reaveling to the affected unit to transfer patients, should be planned. Lialcom with neighbouring units and	met / not met / not applicable	3=Not applicable to Unit	Local Business Continuity and Major Incident plans apply
	with staff from neighbouring units traveling to the affected unit to transfer patients, should be planned. Liaison with neighbouring units and local ambulance services at an early stage is advised.			
6.2	Major Incidents			
VA	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 clans in place to meet this standard	0=Not met	Inadequate logistics to double capacity
2	All compated supporting bornitals with Lovel 2 critical care canability must be prepared to double their normal capacity for Lovel 2 bods for	Here i united - no claims in calce or inter this sampard Met - plane in place to do this - partially met - plane in place but dont meet this standard ( comments box here i) unmet - no claims in place to meet this standard	0=Not met	Inadequate logistics to double capacity
3	minimum adjupting individuality and reference of the adjustice of the adju	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	Met / unmet	2=Fully met	Patients will be taken to Theatres/Recovery
5	exclusively intensive care patients, should the intensive care areas become unusable for any reason. 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	met / unmet	2=Fully met	Business Continuity plans in place. Dedicated Psychologist working in Critical C
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.
ECOMMENDATIONS				
1	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response (EPRR)	met / unmet		
	leads and clinical colleagues to create the intensive care response to a major incident, hospital evacuation or mass casually plans.			
2	leads and clinical colleagues to create the intersive care response to a major incident, hospital evacuation or mass casually plans. Intersive care should have access to emergency planning and response training including strategic/crisis leadership.	met / unmet	0-Mot mat	
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#### Introduction

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 comoleted in collaboration with members of Inis 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 memb 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, 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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Intensive Care Society

### 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)

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:

Prince Philip Hospital Wales 30/06/2023

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	ST	FANDAR	DS	RECOMMENDATIONS		
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Fu M
1	CRITICAL CARE SERVICES: STRUCTURE				1		
1.1	Levels of Critical Care	0%	0%	100%	0%	0%	00
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%	00
1.5	Clinical Equipment	19%	13%	69%	0%	0%	10
1.6	Cardiothoracic Critical Care				0%	0%	00
1.7	Neurocritical Care	0%	0%	0%	0%	0%	00
2	CRITICAL CARE SERVICE: WORKFORCE						
2.1	Medical Staffing	0%	20%	80%	0%	0%	10
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%	5
2.10	Healthcare Scientists Specialising in Critical Care	070	070	10070	0 /0	0070	
2.11	Support Staff	10%	30%	60%	20%	40%	4(
2.12	Support Staff Smaller Remote and Rural Critical Care Units	0%	<u> </u>	100%	20% 0%	40% 0%	4
_			070		070	0,0	
3	CRITICAL CARE SERVICES: PROCESS						
3.1	Admissions, Discharge and Handover	27%	27%	45%	0%	0%	C
3.2	Capacity Management	14%	29%	57%	20%	60%	- 20
3.3	Critical Care Outreach and Rapid Response Systems	0%	0%	100%	20%	0%	6
3.4	Infection Control	0%	0%	50%	0%	17%	6
3.5	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology	0%	0%	83%	14%	29%	4
3.6	Rehabilitation	29%	29%	29%	29%	14%	1
3.7	Intensive Care Follow Up	50%	0%	50%	0%	9%	C
3.8	The Patient and Relative Perspective	29%	29%	43%	50%	10%	4
3.9							
	Staff Support	0%	0%	100%	0%	0%	10
3.10	Inter and Intra Hospital Transfer of Critically III Patients	0%	13%	88%	8%	8%	8
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%	C
4	CRITICAL CARE SERVICES: CLINICAL CARE						
4.1	Respiratory Support	0%	10%	90%	75%	0%	2
4.2	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	50%	50%	71%	0%	2
4.3		0%	0%	100%	0%	0%	8
4.3	Renal Support	0%	60%	40%		0%	-
	Gastrointestinal Support and Nutrition	0%	00%	40%	30%		70
4.5	Liver Support		0001	4=01	30%	10%	5
4.6	Cardiovascular Support	50%	33%	17%	33%	0%	6
4.7	Echocardiography and Ultrasound	64%	0%	27%	89%	0%	1
4.8	Neurological Support	14%	0%	86%	31%	0%	6
4.9	Burns						
4.10	Care of the Critically III Pregnant (or Recently Pregnant) Woman						
4.11	Care of the Critically III Child in an Adult Critical Care Unit						
4.12	Standardised Care of the Critically III Patient	10%	0%	90%	10%	0%	9
							-
Б	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS	0%	0%	0%	0%	0%	10
5 5.1	Research and Development		20%	20%	33%	50%	1
5.1	Research and Development	60%	20/0			50%	
5.1 5.2	Audit and Quality Improvement	60%	200/	500/	50%	50%	0
5.1 5.2 5.3	Audit and Quality Improvement         Clinical Governance	20%	20%	50%		00/	
5.1 5.2 5.3 5.4	Audit and Quality Improvement         Clinical Governance         Critical Care Networks	20% 0%	0%	100%	0%	0%	1
5.1 5.2 5.3	Audit and Quality Improvement         Clinical Governance	20%				0%	1
5.1 5.2 5.3 5.4	Audit and Quality Improvement         Clinical Governance         Critical Care Networks         Critical Care Commissioning	20% 0%	0%	100%		0%	1
5.1 5.2 5.3 5.4 5.5	Audit and Quality Improvement Clinical Governance Critical Care Networks Critical Care Commissioning CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS	20% 0% 0%	0% 0%	100% 100%	0%		
5.1 5.2 5.3 5.4 5.5 6 6.1	Audit and Quality Improvement Clinical Governance Critical Care Networks Critical Care Commissioning CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS Fire	20% 0% 0% 10%	0% 0% 30%	100% 100% 50%	0% 	67%	0
5.1 5.2 5.3 5.4 5.5 6 6.1 6.2	Audit and Quality Improvement Clinical Governance Critical Care Networks Critical Care Commissioning CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS Fire Major Incidents	20% 0% 0% 10% 29%	0% 0% 30% 43%	100% 100% 50% 29%	0% 	<mark>67%</mark> 0%	C 22
5.1 5.2 5.3 5.4 5.5 6 6.1	Audit and Quality Improvement Clinical Governance Critical Care Networks Critical Care Commissioning CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS Fire	20% 0% 0% 10%	0% 0% 30%	100% 100% 50%	0% 	67%	1( 0 22 7( 80

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NoteNoteNoteNote1International problemNoteNoteNote1International problem </td <td>Section 1</td> <td>CRITICAL CARE SERVICES: STRUCTURE</td> <td>Level description</td> <td>Choose level Comments</td>	Section 1	CRITICAL CARE SERVICES: STRUCTURE	Level description	Choose level Comments
IndexMathematical and a part of the second seco	1.1	Levels of Critical Care		
IndexMathematical and a part of the second seco	STANDARDS			
Note of the section	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
NoteNote1Second Second Seco	2	Level of Care classification must not be used in isolation to decide upon a patient's requirements.	met/ not met	2=Fully met
NoteNote1Second Second Seco				
Image: stateImage: state<	RECOMMENDATIONS			2 Mart and Earth In the Link
NoteNo		None.		3=Not applicable to Unit
1     Note: Note	1.2	Outcomes		
1     Note: Note		-		
111000 (	STANDARDS		and annual second state and and and and an anti-	
111			multiprofessional involvement, not met - no review	
1Not				
Normal Normal 		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 on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections antimicrobial use and frequency of multi-resistant infections on benchmark rates of catheter-related bloodstream Infections and the second seco		1=Partially met
1Notational and any				
Image: state s	RECOMMENDATIONS	The HV intensity was assumed a bould assume and device a calibrial waterialized to receive adaptic to intensity any and wateria devices water		
111	1	subsequent outcomes relating to intensive care admission and refusal. Units should develop a consistent approach to patient-centred decision-making, evaluating burdens and benefits of admission to intensive care, and be able to	met - all admissions audited and reviewed, partially met, some audit evidence of this process, not met - no audit	2_Eully mat
Image: spin spin spin spin spin spin spin spin				
1Notation of the second s	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	
III0II	5		National measure	
NormalNormalNormalNormalNormal1NormalNormalNormalNormal	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
NormalNormalNormalNormalNormal1NormalNormalNormalNormal	11	Lavel 9 and 1 Diversel Excilition		
1NoteNoteNoteNote1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector1SectorSectorSectorSectorSector2SectorSectorSectorSectorSector2SectorSectorSectorSectorSector3SectorSectorSectorSectorSector3SectorSectorSectorSectorSector3SectorSectorSectorSectorSector3SectorSectorSectorSectorSector3SectorSectorSectorSectorSector </td <td>1.3</td> <td>Level z and s Physical Facilities</td> <td></td> <td></td>	1.3	Level z and s Physical Facilities		
1Normal 	STANDARDS			
1Normal part of the second part of the secon			met / not met	2-Fully met
Note:Note:Note:Note:Note:1Note:Note:Note:Note:Note:Note:1Note:Not:				3-Not applicable to Unit
And the set of a set o	3	Medicines and fluid storage must comply with HBN 00-03.	met / not met	
And the set of a set o	RECOMMENDATIONS			
IntNotaNotaNotaNota1National sector secto	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
Image of the second s	2	Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.		3=Not applicable to Unit
Image: state			met - non clinical transfer <0.8% of admissions, partially met < 1%, not met >1% of admissions	
Image: state			met, partially met, not met, not applicable	
111 <th< td=""><td></td><td>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.</td><td></td><td></td></th<>		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.		
Image: second		experiences and learning.	met, partially met, not met, not applicable	3=Not applicable to Unit
Image: set of the set of th	7	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
Image: second		or highlight any slippage to timeframes.		2+Fully met
Bit Section	9	Failure to follow HBN 04-02 guidance should be questioned by both Operational Delivery Network and commissioners.	National/regional measure	
Bit Section				
Name         Note of the standard method state of the state of t	1.4	Clinical Information Systems*		
1     Not Control to the property to		*If no CIS then Not applicable		
1     Not Control to the property to				
Image: Note of the state of the st	STANDARDS			
Image: Note of the section o	1	The CIS must comply with the set of common specifications, frameworks and implementation guides that support interoperability as specified with the NHS		2-Net serviceble to Linit
Image: Note of the section		Interoperability Toolkit. (https://dioital.nhs.uk/services/interoperability-toolkit). CIS procurements and customisation must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system.		
A     is along the sequence of the s	2	Intercontrollin Tockik, Inters disellar ihn adverses interconstable tookki. Cite procurements and culomisation multi movie an undisciption collaboration of all stakeholders who would typically use, maintain and develop the system. This mult include input from and users (including representatives of all clinical and group), procurement discers, clinical engineering, the CCD (Clunical This CC S multi have a strong barries control strong and regiments and regiments and regiments and the clinical This CC S multi have a strong barries control and regiments and regiments prime to the critical patient formation regiments analised and system.		2-Fully met
1       Bit and and a set of a set	2	Intercontraliation Touchi, Intrastruitata rins advancess interpresentative toutkit. CCG procurrents are automission run tarti orise a multidesigning collaboratio of all stabeholders who would typically use, maintain and develop the system. This must include input from and users (including representatives of all clinical atal groups), procurrent efficers, clinical engineering, the CCD (Chical Chical domation Officient and CT securities. The CCB must have a rigorous bunches continuity access (BCA) plan and realisines systems on that critical patient information remains available and system must be approximately and a plan sym. These must be a process to ensure that sufficient staff humade in BCA contingnor matures are available 247.	Met = full BCP present and tested, partially = some aspects not expected to continue as usual or BCP untested, Not met = no documented BCP	2-Fully met
Note where the state is the state	2	Intercontraliation Touckis, Intest-Sideal Arts Askineroses/Interpretendentiation controls and a state-backets who would typically use, maintain and develop the system. This must include input from and users (including representatives of all clinical atligracies), procurement efficient, clinical engineering, the CCD (Chical Chical domation Officient and Cl <sup>2</sup> macualities. The CL must have a reprova bunches continuity access (BCA) plans and realising systems on that critical galaxie information memory analysis and system and the CL must have a reprova bunches continuity access (BCA) plans and realising systems on that critical galaxie information memory analysis and systems analising A27. Where patient data management systems (POMS) or electronic patient record (EPR) systems are used, here must be access to a dedicated workstation complete a such bed space. A supportain curved to but moleks and files workstations must be available to foldite letter systems control systems control and systems and accehed space. The approximation patient activity and workstations must be available to foldite letter systems control systems of the system accehed space. The approximation that control acceleration and the system control memory approximation and and accehed space. The approximation that control acceleration a	Met + full BCP present and tested, partially = some aspects not expected to continue as usual or BCP untested, Net met - no documented BCP Met = workstation for every bedgace plus additional workstations for mobile statif, partially met = insufficient mobile workstation, nrt met - absence 'workstation at every bedgace (even Hobile station; partial) events	2=Fully met 3=Not applicable to Unit
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i     initial control or single section of the single sectin o	2 3 4	Intercontrastility Touck, https://doi.org/10.1016/j.ms/2000/00000000000000000000000000000000	Net - Mil BCP present and leads, partially = some aspects not expected to continue as usual or BCP untested. Net met - not documented BCP we - evolutation or evol becapses plus additional evolutations for mobile staft, partially rest - insufficient mobile workstations, not met - absence of workstation at every bedgapee (even if mobile stations available) or alternor of any mobile workstations.	3-AFuly met 3-Met applicable to Unit 3-Met applicable to Unit
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16     of line(v) is other patients or stall from potentially untimitier explorement, and the supplier should provide adequate straining to ensure correct use. The EBME     net / not met     IM-Patially met       RECOMMENDATIONS       RECOMMENDATIONS       1     Standardsation of explorement should be encouraged both within the citical care unit and in other areas where intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive and maintensive provide and maintensive metal and in other areas where intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.     Patially met + 1 time different (potical at explorement used in only 1 area on the intensive care may need to be delivered.	2 3 4 8 8 8 9 1 3 4 5 6 6 7 7 8 8 9 9 10 10 11 11 12 2 3 10 11 12 2 3 11 12 2 3 13 11 12 2 3 11 12 12 13 11 12 12 13 11 12 12 13 11 12 12 13 11 11 11 12 11 11 11 11 11 11 11 11 11	Intercentially Tools, these classical characterized and a multiseleging and information of an advanced on the second of property care, manine and deading the system term of the second	Here - Intil ICC process and tested, partially - some aspects not expected to continue as usual of ICC unsteads.     Here - Intil ICC process and tested partially - some aspects not expected to continue as usual of ICC unsteads.     Here - Intil ICC process and tested partially and unstead on the intil ICC aspect of the intervent aspects and the unstead of unstead of the unstead of the unstead of unstead of the unstead of	3-Var opticable to Unit       0-Var opticable to Unit       0
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access to sufficient ultrasound equipment to ensure that intravascular cathetess can be placed safety and in a timely manner, even in emergent circumstances.	2 3 4 5 5 6 7 3 4 5 6 7 6 9 9 10 10 11 11 5 5 7 8 9 9 10 10 11 11 5 5 7 8 9 9 10 10 11 11 12 13 13 14 4 5 15 15 15 16	<ul> <li>Internet in the content in the statemeter strenger content is a material space of content in the space of content is an internet internet in the space of content is an internet internet in the space of content is an internet internet</li></ul>	We have have been as a fease partially - some aspects not expected to continue as usual of BCP insteaded. Note that - an observation of the system participation of the system partite participation of the system participatio	3-Vary wet       3-Var applicable to Unit       0-Var applicable to Unit
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1.6	Cardiothoracic Critical Care		
1.0	*Not applicable to non Cardiothoracio Critical Care		
TANDARDS			
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of	met / not met	3=Not applicable to Unit
2	GPICS. Each cardiothoracic critical care unit must have designated lead consultant with training in cardiothoracic intensive care. This should be recognised in their job plan	met / not met	3-Not applicable to Unit
3	and they should be involved in multidisciplinary service planning and governance within the unit 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	met / not met	3=Not applicable to Unit
5	resident team must be trained in Cardiac Surgery Advanced Life Support (CALS) and be capable of emergency chest re-opening 247. Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complies with	met / not met	3=Not applicable to Unit
6	national standards. There should be a clear escalation pathway from post-operative care to intensive care. 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	met / not met	3=Not applicable to Unit
7	Care Medicine. 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	met / not met	3-Not applicable to Unit
11	the ICNARC ARCIIC (Assessment of Risk in Cardiothoracic Intensive Care) programme - the national clinical audit for cardiothoracic critical care units. Transthoracic and transpesophageal echocardiography must be immediately available.	met / not met	3=Not applicable to Unit
MMENDATIONS			
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	met / not met	3-Not applicable to Unit
2	general (Level 3) critical care unit. 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	met = clear written protocol, partially met = occurs in practice but referen/accepter dependent, not met =	3=Not applicable to Unit
4	care facility as required. ACCPs, with adequate training and appropriate support, can provide a safe, sustainable alternative to medical staff in the cardiothoracic critical care unit.	escalation does not/cannot occur 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	met / not met	3-Not applicable to Unit
6	period. Perfusion services should be readily available.	met / not met	3=Not applicable to Unit
-	Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an		
7	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*		
1.7			
	Neurocritical Care*		
1.7 TANDARDS	Neurocritical Care* "NOT Applicable if non neurocritical care		
	Neurocritical Care* "NOT Applicable if non neurocritical care Consultants, nursing, resident medical, healthcare professional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in	Mar / not met	9-Met applicable to Linit
TANDARDS	Neurocitical Care* *NOT Applicable if non neurocitical care Consultants, nursing, resident medical, healthcare podessional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in	Met / not met met - all available, partially - some available	3-Mar applicable to Unit 3-Mar applicable to Unit
TANDARDS 1	Neurocritical Care* *NOT Applicable if non neurocritical care Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards collined in the interact datasets of CPUS. TO access to MIC eventilated subjects, and diagnostic analyzageate directal expertise for the following of diagnostic neology (24-hour access to TO: access to MIC eventilated subjects, and diagnostic analyzageate directal expertise for the following of diagnostic neology (24-hour access to TO: access to MIC eventilated subjects, and diagnostic analyzageate directal experiments and analyze compression for the CED and the CED access to TO: access to MIC eventilated subjects, and diagnostic analyzageate response diagnost and monitoring). Access to continuous 24-hour ECD monitoring as the CED access to access to the continuous and access to continuous 24-hour access to TO: access to MIC eventilated subjects, and diagnostic analyzageate response diagnost and monitoring). Access to continuous 24-hour access to TO: access to MIC eventilated subjects, and diagnostic analyzageate response diagnost and access to TO: access to MIC eventilated subjects, and diagnostic analyzageate response diagnost to TO: access to MIC eventilated subjects, and diagnostic access to TO: access to MIC eventilated accessioned diagnost and accessioned accessioned diagnost to TO: accessioned accessioned accessioned diagnost to TO: accessioned access		
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TANDARDS           1           2           3           4           5	Neurocritical Care* "NOT Applicable if non neurocritical care Consultants, nuising, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in the information datasense of DPUS." Consultants, nuising, resident medical, healthcare professional and appropriate circlaid spectra for the following, of approximate cardiology (24-box access to Consultants, nuising, resident medical, healthcare professional and appropriate circlaid spectra for the following, of approximate cardiology (24-box access to Consultants, nuising, resident medical, healthcare professional and appropriate circlaid spectra for the following, of approximate cardiology (24-box access to Consume the disputsion of the disputsion appropriate), bacreas to becomenzy and incordious 24-box EEC monitoring is a furst and the adapproximation access the adaptive and appropriate cardiology and and and and and and and and appropriate cardiology. Access to become the initial availability of a munocritical care back. A care required medical interaction must have access to specialital transmit from neurocolonic card back. A per NEC 0574, diplice patients must have assessment for in-patient rehabilitation if new cognitive, emotional, behaviourd or physical difficulties presist for more than 2, box m.	met - all available, partially - some available kully met - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met - all patients appropriate for encolation discussed, not met (must allow local clinicians professional latitude Not Or test toos done too local or interview) met / not met met - have access humdhatily once ready for discharge from acute center, partially met – have access but	3-Not applicable to Unit 5-Not applicable to Unit 5-Not applicable to Unit 5-Not applicable to Unit
TANDARDS           1           2           3           4           5           6	Neurocritical Cere* "NOT Appricable if non neurocritical care Consultants, nutsing, resident medical, healthcare professionial and pharmacy stalling numbers and work patterns must athere to the same standards outlined in the attention charters of GPACS. Consultants, nutsing, resident medical, healthcare profession in advectory patterns and work patterns must athere to the same standards outlined in the attention charters of GPACS. Consultants, must advect to the standards and appropriate directly approximate the total standards and the standards and appropriate the total standards and the standards and the standards and most to the standards and the standards and most total to the standards and most total and the standards and most total standards and most total and the standards and most total and total and the standards and most total and the standards and most total and the standards and most total and total and the standards and most total and total and the standards and the standards and most total and total and the standards and most total and t	met - all available, partially - some available May net - formally agreed and audited pathways in place, partially met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is MOT refer those clearly too fail or intervition). Mar / not met met - how access immediately once ready for discharge from access center, partially met - laws access but find-hange datas - skin - scill access data - a datassor default - a vession a discuss neuro rehab.	3-Not applicable to Unit 3-Not applicable to Unit 3-Not applicable to Unit 3-Not applicable to Unit 3-Not applicable to Unit
TANDARDS           1           2           3           4           5           6           7	Neuroscritical Care*     NOT Applicable if non neuroscritical care     Not Applicable if non neuroscritical care     Consubarts, nusting, readent medical, healthcare professional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in the detection chapter of GPDG.     Consubarts, nusting, readent medical, healthcare professional and pharmacy stalling numbers and work patterns must adhere to the same standards outlined in the detection chapter of GPDG.     Consubarts, nusting, readent medical, healthcare professional and patromicities and appropriate circular operatives for the following: all diagnostic medicingy (24-hour access to C1: access to MR to venillate duplets, and diagnostic angiography), b) access to biochemistry and indicability are not analyze centropropriate full (CSP), c) have realized adupted.     All cases requiring immediately lifesching neuroimage have imported appropriate care to another of the head analyze centropropriate full care backs of the head neuroimage). Access to percent and the access to special treatment from neuroscience unit.     Aprints that a Glasgov Coma Scale (GCS) score of 8 following a head input any time must have access to specialist neuroimage. Access the project difficulties pensist for neuroscience and the access to applicate difficulties pensist for neutrophase and the access to applicate difficulties pensist for neutrophical March technical to access the additional penetral relabilistics neuroimage and the access to specialist neuroimage and the access.     Neuroscience and the neuroimage and the access to specialist neuroimage and the neuroimage and the access to applicate difficulties pensist for neuroimage and the access to specialist neuroimage and the access.     Neuroimage and the neconcient of the netoticate pensis for neuroimage and the neuroimage	mit - sil available, partailly - some available kup ear - formally agreed and audited pathways in place, pathally met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is NOT refer to ace clearly too fail or intervition). Met / ont met met - how access immediately once ready for discharge from access center, partially met - have access tool charge datas - skin - 200 -	3-Not applicable to Unit 3-Not applicable to Unit
TANDARDS           1           2           3           4           5           6           7           8	Neuroritical Care*  Consuberts neuring resident medial; healthcare potencianal and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in a dispute analyzing the state of the same standards outlined in a dispute analyzing the state of the same standards outlined in the advector of GPCS.  Proceedings and the enables advector of GPCS and the advector of the same standards outlined in the same standards and proceeding and the same standards outlined in the same standards and proceeding and the same standards outlined in the same standards and not state of the same standards outlined is the same standards and not state of the same standards outlined in the same standards outlined in the same state state of the same standards outlined in the same state state of the same state state state of the same state state of the same state state state of the same state state state of the same state s	mit - sil available, partailly - some available kup ear - formally agreed and audited pathways in place, pathally met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is NOT refer to ace clearly too fail or intervition). Met / ont met met - how access immediately once ready for discharge from access center, partially met - have access tool charge datas - skin - 200 -	3-Not applicable to that 3-Not applicable to that
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TANDARDS 1 2 3 4 5 6 7 7 8 9 9 10	Neurocritical Cen*     "NOT Applicable if non neurocritical care     "Not applicable if non-neurophysically (notading determining the disposite applicable in the statement of the intervent is applicable careful data)     "Not applicable if non-neurophysical difficultes persist for more thanking applicable if non-neurophysical difficultes persist for more thanking applicable if non-neurophysical difficultes persist for applicable if non-neurophysical difficultes and applicable in the neurophysical difficultes and applicable in the state applicable inthe state applicable inthe state applicable in the state applicab	mit - sil available, partailly - some available kup ear - formally agreed and audited pathways in place, pathally met - done but not monitored pathway, not met - all patients appropriate for excatation discussed, not met (must allow local clinicians professional tatitude is NOT refer to ace clearly too fail or intervition). Met / ont met met - how access immediately once ready for discharge from access center, partially met - have access tool charge datas - skin - 200 -	S-Nor applicable to Unit S-Nor applicable to Unit
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TANDARDS 1 2 3 3 4 5 6 6 7 7 8 9 9 10 10 11	Everschilde Care*         TeXT Applicable if non neuroritical care         TeXT Applicable if non neuroritical care         Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must ablere to the same standards collined in         In an internal abalence of CPVCS.         Consultants, nursing, resident medical, healthcare professional and pharmacy staffing numbers and work patterns must ablere to the same standards collined in         Text and the resident of CPVCS.         Consultants, nursing, resident medical, healthcare professional and approximately internal staffing resident and approximately is a const to beneficial constraints of CPVCS.         Text professional and the approximately is a const to beneficial constraints and approximately is a const to beneficial constraints of CPVCS.         Constraints provided by lifessing neuromapproximate abalence adaptions and monotromy and monotromy and the constraints of the related stafficial test to be abalence and approximately in the must have access to specialat transment from neuroconce unit.         App method 2014 display attents must have assess the patient of the social straints of the neuroconce unit.         App method 2014 display attents must have access to specialat transment from neuroconce unit.         App method 2014 display attents must have access to specialat transment from patient and have access to patient and have access.         Reuncolicat care must have recources to support regord restrokers of the all shad method for the all shad dimeticants are installed associated for the set advector of the set and dimeticant in the set access to the set and dimeticant in the set access to potential transment for advectoring and methods.         Patients with automachined for the set advectoring of the set advectoring the set advectoring and methods.         Constraints providing attents that the professional restructs of the set advectoring and method sectors in managing critically il	reat - all available, partially - some available the - all available, partially - some available bit y me - formally agreed and available pathways in place, partially me - done but not monitome pathway, not me - all patients appropriate for exclusion discussed, not met (must allow local cliniciane professional latitude is NOT refer torse clearly too tail to extension) met - local available, partially - SOT part reads, not met - no access or doings - 4 weeks to access new or table met - local available, partially - SOT part reads, not met - no access or doings - 4 weeks to access new or table in - all partially regime for exclusioned in our no access or doings - 4 weeks to access new or table is NOT refer torse clearly too ital for intervention). met / not met met / not met met / not met met / not met	A-Nar applicable to Unit     S-Nar applicable to Unit
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TANDARDS 1 2 3 4 5 6 7 8 9 10 11 1 MMENDATIONS 1 2	Evenomistical Care*     NOT Applicable If non-interactional care     Not Applicable If non-interactional care     Security and a security and a security of the secure set overlapping overlapping of the secure set overlapping overlappin	reat - all available, partially - some available (b) met - formally agreed and available (pathways in place, partially met - done but not monitored pathway, not met - and a some appropriate for encodation discussed, not met (must allow local chickane professional tathue met - and and met appropriate for encodation discussed, not met (must allow local chickane pathway, not discharge data) within the 200 pathway. Some that is a some some entries, patholly met - have access to discharge data) within the 200 pathway. Bot data have been availed and the some and the some and discharge data) within the 200 pathole. The some some entries, patholly met - have access to discharge data) within the 200 pathole. The some some entries a pathole is an an entry of met brace check to be addressed, not met (must allow local chickane professional latitude to NOT infer those check to be add to intervention). met / not met met / not met met / not met met - meterotrabe at any pathol in pathway, patholy met - available but not necessarily during ordical care advard or advard and the first week alter injury (may be speciality pays or pathology or consultant).	Arhat applicable to Unit Arhat applicable to Unit Bahat applicable to U
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TANDARDS 1 2 3 4 5 6 6 7 8 9 10 10 11 11 MIMENDATIONS 1 2 3 4 4	Every series of the second series of the second series of the series of the second series of the series of th	reat - all available, partially - some available (b) met - formally agreed and available (pathways in place, partially met - done but not monitored pathway, not met - and a some appropriate for encodation discussed, not met (must allow local chickane professional tathue met - and and met appropriate for encodation discussed, not met (must allow local chickane pathway, not discharge data) within the 200 pathway. Some that is a some some entries, patholly met - have access to discharge data) within the 200 pathway. Bot data have been availed and the some and the some and discharge data) within the 200 pathole. The some some entries, patholly met - have access to discharge data) within the 200 pathole. The some some entries a pathole is an an entry of met brace check to be addressed, not met (must allow local chickane professional latitude to NOT infer those check to be add to intervention). met / not met met / not met met / not met met - meterotrabe at any pathol in pathway, patholy met - available but not necessarily during ordical care advard or advard and the first week alter injury (may be speciality pays or pathology or consultant).	A-Nar applicable to Unit
TANDARDS	Neurostical Care*  Consuberts noting sectors reading healthcare polescional and pharmacy staffing numbers and work patterns must adhere to the same standards outlined in a distance data and approximate include and and approximate include and approximate and experises for the following: a dispatcies making (KPA Public Care Staffic Care Staffi	net - all available, partally - some available find - all available, partally - some available the - all parters appropriate for exclusion discussed, not met (must allow local clinicium professional tatitude the - all parters appropriate for exclusion discussed, not met (must allow local clinicium professional tatitude the - all parters appropriate for exclusions discussed, not met (must allow local clinicium professional tatitude the - all parters appropriate for exclusions discussed, not met (must allow local clinicium professional tatitude the - all parters appropriate for exclusions of users a summar a clinicity - a venet to access means when met - all parters parters and the meansteinen and - all parters parters and the meansteinen and - fort met met - meansteine the summarized and the meansteinen met - meansteine them clinicity meansteinen met - meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen meansteinen means	A-lar applicable to Unit S-lar applicable to Unit
TANDARDS 1 2 3 4 6 7 8 0 0 10 11 1 2 3 1 2 3 4 5 6 6 1 1 2 5 6 6 6 6 6 6 6 6 6	Evencentical Care*         NOT Applicable in non-neuroscitical care*         NOT Applicable in non-neuroscitical care         Consuberts notifing excited media/ facilitate polescited and pharmacy staffing numbers and wok patterns must adhere to the same standards outlined in         an advance to advan	end - sill analizable, partially - some available Med - sill analizable, partially - some available (b) met - formally agreed and audied pathengs in place, pathally met - done but not monitomed patheny, not met - and patheness perspective for encadation discussed, not met (must allow local chickame professional tatitude is NOT refer those clearly too hall to intervention) met - Ana access immediately crone reacy for discharge from acute centre, partially met - have access to the discussed of the took clearly too hall to intervention) met - 2AP partially -50° per week, not met - available least han leas. met - 2Ap partially -50° per week, not met - available least han leas. met - 2Ap partially -50° per week, not met - available least han leas. met - 2Ap partially -50° per week, not met - available least han leas. met - 2Ap partially -50° per week, not met - available least han leas. met - 2Ap partially approaches for exacidation discussed, not met (must allow local chickame professional tatitude to NOT refer those clearly uso field to intervention). met - near the exact have protein in pathway, partially met - available bot not necessarily during ontical care size, not met met - near-math, consult whith near least hall in highly (mag has speciated physics or suncation error consultant), partially met - near-exact have be transferred, you free to reader and physics or suncationer or consultant), partially met - near-exact have be transferred, you free to reader and physics or suncation error consultant). met - meter during constrained and what data , apartially - met recommendation but no avails data, not met - nearboxic / provinced.	Aviter applicable to Unit

	CRITICAL CARE SERVICES: WORKFORCE	Level description		
2.1	Medical Staffing			
STANDARDS	Patients' care must be led by a consultant in Intensive Care Medicine, who is defined as " a consultant who is a Fellow/Associate			
1	Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine. A consultant in Intensive Care Medicine wee	et = 24/7 cover by consultant in ICM, partially met = all daytimes covered by ICM consultant but 1-2 nights per sek covered by an anaesthetist with direct telephone access to a named "second on call" ICM consultant not	2=Fully met	
2	activities will be exclusively in ICM and the Consultant will not be responsible for a second speciality at the same time."	et = anything else et = daytime consuttants work blocks of 3 or more days, with job planned handover time, partially met = blocks	2=Fully met	
2	Consultant work patterns must deliver continuity of care. of <	<3 days or days themselves divided but with clear handover, not met = anything else illy met = 7 days a week, partially met = 5 days per week	2=Fully met	
4		ilv 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	at / not met	2=Fully met	
6	a doctor or ACCP with advanced airway skills.	t / not met	2=Fully met	
7	A consultant in Intensive Care Marticine must be immericately qualitable 24/7. The consultant responsible for intensive care out of bourse	t / not met	2=Fully met	
8	Met must be able to attend within 30 minutes. A sinal must be able to attend within 30 minutes.	et / 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	et = >95% of days 2 ward rounds occur, partially met = 90-95%, not met = <90%	2=Fully met	
10		et - all met 7 days per week, partially met - ( define missing groups ) or only 5 days per week, not met - not heived	1=Partially met	
11	Met	et = staff confirm rota is resilient, partially met = staff believe rota has features that are unsustainable in the long m. not met = failed rota requiring regular locum cover	1=Partially met	
				•
OMMENDATIONS				
1	The consultant rota should seek to avoid excessive periods (> 24 hours) of direct patient consultant responsibility. met	et / not met	2=Fully met	
2	The resident rota should be compliant with working time directives (i.e. Working Time Directive 2003) met	et / not met	2=Fully met	
2.2	Registered Nursing Staff			
	1			
STANDARDS			0.5.4	
1		at 98% of the time or not met	2=Fully met	
2	Each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service		2=Fully met	
	e.g. a Band 8a Matron. There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides met	et / not met et = supernumerary nurse does not have their own patient >89% of time, partially met = supernumerary nurse	2=Fully met	
4	the supervisory clinical coordinator role on duty 24/7 in critical care units. Units with fewer than six beds may consider having a is or	occasionally used in emergency to care for patient on <5% shifts, not met = supernumerary nurse is required care for their own patient >5% shifts	1=Partially met	Funded establishment can su
5	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 Met	at = unit >11 beds always has second supernumerary nurse avaiable, Partially = available >60% shifts, not met unit has >11 beds and no additional nurse	3=Not applicable to Unit	
	be incremental depending on the size and layout of the unit (e.g. multiple podsbays, single rooms). Consideration for the need of and additional staff also needs to be given during events such as infection outbreak. Each critical care unit must have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD	anii nas xi ii ueos ano no apononai nurse		-
6	framework for intensive care nursing staff and pre-registration student allocation. This should equate to a minimum of 1.0 WTE per 75 met nursing staff.	et - 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 Met	tt = always provided until competence achieved, partially = provided but may have own patient before full moetencies completed. Not met = anvthing else	2=Fully met	
8		at 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.	at = >95% of shifts, partially =90-95% shifts, not <90%	0=Not met	
10		et or not met	1=Partially 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.	et or not met	2=Fully met	
OMMENDATIONS				
1	Step 1 of National Competencies for Adult Critical Care Nurses should commence when a nurse with no previous experience of the specialty beains working in Intensive Care Medicine.	et / not met	2=Fully met	
2	Part meletration adult intensity once suming asymptot should be supprised a minimum of \$0 section at L and \$. To most the comision	et / not met	2=Fully met	
3	Post-registration about interestve care nuising courses should be awardeed a minimum of to cheats at Level 6. To meet the regulate standard, courses must adopt the core curriculum described in the National Standards for Critical Care Nurse Educators (2016). Additional Clinical Nurse Educators will be required for larger units, i.e. 1.0 WTE for approximately 75 staff. Clinical Nurse Educators	tional measure		Fully met with 2 post reg cou
4	should be serior intensive care nurses who have attained Step 3 competence, have completed a post-registration intensive care award and be in post-registration intensive care award and be in post-registration intensive care award See	e above	3=Not applicable to Unit	
5	Desistered surges supplied through an assess to work is intensive one should provide suideness of appropriate supplicate and	et / 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	et - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	
Ŭ	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.	er - porcy in place, partially mer - no porcy our knowed, nor mer - no porcy and nor knowed	z – ruly mex	
7				
	Supernumerary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive care nursing.	et / not met	0=Not met	Discuss with Sandra
	care nursing.	t / not met	0=Not met	Discuss with Sandra
2.3		( not met	0=Not met	Discuss with Sandra
	care nursing.	(/ not met	0=Not met	Discuss with Sandra
2.3 STANDARDS	Cele nursing. Inter Workforce, Induction & Training of Medical and Nursing Staff			Discuss with Sandra
STANDARDS	Core numme     Workforce, Induction & Training of Medical and Nursing Staff      Workforce, Induction & Training of Medical and Nursing Staff      Each critical care unit must have a dedicated supernumency Circled Maria Educator (1 WTE per approximately 75 staff), response (1 more staff)     Each critical care unit must have a dedicated supernumency Circled Maria Educator (1 WTE per approximately 75 staff), response (1 more staff)     Each critical care unit must have a dedicated on CPD Intervence care must must add and one-macroscole modernet.     An unrung staff approximate in Intervence care must be allocated approximately approximately more response on the staff approximately more response on the staff approximately more response on the staff approximately approximate in the response of the staff approximately more response on the staff approximately approximate in the response of the staff approximately more response on the staff approximately more response on the staff approximately approximately in the response of the staff approximately more response on the staff approximately more response on the staff approximately ap	e above 22.6	2=Fully met	Discuss with Sandra
	Case nursing     Workforce, Induction & Training of Medical and Nursing Staff      Each critical case unit must have a dedicated appendimentary Clinical Nurse Educator (11VTE per approximately 75 staff), responsible for secondariants are dedicated appendimentary Clinical Nurse Educator (11VTE) per approximately 75 staff), responsible for secondariants are dedicated appendimentary Clinical Nurse Educator (11VTE) per approximately 75 staff), responsible for secondariants are dedicated appendimentary Clinical Nurse Educator (11VTE) per approximately 75 staff), responsible for secondariants are dedicated appendimentary Clinical Nurse Educator (11VTE) per approximately 75 staff), responsible for secondariants are dedicated and the secondariant and the secondariant are secondariants and the secondariants are secondariants and the secondariants are secondariants and the secondariants are secondariants are secondariants and the secondariants are secondariants and the secondariants are secondariants are secondariants and the secondariants are secondariants and the secondariants are secondariants are secondariants and the secondariants are secondariants and the secondariants are secondaria			Discuss with Sandra
STANDARDS 1 2	Cele nursing     Workforce, Induction & Training of Medical and Nursing Staff     Each critical care unit must have a dedicated supernumerary Chricial Nurse Educator (1 WTE per approximately 75 staff), responsible for specific controls of the sub-action and starting and cele exolutions that sub-action and training and CPS Intervents for intervent cele nursing and the sub-action and starting and cele exolutions that sub-action and training and the sub-action and starting and cele exolutions that sub-action and starting and cele sub-action and starting and cele sub-action and starting and cele sub-actional actions and the sub-action and starting and cele sub-action and starting and cele sub-actional actions and the sub-actional actions and the sub-action actions actions and the sub-action actions actions and the sub-action actions actions actions and the sub-action actions actio	e above 22.6 e above 22.7	2=Fully met	Discuss with Sandra
STANDARDS 1 2 3	Cele nursing         Initial           Workforce, Induction & Training of Medical and Nursing Staff         Each critical care unit must have a dedicated supernumenary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for some staff of the supernumenary provides the staff of the supernumenary for instance and supernumenary provides the staff of the supernumenary for instance and supernumenary provides the staff of the supernumenary for instance and supernumenary provides the staff of the supernumenary for instance and supernumenary provides the staff of the supernum provides the for the staff of the supernum of the staff of the supernum provides the staff of the supernum of the staff of the staff of the supernum of the staff of the supernum of the staff of the staff of the supernum of the staff of the supernum of the staff of the staff of the supernum of the staff of the supernum of the staff of the	e above 22.6 e above 22.7 e above 22.7	2=Fully met 2=Fully met 2=Fully met	Discuss with Sandra
STANDARDS 1 2 3 4	Cele nursing     Workforce, Induction & Training of Medical and Nursing Staff     Workforce, Induction & Training of Medical and Nursing Staff     Each critical care unit must have a dedicated supernumerary Chricial Nurse Educator (1 WTE per approximately 75 staff), responsible for successful and the subscription of the	e above 22.6 e above 22.7 e above 22.1 - recommendation ee above 22.8	2+Fully met 2+Fully met 2+Fully met 2+Fully met	Discuss with Sandra
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STANDARDS 1 2 3 4	Cele number     Cele number     Workforce, Induction & Training of Medical and Nursing Staff     Workforce, Induction & Training of Medical and Nursing Staff     Each critical care unit must have a dedicated supernumenary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for second and the sec	e above 22.6 e above 22.7 e above 22.1 - recommendation ee above 22.8	2+Fully met 2+Fully met 2+Fully met 2+Fully met	Discuss with Sandra
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Cele number     Cele number     Workforce, Induction & Training of Medical and Nursing Staff     Cele number     Workforce, Induction & Training of Medical and Nursing Staff     Cele number of the staff of th	e above 22.6 # above 22.7 # above 22.1 recommendation ## above 22.8 # above 22.11	2-Fully met 2-Fully met 2-Fully met 1-Partially met	Discuss with Sandra
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1         2           3         4           5         6           7         7	Cele numbro         Units           Workforce, Induction & Training of Medical and Nursing Staff         Each critical care unit must have a dedicated supernumenary Crinical Nurse Educator (1 WTE per approximately 75 staff), responsible for second and the staff of the second and the	e above 22.6 e above 22.7 e above 22.7 e above 22.1 e above 22.8 e above 22.8 e above 22.11 et - Inicudes all elements, partially met - some elements, not met - no identifiable written programme.	2-4Fully met 2-4Fully met 2-Fully met 1-Partially met 2-Fully met 1-Partially met	Discuss with Sandra
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51ANDARDS 1 2 3 4 5 6 7 7 8	Center numbring         United           Workforce, Induction & Training of Medical and Nursing Staff         Exch critical care unit must have a dedicated supernumenary Clinical Nurse Educator (1 WTE per approximately 75 staff, responsible for second and the control of the second and the second an	e above 22.6 e above 22.7 e above 22.7 e above 22.7 e above 22.8 e above 22.8 e above 22.8 e above 22.11 et - inicudes all elements, partially met - some elements, not met - no identifiable written programme. et - meets all elements, partially met - some elements met, not met - no regular teaching et - meets all elements, partially met - some elements met, not met - no regular teaching et - meets all elements, partially met - some elements met, not met - no regular teaching	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Partially met 2-Fully met 2-Fully met	Discuss with Sandra
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TANDARDS           1           2           3           4           5           6           7           8           9           10           11           20           21           22           23           24           5           7           8           10           11           DMMENDATIONS	Cent mutting         Units           Each critical care with much have a dedicated supernumerary Chrical Nurse Educator (1 WTE per approximately 75 stdf), responsible for successful and supervised of the successful and supervised of the successful and succesful and succesful and successful and succesful and successful and	e above 22.6 e above 22.7 e above 22.7 e above 22.7 e above 22.8 e above 22.8 e above 22.1 at - indicudes all elements, partially met - some elements, not met - no identifiable written programme. At - meets all elements, partially met - some elements met, not met - no identifiable written programme. At - meets all elements, partially met - some elements met, not met - no identifiable written programme. At - meets all elements, partially met - some elements met, not met - no identifiable written programme. At - meets all elements, partially met - some elements met, not met - no identifiable written programme. At - orders all elements, partially met - some elements met, not met - no identifiable written programme. At - orders all elements, partially met - some elements met, not met - no identifiable written programme. At - orders all elements, partially met - some elements met, not met - no identifiable written programme. At - orders all elements, partially met - some elements met, not met - no identifiable written programme. At - orders all elements, partially met - some elements met, not met - no identifiable written programme. At - orders all elements, partially met - some elements met, not met, no ime allocated. At - orders all i not met / ord applicable ( if never using agency)	2-Fully met 2-Full	Via agency screening
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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	Met = SOP in place, not met = no SOP	3=Not applicable to Unit	
7	that any incidents are reviewed as part of the unit's dovernance arrangements. It is recommended that line management of ACCPs forms a tripartite arrangement between an ICM consultant, ICU clinical supervisor and		3=Not applicable to Unit	
	professional lead such as a senior nurse or AHP from the ACCP's base profession. Continuing professional development (CPD/appraisal) for ACCPs should be undertaken according to the FICM CPD/appraisal guidance			
8	on an annual basis.	met/not met	3=Not applicable to Unit	
2.5	Pharmacists			
STANDARDS	1			
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	met -7 days per week, partially met 5 days per week.	1=Partially met	
4	per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020. The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at	met / not met	0=Not met	
	least Advanced Stage II (excellence level) in adult critical care pharmacy. Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so			
5	(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	0=Not met	
RECOMMENDATIONS				
	To maintain the continuity of the service during annual leave, sick leave and training leave, additional appropriate resources will be	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no	2=Fully met	
	required (20% minimum is recommended).	cover or on call type cover only		4
2	Intensive care pharmacists should undergo an independent, recognised process to verify competence level.	met / not met	0=Not met	4
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
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	competence of small teams and sole workers. This supports General Pharmaceutical Council (GPPC) revalidation. Where a team of intensive care pharmacists is in place, there should be a structured range of excertise, from trainee to Fellow level.	met / not met	0=Not met	
				1
6	Intensive care pharmacists are encouraged to become active independent prescribers.	Statement		4
2.6	Physiotherapists			
STANDARDS				
	Physiotherapists must participate in opportunities for integrated decision making and dissemination of clinical information. This may			
1	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 methods in junice stell, and must are difficult exceptions and any provide training the service delivery.	met / not met	1=Partially met	
3	and mentorshib to junior staff, and oversee clinical oovernance and quality assurance. All physiotherapy staff must receive appropriate competency-based training to ensure delivery of high-quality physiotherapy intervention	met / not met	2=Fully met	1
	within critical care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover. Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care, ensuring			
4	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	1=Partially met	5 day rehab working only, underesta
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	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	0=Not met	
	intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation goals. Patients receiving rehabilitation must be offered therapy by the multidisciplinary team across a seven-day week, and of a quantity and			
7	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 ofte
8	Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team(s) following discharge from intensive	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	
	care. This should include the holistic individualised structured rehabilitation plan.			
	1			
RECOMMENDATIONS				
	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			
1	comprehensive respiratory care and holistic rehabilitation. However, further work is recommended of paramount importance exploring demand-capacity models to robustly determine physiotherapy stalling ratios in intensive care. The suggested ratio would be one WTE	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 fundir
	physiotherapist to four ICU Level 3 beds			
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 ofte
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 Agenda for Change (AfC) bands applicable to the local service.		0. Not made	
4	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 core standards for service provision which	met / not met	0=Not met	
v	reflects both national guidance and standards and local variations. The intensive care physiotherapy service or, where appropriate, as part of the MDT, should have robust and evidence-based clinical	iner / nor mer	- Hormax	
7	guidelines/standard operating procedures surrounding airway clearance interventions and specialist rehabilitation interventions including	met / not met	0=Not met	
	early mobilisation of patients in intensive care. The lead physiotherapist, or appropriate deputy, should participate in all relevant local (and where appropriate, regional) intensive care			
8	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	met / not met	3=Not applicable to Unit	
	should also include active participation/collaboration with their regional Critical Care Operational Delivery Network. The physiotherapy intervention(s), as part of the patient's individualised, structured rehabilitation plan, should be matched to the acuity,			
9	dependency and complexity of the patient, considering the patient's clinical needs and tolerance to intervention. This should align with the	met / not met	1=Partially met	Rehab is 5 days a week only with lin
	individualised, patient-centred rehabilitation goals and a holistic rehabilitation approach should be taken across a 24-hour period. Physiotherapists should play a key collaborative role in the coordination and delivery of ventilation and tracheostomy weaning plans,			
10	including post-extubation and post-decannulation care. Additionally, physiotherapists should be a core part of the multidisciplinary delivery	met / not met	0=Not met	No structured MDT approach to wea
11	of non-invasive ventilation in intensive care. Targeted sirway clearance interventions should only be considered in selected patients when clinically indicated. Routine secretion	met / not met	2=Fully met	
	clearance therapy for all invasively-ventilated patients is not recommended.			-
12	Where a local intensive care follow-up clinic/services exists, a physiotherapist should contribute to this service.	met / not met	0=Not met	
				Limited follow up by telephone by tel
2.7				Limited follow up by telephone by ter
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2.1	Dietetics			Limited follow up by telephone by te
2.7 STANDARDS	Dietetics			Limited follow up by telephone by te
	Dietetics	met / not met	2=Fully met	Limited follow up by telephone by te
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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	1=Partially met	
3	Speech and Language Therapists should contribute to a suitable tracheostomy or non-invasive ventilation weaning plan for complex or Iong-stay patients.	devices only, not met = no access (apart from simple white boards/paper) met / not met	0=Not met	
4	long-stay patients. 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	met - FEES available 5 days/week, partialy met - adhoc availability, not met - no service	0=Not met	
6	patients. Speech and Language Therapists should work as an integral member of the multidisciplinary team on the critical care unit, contributing to		1=Partially met	
6	all multidisciplinary ward rounds, tracheostomy teams, clinical governance groups, audit, research, education and policy development. Swallowing and communication recommendations and treatment plans should be included in any medical handover when the patient is	met - SLT attend daily ward rounds 5 days a week, partially met - available on request, not met = no service		
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. Patients who are being considered for risk feeding should have access to an SLT assessment in order to clarify their level of aspiration	Met (included in standardised handeover process) or not met	1=Partially met	
8	Patients who are being considered for risk feeding should have access to an SL1 assessment in order to clarity their level of aspiration risk and optimum oral feeding consistencies.	met > 90% of referals 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 f
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	0=Not met	No dedicated OT, but an OT that c
2	Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and	depts only	0. No	
2	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	
RECOMMENDATIONS				
1	There should be an identifiable lead occupational therapist with appropriate experience, who will be accountable for service provision and	met / not met	0=Not met	
	development. The occupational therapy clinical lead should be responsible for supporting learning opportunities, training and clinical supervision for			
2	unior staff providing occupational therapy services in intensive care. The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation	met / not met	0=Not met	
3	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 wit
	specialità dal rece una la sadarezza siny ning nem priyanali ana nen priyanali impairment ancenny decopational performance.			
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 pharmalogical stratergies. Not met	2=Fully met	
RECOMMENDATIONS				
	Psychologists should ensure that delirium is accurately assessed by nurses using a validated instrument, and that when delirium is		2 - Fully met	
	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 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 care6 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	met/not met	2=Fully met	
5	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.	Internot met	2 -r any mex	
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	met = 75% assessed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met = not assessed	1=Partially met	
	individualised structured rehabilitation programme that is formally documented and handed over at the time of transfer to general wards.	IIII assesseu		
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.	met = always available at FU clinic, partially = available by referral, not met = not avaiable	3=Not applicable to Unit	
	As part of the critical care unit MDT, the psychologist should provide: a) Training for staff to increase knowledge and understanding of			
10	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,	Met = all elements, partially = some, not = none (could be split)	2=Fully met	
	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.			
	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 larview, decreasion or PTSD: these should be offered by osychologists in a verif-exourced follow-to service and should include trauma-			
11	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	Met = all elements, partially = some, not = none (could be split)	1=Partially met	
11	anxiety, depression or PTSD; these should be offered by psychologists in a well-resourced follow-up service and should include trauma-	Met = all elements, partially = some, not = none (could be split)	1=Partially met	
11	avoide, depression or PTSD: These should be offined by psychologists in a wide-resourced follow-up service and should include summarized avoided, depression or PTSD: These should be offined by psychologists in a wide-resourced follow-up service and should include summarized avoided, or resourced and these should be offined by psychologists and wide-resourced follow-up service and should be avoided and the should be avoided and the should be avoided and the should be avoided and services, and () Diroj-in support groups for interview care patients and their families after discharge from hospital, held in the hospital commandum.	Met = all elements, partially = some, not = none (could be split)	1=Partially met	
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12	avaiety, depression of PTSD. These should be differed by spychologists in an evel-resourced follow-up service and should include trans- motive of the service of PTSD. These should be differed by spychologists in an evel-resourced follow-up, service and should include transmi- errors, or incrementations for GPD, these interferes to ensembles or interfere to patients on the two scenes boat psychologist services, and g) Drop-in support groups for interview care patients and here it in the hospital of the services or incrementations for GPD, these interview care patients and here it is allowed to the services of the service of the service of the service of the service of the services of the service of the service of the services of the service of the services of the services of the services of the services of the service of the service of the service of the services of the service o	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1=Partially met	
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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 timular use alloa should have a table term or desinated lime anoted to a sunable memory to shall for data emay to a nationally recognised audit programme (such as ICNARC or SICSAG) and responsibility for the validation of these data. The Intensive Care	met = full cover wiht 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 relevent 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 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 rung training bodies 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
occiono			Lore	Comminda
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 = >99%, 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 = >99%, partial = >90%, not <90% or no data	1-Partially met	
4	Patients must have a clear and documented treatment escalation plan. Patients must be reviewed, in person, by a consultant in Intensive Care Medicine as urgently as the clinical state dictates and always	Met >95%, partial 80-95%, not <80 or no audit evidence 95% of the time - Met, <95% or no data - not met	2=Fully met	
6	within 12 hours of admission to critical care. Transfer to other critical care units for non-clinical reasons must be avoided where possible.	met = non clinical transfer <0.6% 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. Discharge from critical care to a general ward must occur within four hours of the decision and must occur between 07:00hrs and	met / not met met = >80%, partially = 60-80%, not <60%	0=Not met	
10	21:59hrs. 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	2-Fully met	
11	Patients undergoing specialist care must be repartiated to a healthcare organisation closer to their home when clinically appropriate to continue their enabilitation, and this must occur within 48 hours of the decision to repatriate.	< 85% met, 75-85 partially met, < 75% or no data not met	0-Not met	
RECOMMENDATIONS	Nane			
	IWIR			
3.2	Capacity Management			
STANDARDS	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not		
1	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 hot 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	met / not met	2+Fully met	
3	decisions be even-ridden by non-clinical operational management teams. 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	0-Not met	
5	Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit. Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic	met / not met	2+Fully met	consultant to consultant discussion
6	Excalator plans must differentiate between escalation during 'normal' operation and escalation during major incidents or securities scenarios. Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief eventive level to allow the duty intensive care consultants and duty nurses in charge to coordinate the usage cli Intensio care beds across the network.	met / not met	1+Partially met	
7		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 hiresholds for restriction of planned activity to asist ineighbouring critical care units Regional Intensive Care Networks must have an agreed policy on escalation of care and repartation between secondary and tertiary units to include escalation and. If required, profitation of transfers over local electrice activity.	met / not met / not applicable met / not met / not applicable	3=Not applicable to Unit 3=Not applicable to Unit	HB escalation plan
9 10	Regional Intensive Care Networks must ensure that a system to record capacity across the network is in use, and that this is updated	met / not met / not applicable met / not met / not applicable	3=Not applicable to Unit 3=Not applicable to Unit	
11	regularly. 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	Critical care units should determine the emergency capacity they require to meet Standard 1 locally based on their administra and			
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 vaniables for emergency variations before accessing electrice 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. Training should be provided to nursing staff in areas used for critical care escalation.	met = 1:36 or greater, partially 1:45-1:35 met = comprehensive documented training plan in place, partially = some training but not	1-Partially met	medical patients only
3	When using alternative areas of the hospital to provide critical care capacity, there should be adequate senior nursing and medical input	met = immediate access to ICU resident / registrar /nurse in charge for advice + twice daily consultant	1+Partially met	
4	such that the standards of care provided to those patients meet the standards provided to the patients within the critical care unit.	ward round	2=Fully met 1=Partially 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 enginant eleverisk estabilistic the emergency capacity in neiphodum curits. Chicka care units may find it useful to develop a statistical model locally that provides predictable data on the number of emergency admissions they avoid plan to accoundate in each 24 hour period, that the inmodel to assist decision mailing on when it is able to	met / not met	1-Partially met	
6	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. All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical	met / not met	2+Fully met	HB policy
1	process. 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 tall operate the same language across the patient	met / not met met / not met	2=Fully met 2=Fully met	HB policy
2	process. All hospitals must use a validated track and trigger early warning score system that allows rapid detection of the signs of early clinical			HB policy
	process. All hospital 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-prepared adult patients over (15 years. The National Early Warning Score (NEWS-2) is the ecommended for call systems and enhances the benefits dar a park varying ascheme. As and if a multi-toper score, as units early ware score ware store store toper and the score of the sco			Hit notice
1 2 RECOMMENDATIONS	process. an end of the standard of the sta		2-Fully met	Hill notivy
	process. All hospital must use a validated track and trigger only warning score system that allows rapid detection of the signs of early dirictal deterioration in all non-programs all patients over 16 years. The National Early Yaming Score (VENS-G) is the recommonded for all patients and the second score of the second score of the second score of the second score of the second score patients and enhances of the second score of the second score of the second score of the second score of the score of the deterioration action. Each hospital should have a graded clinical response strategy consisting of three levels: low, medium and high. Each level of tesponse should deal what is required from all in tempo of observational requerce, vibilar and competence, interventional theories and application should deal what is required from all in tempo of observational requerce, vibilar and competence, interventional theories and application should deal what is required from all in tempo of observational requerce, vibilar and competence, interventional theories and patient allow allow allows and application of the second opplication of the second competence, interventional theories and second should deal what is required from all in tempo of observational requerce, vibilar and competence, interventional theories and second should deal what is required from all in tempo of observational second competence, interventional theories and second should second second competence of the second competence of			Hit notiv
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	process.	net / tot met	2-Fully met	HB solov.
RECOMMENDATIONS	process. A second seco	met / not met	2-Fully met	Hit solicy Hit policy
RECOMMENDATIONS 1 2 3	process.	met / not met met / not met met 24/7, partally met daytime only or 5 days per week, not met - less than this frequency. met / not met	2-Fuly met 2-Fuly met 2-Fuly met	Hit solicy Hit policy
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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 formul, permanently recorded report covering the entirety of the investigation. There must be seen-day availability of radiology services, appropriate to the specialities being cared for, to allow timely investigation of critically if patients. This would include, for example, ultravourd and CT-scaming to aid sepsis diagnosis and source control, and in the entire of the integration of critically if patients. This would include, for example, ultravourd and CT-scaming to aid sepsis days about cortex and an entire of the entire of	met / not met	2=Fully met	
6	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	not always available
RECOMMENDATIONS	Microbiology advice should be from an adequately senior clinician, and onsite, face-to-face interaction is encouraged.	Met / not met		
2	Critical or unexpected results of clinical pathology, microbiology or radiological investigations should be actively communicated to a	policy in place = met. no policy = not met	2=Fully met	200
3	responsible clinician according to local fails and policies. 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 il patients at all times.	met / not met	1=Partially 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 coeration 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	met / not met	0-Not met	
8	unless life-savino treatment is necessary, or the oatient is unconscious or otherwise incatable of being assessd. Liaison professionals should be available to advise on issues around mental capacity and there should be working arrangements detailing who is reasonable for assessing oatients who may need to be detained under mental health lexistation.	met / not met	2+Fully met	patients must be medically fit for crisis team assessment
	THICKE INSPORTANCE DE LEARNING MERSING THIS THIS TEOR IN HE MEMBER WHEE THETHE TRAINT CONSIDER.			
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	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	
	plans should be updated accordingly. All patients must be screened for delinium at least daily, and when changes or fluctuations in behaviour occur; in the event of a positive		2 Fully and	
3	delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors completed. 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	2=Fully met	
4	Patients who stay in critical care for more than four days and are at risk of morbidity must have their ongoing rehabilitation needs	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	0=Not met	
5	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	>85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet		
7	rehabilitation and should occur as soon as feasible and appropriate. Adults who were in critical care and artis ked 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	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per	met 7 davs a week = met. met 5 davs oer week = partial/v met. not met consistent/v = unmet	1=Partially met	I
2	usek: provision should be made for other therapy services to be provided as needed at weekends. Specialist rehabilitation co-ordinator reles 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 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doens't exist	0=Not met	
	ensure hat assessments, referrals and documentation are completed and transferred to ongoing services and teams. 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	A		
3	de un-processional of multi-processional in nature and recluiter nom nutsing of allice neatifit bacquipunds. Insée finaly and centario enhanced delivery and increased dificiency of rebabilitation screece delivery, as vertice all so rugbyre phasibilitation to be delivered following discharge firm critical care. Further work is required to determine the accoparity enhances appropriate for the stage of recovery. Rehabilitation curcioners should be monitored and progression made using outcome measures appropriate for the stage of recovery.	Statement		
4		met = rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially = on is: only, unmet = no progression monitoring		
	The rehabilitation plan that forms part of the handwore of care on discharge from critical care should address at relevant domains for individual address including, but not extended to Jphysical, intronom, communications, social, spirinka, unitriorial and approxidocidad. To facilitate the rehabilitation component of the formal handwore of care on discharge from critical care to a general ward, weekly multidisciplinary streambilitation ward rows should be led by as seriar remoter of the critical care units professional team and result in an	met / not met		
6	multidisciplinary rehabilitation ward rounds should be led by a senior member of the critical care multi-professional team and result in an undate to the rehabilitation coals. These should be set in conjunction with the patient and/or carer where approximate. Expectations of both patients and families should be identified requirity and addressed in a consistent manner by the most approximate.	met / not met	0=Not met	
7	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 diantes, either paper or electronic, and may include photos, videos and written information. This material may be collected prospectively or entrospectively depending on the desire of patient	met / not met		
	proces, videos and written information. This material may be collected prospectively or retrospectively depending on the desire of patient and family.			
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. Patients discharged from the critical care unit must have access to an intensive care follow-up programme, which can include review of	met = all patients provided with rehab goals, partially = selected patients, unmet = none	2=Fully met	
2	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	The follow-up programme should be formally and clearly communicated to the patient and their relatives on discharge from critical care,	and all askeds and the askeds askeds much		
RECOMMENDATIONS 1 2	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 are should also be informed through the discharge summary. The follow-up programme should ensure the discharge of structured and supported self-directed involutionation and patients at critical care.	met – all patients, parlially = selected patients, unmet = none met – all patients, parlially = selected patients, unmet = none		
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	Staff well-being is an organisational priority. Units must monitor and regularly review metrics of staff well-being as quality indicators (e.g.			
5	Stati wendeng a ar organisational priority. Units most manifer and regularly review memors of stati wendeng as quarry moticators (e.g. sickness rates). All staff must have opportunities for personal development reviews including annual appraisals.	met - quartierly , partially met 1-2 yrs, unmet - not monitored or mroe than 2 yearly intervals 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		Not specifically with thius title but regular meetings to encourage feedback
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	Space available Could be larger
RECOMMENDATIONS				
RECOMMENDATIONS	All staff engaged in a managerial or leadership role should have access to appropriate mentoring and/or coaching services to support	met / not met	2-Fully met	
2	them in their role. 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	met / not met	2=Fully met	
6	This includes routine clinical practice (e.g. multidisciplinary rounds, mortality and morbidity meetings), as well as specific reflective events (e.g. Schwartz Centre Rounds, dehiefine following medical emergencies). 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 III 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	met / not met	2=Fully met	
3	checked immediately before use. 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	met / not met	2=Fully met	
5	record. A named intensive care consultant must take overall responsibility for the decision to transfer a patient and the level of support required,	met / not met	2=Fully met	
6	but does not necessarily have to undertake the transfer. Inter-hospital transfers must be undertaken in a timely fashion according to the patient's clinical condition.	met / not met 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	Inospital. This must be agreed prior to the transfer being undertaken. 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.	Percentge occuring within 48 hours of decision. Met > 85%, partailly met 75-85%, not met < 75% of the time or no data collected.	1=Partially met	
RECOMMENDATIONS	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		
1	The reason for any transfer should be documented in the patient's notes. This should include an assessment of potential benefits against	meet standard and no risk assessment	2=Fully met	
2	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 (deally daily and a log of checks maintained) or, if sealed with a tag, then a daily check that the seai is unbroken. The	met = checked with log and tagged, partially = daily check but not tagged or logged, unmet = no	2-Fully met	
	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.	checking or significant deficiencies in kit available		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. Where multiple teams are involved in a patient's care, appropriate handover should be undertaken between the teams prior to transfer.	Statement		
9	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	met / not met	2+Fully met	
10	need for transfer. This discussion should be documented. There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area.	met = 95%, partially = 80-95%, unmet <80% documented	2-Fully met	
11	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 transfer is one that has not been undertaken 48 hours after the transfer is one that has not been undertaken 48 hours after	met / not met	2-Fully met	
12	the time of referral to the senseral citical care unit. 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		2-Fully met	
	does not delay a patient transfer. Similarly, isolation facilities must be available for immunocompromised patients who require them.	met / not		
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. There should be a system for monitoring the quality of inter hospital transfers and governance arrangements which includes capture of the standard of the service of the s	met / not met met - well established processes, data avaiable, partially met - reviewed, limited data available, not met.	2+Fully met	
14	notes and/or sector and the sector a	real-vent calabration or not at all met = both / partially met = one or the other / not met = neither	0+Not met	
15	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and	Statement		
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	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and	Satement		
16 3.11	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.	Satement		
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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 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					
ь	If a patient has capacity, their decision must be respected, even if the treating clinician considers the decision to be unwise.	Statement					
0	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	commune organization and destinates schements in a resting cinican must not accumaterativ. 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 recognized norwane.	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 discute about best interests between the medical team and family.	Statement					

4.1

CRITICAL CARE SERVICES: CLINICAL CARE

**Respiratory Support** 

Level

Level description

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		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.		2=Fully met
7	Units must have immediate access to point-of-care testing to enable arterial blood gas analysis.	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.	west widelings for all and an invite data within last 0 years, and all west and a summer wideling an invite in a	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.		0=Not met	
ſ					

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.		2=Fully met	
2	Units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.	met / not met	1=Partially met	i

RECOMMENDATIONS 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. 1 =Not met Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing 2 patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved =Not met dietitian members. 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 These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation Not met 3 management, based on agreed protocols. Early mobilisation and rehabilitation are likely to prevent weaning delay and failure. Units should have protocols in place and 4 met / not met Not met esources to provide these services as described in the section of this document on rehabilitation (Chapter 3.6). 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. 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 wearing. 5 met / not met =Fully met 6 met / not met / NA if no regional weaning service =Not met with weaning . with weaning .
The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation centres
met / not met / NA if no regional weaning service 7 =Fully met and protocols should be in place to aid these decisions.

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	
	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	

Comments

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 u
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.	some omissions or >3y since review or no audit evidence, unmet = no guideline or fails many of these	1=Partially met	Guidance needs u
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 critica care dietitian or clinician with appropriate specialist training or experience.	I 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 WIC
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
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 pl
4.5	Liver Support			
STANDARDS				
	Contact with regional liver and or liver transplant centre must be made early following admission to a critical care unit of a patient	2 hourse h		

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	

e is underway as part of all wales systems
eds updating
eds updating

ECOMMENDATIONS				
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	intracranial hypertension being a recognised complication in patients with ALF. Strategies to monitor and manage ICH should be available in contract management in the contract of the contra	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	
	An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer to another centre.		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

providing extra-corporeal circulatory support.

#### Echocardiography and Ultrasound

STANDARDS 1 The gold standard investigation is a comprehensive study, performed and reported by a fully trained clinical specialist. Statement A more limited study, focusing on a specific clinical question, is appropriate in many instances. This must be performed by a 2 met / not met Not met trained and competent practitioner. 3 Individuals who scan and report independently must be trained to a level that is appropriate for their clinical practice. met / not met =Not met The service must have a nominated lead consultant with dedicated time in their job plan that is sufficient to reflect the demands of met / not met Not met 4 the service and associated governance processes. Ultrasound equipment must be readily available, serviced regularly and up to date. There must be sufficient equipment to ensure met= immediate availability (ie on unit) of ultrasound machine for vascular access and rapid access of 5 immediate access for ultrasound guided vascular access at all times. Linear, curvilinear and phased array probes are required to machine for focused echo/lung ultrasound / partially = not all elements eg only 1 machine on a large unit / 2=Fully met not all probe types/ not met provide a comprehensive ultrasound service. 6 Infection control measures must be adhered to at all times. met / not met 2=Fully met The disinfection and storage of transoesophageal echocardiography probes must follow national guidelines. A record must be met / not met / not applicable ( no TOE) Fully met 7 retained in order to identify and track patients after device usage in the event of future complication/infection. All images must be securely stored for quality assurance purposes with appropriate data governance. Reliance on the ultrasound met = all images are stored, reviewed by trained echo specialist and uploaded to PACS, partial = uploaded 8 Not met but not reviewed or reviewed but non centralised storage, unmet = images not safely archived in PACS machine storage capacity is not a secure method. 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 Whenever scans are performed to inform clinical decision making, a structured report must be generated and stored in the 9 Not met patient record. 10 Training scan reports must not be stored in the patient record unless someone suitably trained verifies the document first. met / not met Not met Fully met = peer review process at least monthly, partially met = peer review less frequently, not met = no 11 Quality improvement, audit, and peer review activity must occur regularly. Not met regular system of peer review (excludes ad hoc peer review) Transoesophageal echocardiography (TOE) must be immediately available in all cardiothoracic critical care units and those units met / not met / not applicable ( no TOE) 12


OMMENDATIONS				
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	
	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	
	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	
		met / not met / not applicable	0=Not met	
9	equipment is replaced every seven years, however ultrasound equipment may need to be updated more frequently to keep up	met / not met	0=Not met	
	1 2 3 4 5 6 7 8 9	1       All critical care units should be able to ensure the provision of point-of-care ultrasound.         2       The service should be supported by a fully trained link-person within the cardiology and radiology departments, as appropriate.         3       Individuals who participate should regularly attend their institutional ultrasound meetings.         4       Individuals who scan and report independently should keep a personal logbook of their images and reports.         5       Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to more advanced accreditation.         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.         7       Regional networks and electronic image transfer systems should be created to allow for prompt access to review scans by a	1       All critical care units should be able to ensure the provision of point-of-care ultrasound.       met / not met         2       The service should be supported by a fully trained link-person within the cardiology and radiology departments, as appropriate.       met / not met         3       Individuals who participate should regularly attend their institutional ultrasound meetings.       met / not met         4       Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to meet advanced accreditation.       met / not met         5       Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to meet advanced accreditation.       met / not met         6       Images and reports should be uploaded together to the same archive used by the host institution's cardiology or radiology or participate. Reports should not be actrived before they have been verified by a trainer.       met / not met         7       Regional networks and electronic image transfer systems should be or prompt access to review scans by a specialist with Level 2 accreditation, or equivalent, when this is required.       met / 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 applicable	1       All critical care units should be able to ensure the provision of point-of-care ultrasound.       met / not met       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 met / not met       met / not met       0=Not met         6       Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to met / not met       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 be created to allow for prompt access to review scans by a reatifier.       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 / not met / not applicable       met / not met / not applic

Neurological Support

#### STANDARDS

4.8

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	
	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	
	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

	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	
	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 controling 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 - referal 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	Isurvival 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	
	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	

Ì	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	
		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 quidelines 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	
		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	
	ĥ	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	

Care of the Critically III Pregnant (or Recently Pregnant) Woman

#### STANDARDS

4.10

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	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

3=Not applicable to Unit 3=Not applicable to Unit	
3=Not applicable to Unit	
3=Not applicable to Unit	
2-Not applicable to Unit	

4.11

#### Care of the Critically III Child in an Adult Critical Care Unit

STANDARDS

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	


	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	
	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	
	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 III Patient	

### STANDARDS

1		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	
		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	
	All patients must be assessed regularly for evidence of pain, with analgesia optimised to minimise sedation requirements.		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	
		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		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	
	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

	For patients without ARDS, a tidal volume of 4-8 mls/kg PBW and a peak/plateau pressure (depending on mode) of below 30 cmH20 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	

5.1	CRITICAL CARE SERVICES: ADDITIONAL COMPONENTS	Level description	Level	Comments
	Research and Development			
STANDARDS	All individuals participating in R&D activity must have completed Good Clinical Practice (GCP) training for research and keep this up			
1	All individuals participating in K&U activity must have completed Good Ulincal 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 standards. Critical care units should participate in research networks, which are organised at Local Clinical Research Network (LCRN) level	met / not met or not applicable met / not met or not applicable	2=Fully met	
3	through the regional National Institute of Healthcare Research (NIHR) Critical Care research network lead. 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 (SDMe) about onooing research. for example through costers, leaflets, or within generic intensive care information resources. Critical care units participating in research should have clear procedures for approaching patients, families and SDMs in a manner	met / not met or not applicable met / not met or not apolicable	2=Fully met 2=Fully met	
6	that minimises stress, but provides adequate information in a timely manner. 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		·	
5.2	Aduit and Gdainy improvement			
STANDARDS 1	Critical care units must have a structured and planned clinical audit programme to compare practice to published standards. There	met / not met	1-Partially met	
2	must be an identified lead for the audit programme. Critical care units must participate in a National Audit Programme for Adult Critical Care, such as the Scottish Intensive Care Society Audit Group (SICSAG) 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 pational scheme where applicable. Critical care units should	met / not met	0=Not met	
4	stor report the incidence of initiabation-associated pneumonia. All units must participate in national audit programmes for neoscomia infections in initiative care, for example, Public Health England Infections in Chitacl Care Programme (ICCOP) and Sorbiti- neoscomia infections in CLI audit arcomment. Chitacl acre units must measure injuli-im discharges in order to encourage and support local improvement to reduce night-time	Discharges after 21:59 as percentage of all eligible admisisons - met <2% partially met, 2-4% not	0=Not met	Data not reviewed
5	Intensive care discharges. 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>4% met - annual process, partially met, undertaken every 1-2 years, unmet, never done or less than 2 yearly	0=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	met/ unmet	0=Not met	
2	Liob plans of all intensive care staff (medical, nursino, pharmacists, healthcare professionals and anciliary staff). Hospitals should have a quality improvement (QI) programme in place for each critical care unit in their organisation. The programme should alm to deliver sate, efficient, effective, patient-centred, isnely and equitable patient care, which is evidence based, and should	met / unmet	1=Partially met	
3	follow recognised guality improvement methodology. 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 5	Audits should be linked to Q1 programmes. Units should have robust data-collection systems in place that support the collection of activity and quality data for local and national audit grouprammes. 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 aspect locally.	met - robust data contection and restances for point ocal and national autor, paintainy met - robust data collection and feedback for national audit only, not met - no robust systems for data collection or met / not met / not applicable	0=Not met 2=Fully met	
6	All critical care units must measure and report their delayed discharge, out of hours discharges, non-clinical transfers and readmissions within 48 hours of discharge, as a potential indicator of resource pressures. It is recommended that units should also	mer. not mer / not apprease Met - submit all data to ICNARC / SICSAG data tools, patially met - one or more data submissions missing . not met - poor data compliance with ICNARC / SICSAG	1=Partially met	DTOC figures captured by IRIS, Nil to other measure
	measure early discharces as they may be a marker of insufficient resources.			
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 dinicipal lead or clinical infector for critical care.	met / not met	1=Partially met 2=Fully met	Medical support under discussion
	plans must be formulated in response to incidents. Units should also learn from things that go well, a process described in accellence recording. Units must hold regular structured multidiscipinary clinical governance meetings, where they discuss unit morbidity and mortality, exclusion all devices and any direct and oper mirror. A write neuron of nations them and learcon learn though be not and a processing of the structured multidiscipinary clinical governance meetings.	met / not met		
3	Including all easting, critical incidents and near miseus. A written record of actions taken and lessons learnt should be kept and a innerly and reliable method for dissemination of shared learning should be halons. Three should be clear structures in piace for dissemination findings to staff, and deficiencies in care should lead to measurable chance. Regular feedback must be obtained from service users and staff about the quivily of care delivered, for example by the use of safety	met - meets full standard with minimum of quarterly meetings, partially met - meets standard but less than quarterly, unmet - doesnt meet the standards met - undertake critical care led staff safety and relative surveys at least once a year, partially met is	0=Not met	
4	regione included induce to bearrier to a the back and a set to back and a set to be any dealing of the back of the	the second secon	0=Not 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 maintain a risk register that is regularly reviewed and updated by both senior managerial and clinical staff. The unit must may processes to ensure clinical staff are aware, is a timely fashion, of key learning points from national safety alerts	met - in place, quarterly review, partially met, in place less than quarterly review, unmet - not in place	1=Partially met	
7	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 oplicies)	met / not met	2=Fully met	
8	whenever needed. Staff who have to conduct reviews of patient safety incidents, not cause analysis and appreciative enquiry must be trained in the management of these processes so that the reviews are conducted sensitively and constructively. Similarly, effective quality moreovernet requires staff that are rained in oughly moreovernet methodolov.	met / not met	2=Fully met	
9	Each unit must have local sately standards for invasive procedures (including tracheostomy, bronchoscoy), 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	met / not met	2=Fully met	Critical care LocSSIP in place
10	Information transfer, procedural verification, a safety briefing and time cut, and a sign out and debriefing. An example of this process is the NHS Enaland Safety standards for invasive procedures. 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	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 guarterly, partially met, done annually, not met, not done - use comments box	0=Not met	
2	Units should regularly review guidelines from professional organisations and other sources of evidence to ensure that the unit	met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed	1=Partially met	
3	Operating Procedures. The unit should identify key performance indicators (KPR) that describe outcomes of their service. Such KPIs may be generic and common to move units, such as complication rates, e.g. delinium rates, pain scores or pressure sores. Alternatively, these may be unit	met / not met	0=Not met	
4	specific, for example rates of emergency theracetomy on cardiac critical care units. Staff should be recognised as the key resource in intensive care. A thilly engaged, well-intoxicated well-intained and well-ind workforce is essential to allow excellence in clinical care to flourish. Staff sickness rates, turnover rates and information from appraisal, staff	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	leedback and exi interviews should all be monitored to ensure stall welfare. Uhits should work with other units within their network, an anticnality, to share learning, disseminate best practice, quality improvement and for benchmarking and peer netwe purposes. The governance of critical care units is rightly audited by outside generice, including intensis care anterios. The external responsibility for the versight of governance arrangements varies between	met = Units participate in Network led program to share best practice and QI// not met	0=Not met	
6	the devolved nations. The unit should be able to demonstrate that it is continuously working to improve patient care using recognised quality improvement techniouss delivered by approximately 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. Critical care (ONE must support commissioners in the delivery of their commissioning functions: through creating and delivering		2-Fully met	
2	commissioned pathway, quality improvements, innovation and standardisation of clinical practice. They provide a mechanism for pres meaker and headminks sale assessment in the network. 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, valving and supporting local strategies for adult critical care services across the essential essential content insubation essential essential across the essential essential essence within a geographical atrato tene tempency.	met / not met / not applicable	2=Fully met 3=Not applicable to Unit 2=Fully met	
2	commissioned pathway, quality mprovements, innovation and standardiation of orlicical practice. They provide a mechanism for pre- torem and benchmarks and assessment in the national. In the national standard and the national standard and the commissioning functions, though crasting and distinging encoders, quality improvements and efficiency access the pathway, and developing, developing and supporting local strategies for adult intella care answers areas strate assessment advices on monocare and advices on the strategies and the strategies and advices on the strategies and advices on the strategies for adult intella care answers areas strategies and advices on the strategies and advices on the strategies for advices and advices and advices on the strategies advices and advices on the strategies and the strategies for advices and advices and advices and advices and advices and advices on the strategies and the strategies advices and advices and advices and advices and advices advices	met / not met / not applicable	3=Not applicable to Unit	Linsure of funding
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2 3 4 5 7 8 8 7 7 8 9 9	commissioned pathway, quality representative, timovadion and standardisation of orional practice. They provide a metahanism for peer contrasticative and communicative structures in the delaway of the commissioning functions. They provide a metahanism for peer provides a metabolic structure and efficiency across the pathway. And developing, developing and supportantial contrasticative address of the structure	med i not med i not applicable med i not med i not applicable	S-Ner applicable to Unit S-Ner applicable to Unit S-Fully met S-Fully met	Unsure of Linding
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2 3 4 8 8 8 9 4 6 7 7 8 8 9 9 10 10 5 5 5 11	Terminational pathway, gualar progressments, threading and standardisation of forcial practice. They provide a metahanism for per- ficial ates COM and a logical commissions in the desiry of the commissions in the desire of the desir	mel / not mel / not applicable mel / not applicable mel / not	3-Hot applicable to Unit 2-aFully met 2-aFully met 2-aFully met 2-aFully met 2-aFully met 3-aFully met 3-aFully met 3-aFully met	
2 3 4 5 7 7 3 4 5 6 7 7 8 9 10 10 5 5 5 7 10 7	Commissional pathway, quality improvements in the data of the commission qualitation. They provide a metahanism for per- sional and code and subject commissions in the data of the commission qualitation. They provide a metahanism for per- sional code of the commission of the data of the commission qualitation. They provide a metahanism for per- sional code of the code of the code of t	me I not meI not applicable meI not applicable meI not meI not meI not applicable meI not meI not meI not applicable meI not meI no	3-Met applicable to Unit 2-aFully met 2-aFully met 2-aFully met 2-aFully met 2-aFully met 2-aFully met 3-aFully met 3-aFull applicable to Unit 3-aFull applicable to Unit	
2 3 3 4 5 7 1 2 3 3 4 4 5 3 7 6 5 7 7 8 6 7 7 8 7 8 7 7 8 7 7 8 7 7 8 7 7 8 7 7 7 8 7 7 7 7 8 7	Increasing a pathway, gualar progressments, introvidion and standardisation of inclual practice. They provide a metahanism for gene provide a metabolism of constraints and effectively areas the pathway, and developing, developing and support provide a metahanism for gene provides and constraints and effectively areas the pathway, and developing, developing and support provides a metahanism for gene provides and constraints and effectively areas the pathway, and developing, developing and support provides a metahanism for gene provides and constraints and effectively areas the pathway, and developing and support provides areas and an paragraphic and the provides and the pathway of a realistic relation area areas a when a paragraphical areas to not emergency provides the developing and the provides and and areas areas a when a paragraphical areas to not emergency provides and developing and the pathway of a realistic relation area areas a when a paragraphical areas to not emergency provides and developing and the pathway of a realistic relation area areas and the paragraphical areas to not emergency provides and developing and and and areas areas areas and a paragraphical areas to the and and and and and and and paragraphical areas and the angle and and and and and paragraphical areas and the angle and and and and and paragraphical areas and	rel / rot mel / not applicable     mel / rot applicable     mel / rot mel / not applicable     mel / rot mel / rot applicable	3-Met applicable to Unit 2-aFully met 2-aFully met 2-aFully met 2-aFully met 2-aFully met 2-aFully met 3-aFully met 3-aFull applicable to Unit 3-aFull applicable to Unit	

RECOMMENDATIONS			
	These recommendations may not be applicable to those units outside of England and Wales		
1	Collection of all 34 fields in CCMDS is recommended. This should be done by dedicated trained personnel.	met / not met	3-Not applicable to Unit
2	There should be clinical oversight of the CCMDS data entry/data submission to ensure accuracy of data.	met / not met	3-Not applicable to Unit
		met / not met	3-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	3=Not applicable to Unit
5	A lead commissioner should be identified with a commissioning forum for each critical care service.	met / not met	3-Not applicable to Unit

1       Note:       Note:<       Note:       Note:       Note:       Note:<       Note:< </th <th>Section 6</th> <th>CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS</th> <th>Level description</th> <th>Level</th> <th>Comments</th>	Section 6	CRITICAL CARE SERVICES: EMERGENCY PREPAREDNESS	Level description	Level	Comments
Normal Section         Normal Section         Normal Section           1         Normal Section         Normal Section         Normal Section           2         Normal Section         Normal Section         Normal Section           3         Normal Section         Normal Section         Normal Section           4         Normal Section         Normal Section         Normal Section           5         Normal Section         Normal Section         Normal Section           6         Normal Section         Normal Section         Normal Section           7         Normal Section         Normal Section         Normal Section           8         Nor		-			
1     4.8000 and main and mage and application and a	6.1	Fire			
Second	STANDARDS				
1       No.	1		Met or unmet	2=Fully met	
1NoNoNoNo1Second particulation of the second particulation of t	2	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	Met or unmet	1=Partially met	Departmental fire plans currently being updated to include guidance from the Asso
A. I. Solution of the second	3	brackets, b) the safe storage of oxygen cylinders and c) following the recommended sequence of events when turning on an oxygen	Met / unmet	2=Fully met	
1       Schwarzsch	4	Units must comply with current Department of Health regulations regarding the fire-retardant nature of mattresses, bedding, flooring and	Met / unmet	2=Fully met	
J.         South Control (Control (Contro) (Contro) (Control (Control (Contro) (Contro) (Contro) (Contro)	5	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	
Image: Section of the sectio	6	hospital's critical care unit should it need to carry out an emergency evacuation.	Met / unmet		Major Incident plans in place, along with Business Continuity plans. Activity 18 rela
1         Note of the second seco	7	Medicines and Healthcare products Regulatory Authority (MHRA).		2=Fully met	
1       Notational section of the sectin of the section of the section of the section	8	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		1=Partially met	Fire training is mandatory. Arranging unit specific training
But         But <td>9</td> <td></td> <td>met = &gt; 90% of staff compliant , partially met &gt; 75%,, not met &lt; 75%</td> <td>1=Partially met</td> <td>Sandra confirm details please</td>	9		met = > 90% of staff compliant , partially met > 75%,, not met < 75%	1=Partially met	Sandra confirm details please
Image: Second	10	provided on a temporary basis; b) provision of equipment and drugs; c) evacuation case at each bed space; d) ringe of patients (the least unwell patients) being evacuated first and the most numeli patients last; c) epossible co-existing power and/or equipment battery failure; () 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 series evacuations will be required with a	Met / unmet	0≕Not met	Departmental fire plans currently being updated to include guidance from the Asso
Image: Section of the section of th					
1         1	A	Evacuation policies should include liaison with the Bronze (Operational), Silver (Tactical) and Gold (Strategic) commanders in conjunction with the service fire offers on scene. Timing of automatice is equilible a manufactor in a scene of the scene of		1-Dartially mot	Fire evenuation plan discusses Lisions with boasited for any starting to the
Image: Note: Constraints of the second sec	2	transfer; if evacuation occurs too late, then patients and staff may be harmed by fire and smoke.			
1         Mathematical Market Mar	2	practised.	the last 2 years		r no evacuation exercises have been requested from the fire team. Current Covid
National Control         National Control         National Control         National Control         National Control         National Control           1         Intermediational Control         National Control         Natio	3	Idiowed up for signs of a trauma stress reaction or Post Traumatic Stress Disorder (PTSD). The Trauma Resilinee, Management (TRIM) system is a screening tool used in the military and more recently used successfully in healthcare which could be considered. Critical care networks should develop systems to support planning for, and management d, a major incident in one critical care unit within	Met - system available / unmet - no system in place to do this	1=Partially met	Included in Fire Plan
Notes         Notes         Notes         Notes           0         Notes in prior transmission of transm	4	with staff from neighbouring units travelling to the affected unit to transfer patients, should be planned. Liaison with neighbouring units and	met / not met / not applicable	3=Not applicable to Unit	Local BCP and Major Incident plans apply
Notes         Notes         Notes         Notes           0         Notes in prior transmission of transm					
1         Name         Non-second second seco	6.2	Major Incidents			
1         Name         Non-second second seco	0711101000				
1NameNameNameNameName1NameNameNameNameNameName1				0=Not met	innademuaute logistics to double capacity
1       Name       Name       Name       Name       Name         1       Anome       Anom       A		All nominated supporting hospitals with Level 3 critical care capability must be prepared to double their normal capacity for Level 3 beds	Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box		
Image: section of the section of th	3	All hospitals with intensive care capacity must have in place plans to support the retrieval or transfer of patients; supporting hospitals		1=Partially met	
1     2     3 <td>4</td> <td>Care Operational Delivery Network areas and beyond. All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but not</td> <td></td> <td></td> <td>Patients will be taken to Theatres/Recovery or the day surgery unit depending upo</td>	4	Care Operational Delivery Network areas and beyond. All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but not			Patients will be taken to Theatres/Recovery or the day surgery unit depending upo
Image: A section of the same show the sam	5				
1         Markate         Markate         Markate         Markate         Markate         Markate           1         Markate		All hospitals must have a recovery plan to ensure a rapid return to normality once the incident is closed. This must include adequate rest			
Image: Constraint of the stand of	7		met / unmet	1=Partially met	Action Cards included in major incident and fire plans
Image: Constraint of the stand of					
Image:	ECOMMENDATIONS				_
1       Instance or use of the data price of the locating sequence (unique sequence) (unique sequence)       A definition       A definition         4       Instance or use of the data price of the locating sequence (unique sequence)       A definition       A definition       A definition         4       Instance or use of the locating sequence (unique sequence)       Instance or use of the locating sequence (unique sequence)       A definition       A defini	1		met / unmet		
Image: Control         Image: Control         Image: Control         Image: Control           Image: Control         Marge: Contro         Marge: Control	2		met / unmet		
Image: space of the space of	3		met / unmet - within the last 2 years	0=Not met	
1     Main and advancementation of the main and advancementation of the main advancementatio advancementation of the main advancementat	4	Intensive care leads should work with their EPRR team to facilitate exercises in the evacuation of very dependent patients from any part o their hospital. This should include practical use of ski sheets, and other patient handling aids, as well as rehearsing the decision making	met / unmet - within the last 2 years	0=Not met	
Inter de la material par legende la marte al a province la material par legende la marte al material par legende la materia material par legende la materia materia material pa	5	and forward planning required by shift leads to support a controlled, staged evacuation. Intensive care staff should be prepared to take a central leadership role in any major incident and should be prepared to send teams	met - plans in place to enable to do so unmet - no plans	0=Not met	Would participate as designated in local major incident response
Market media ganget         Market media ganget         Market media         Market media           1         Selection         Selecion         Selection         Selection		The plan to double the number of intensive care beds should include an inventory of where equipment is to come from, where the beds			
Image: A state and a stat		functioning of the hospital around it.			
2         Condent         Cond	· · · · · · · · · · · · · · · · · · ·	the intensive care service planning.			
Image: Constraint of the state state of the state state of the state state of the state sta		counselling.			
STALLARDON       Methods       Set outcode care unit must ensure there are back controgency plans for the hindi adaton and management of citical plans must.       Methods are unit must ensure there are back controgency plans for the hindi adaton and management of citical plans.       Methods are unit must ensure there are back controgency plans for the hindi adaton and management of citical plans.       Methods are unit must ensure there are back controgency plans for the hindi adaton are unit must ensure that is ensure that a required.       Methods are units and must ensure the regular plans.       Methods are units and must ensure the regular plans.       Methods are units and must ensure the regular plans.       Methods are units and must ensure the regular plans.       Methods are units and must ensure the regular plans.       Methods are units and must ensure the regular plans.       Methods are units and must ensure that is expected and must ensure the isotent ensure that is expected and must ensure that is expected and must ensure the result ensure the result and must ensure that ensure that and ensure the result ensure that	9	enable quality post-incident lessons to be investigated, communicated and learnt.	met - wittin pan, unnet - nu in pan	U-NOT MOL	
1       Be drived care unit must ensure these are load ordinging by given for the initial iduation and management of critically given the initial iduation and management of critical is exceeded in a diverse and initial iduation and management of a section with an exceeded initial iduation and management of a section with a diverse and initial iduation and management of a section with a section of critical is exceeded in a diverse and initial iduation and management of a section with a section of critical is exceeded in a diverse and initial iduation and management of a section with a section of critical is exceeded in a diverse and initial iduation and management of a section with a section of critical is exceeded in a diverse and initial is exceeded in the initial is e	6.3	High Consequences Infectious Diseases: Initial Isolation and Management			
1       Be hortical care unit must ensure these are load cortingery plans for the hull alcalous and management of critically il planters with in plane and tested within 2 years, parking ymet - plan in place and tes					
Link production fraction must be finguing production freeworts in closely do used use do used use for use programmed and used to use by specified to use of use programmed and used to use by specified to use	STANDARDS				
a         proceed and sufficient stacks are ready available for use by appropriately trained intense one staff in the event is required.         intervalue         intervalue           COMMENDATION         A consultari in intensive Care Medicine should have responsibility for intensive care staff in the event is required.         intervalue         before         before </td <td>1</td> <td>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.</td> <td>Met - plan in place and tested within 2 years, partially met - plan in place but not tested within 2 yrs, unmet - no plan</td> <td>2=Fully met</td> <td></td>	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	
Interview         Interview         Interview         Interview         Interview         Interview         Interview           COMMENDATIONS         Interview         In	2		met / unmet	2=Fully met	
1       A consultant in intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience responsibility. For the aspect of the aspectivity is defined. Indefined. With the unit of and characterize intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience and ensive merc circle III planning. The management of aspectivity is defined. Indefined. With the unit of and unnet       met / unnet       met / unnet       Indefined       Indefined       Indefined         3       A circle are ware mer circle III planning unnet with a infCDD hould be decisated to that paire responsibility with unit and assected a ratifies with unit and and assected a ratifies with unit and and assected a ratifies with unit and assected to the paire with a sected to the paire responsibility with assected a ratifies with unit and assected a ratifies with unit and assected to the paire with a sected to a sected with a sected to the paire		procured and sufficient stocks are readily available for use by appropriately trained intensive care staff in the event it is required.			
1       A consultant in intensive Care Medicine should have responsibility for intensive care aspects of local emergency planning and resilience responsibility. Inconsenting lans, for the aspectivity is defined. Index plants with suspected fully consequence infectious diseases may be located, either with in the unit and chical area where cincical plants with suspected fully consequence infectious diseases may be located, either with in the unit and eventue. The should be provided on a regular to with suspected fully consequence infectious diseases may be located, either with a plan to do so, unmet - no plan       2eFully met         3       A Indicated area management of a plant with a VCD blocab de decidated to that paired and the aspected or the provided to respectively identified. Use any plant subject or continue with a VCD blocab de decidated to that paired and the aspected or the provided to perform and the stating of the provide on a regular basis to ensure critical care staff are familier with uniting and safety removing the PPE provide relet - within plant to do so, unmet - no plant       2eFully met       Inities discuss with a plant do aspected or continue dependent to the paired and the aspected or continue dependent to the paired and the aspected or continue to appected management of aspected with a Maximum and safety removing the PPE provide relet - within plant to do so, unmet - no plant       2eFully met       Inities discuss with a plant do aspected with a fully security the provide content with a Maximum and treated and inclus and provide content with the Aspected or content with the aspected or content with the aspected or content with a spected with a plant do aspected with a fully security the	ECOMMENDATIONS				
2Alcolar any where clickly 1 patient whit supperted high consequence interfaces supper to balance with the possible click supper to			met / unmet	0=Not met	
1       Reference       Short Mark       Interval       Int	2	A clinical area where critically ill patients with suspected high consequence infectious diseases may be isolated, either within the unit or	met / unmet	1=Partially met	Limited side rooms
3       indicute where possible.       indicate where possible.       indicate where possible.       indicate where possible.         4       Training block be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provide.       indicate where possible.       indicat where possible.       indicate wh		All clinical equipment used in the management of a patient with a HCID should be dedicated to that patient alone. Equipment should be			
It is should incorporate and a fit segind or segind or provide concurrent care for confirmed (Link H-F-F) and a fit care in the subject of confirmed (Link H-F) and the desidated to the care of that patient on a fit within plan to do so, unmet - no plan       2=Fully met         6       Configure care in the subject of confirmed (Link H-F) and the desidated to the care of that patient on a fit care includ a concurrent care for other patients, thus limiting the risk assessed in accordance with the advice on correct disposal of the waste will be provided.       met - within plan to do so, unmet - no plan       2=Fully met         7       Patients with a suspected viral haemorthagic fewer (ACD) WHP Risk Assessment algorithm and investigations to could near includ) and viscory Coronnities on Dangerous patient with a suspected Viral haemorthagic fewer (ACD) with the advice on correct disposal of the waste will be provided.       met - within plan to do so, unmet - no plan       2=Fully met         8       Patients with a suspected Viral haemorthagic fewer (ACD) with ead on correct disposal of the waste will be provided.       met - local procedure       amet - within plan to do so, unmet - no local procedure       2=Fully met         8       Patients with suspected Viral haemorthagic fewer (ACD) guidelines, as appropriate diagnostic cincinal advice and to clicks assesses the could main and propriate diagnostic cincinal advice and to clicks assesses to be provided under the select procedure in place, unmet - no local procedure       2=Fully met         9       Following reporting of a patient with a suspected VICE all place discus assesses to UCD advice asses and/or microbiology and virology services should be reported immediately to lo	-	single use where possible. Training should be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provided.			
clinical shift and should not provide concurrent care for other patients, thus limiting the risk accessment layorithm concurrent series for holding serie		This should incorporate annual fit testing of respiratory protective equipment (e.g. FFP3 masks). 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			
Belands       Contract of the subject of the states were of the ortex of the values of the values of the product of the values of the value	6	Contingency planning should incorporate plans for holding securely the large volume of clinical waste resulting from clinical care including	met - within plan to do so, unmet - no plan		Hospital plan
7       Pathogens Viral Haemorrhagic Fever (ACDP VHF) Risk Assessment algorithm and investigations to exclude malaria promptly in met - local procedure in place, unmet - no local procedure       set       set         8       Pathogens Viral Haemorrhagic Fever (ACDP VHF) Risk Assessment algorithm and investigations to exclude malaria promptly in met - local procedure in place, unmet - no local procedure       set       set         8       Patients with suspected aliborne HCDD should be risk assessed according to national guidelines, as appropriate).       met - local procedure in place, unmet - no local procedure       2=Fully met         9       Following recognition of a patient with a suspected HCDD: a) local infectious disease and/or microbiology and virology services should be reported immediately to local health protection aldorice is available to clinicians accoss the UKJ for further clinical advice and to facilitate access to ukJ be reported immediately to local health protection aldorice is available to LKJ for further clinical advice and to facilitate access to ukJ be reported immediately to local health protection authorities (e.g., the local procedure in place, unmet - no local procedure       2=Fully met         10       Critical care unts accepting international medical transfers should perform a risk assessment prior to transfer if a patient is being transfer of form a currity with know HCDI outbreaks or countrise where there is a significant risk of specific HCDEs; refer to nation transfer if a patient is being transfer form accepting international medical transfer is a significant risk of specific HCDEs; refer to nation       met - local procedure in place, unmet - no local procedure       2=Fully met		Patients with a suspected viral haemorrhagic fever should be risk assessed in accordance with the Advisory Committee on Dangerous			
<ul> <li>MERS guidance collections, 4 or generic airborne HCID guidelines, as appropriate).</li> <li>Folowing recognition of a patient with a suspected HCID: a) coll infectious diseases and/or microbiology and virology services should be reported immediately to local heatth protection authorities (e.g. the local procedure in place, uniter - no local procedure in p</li></ul>	7	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		
notified and advice sought, including guidance on obtaining appropriate diagnostic clinical aspeciments, b) Local clinicians should liaise with the Imported Fever Service (note this service) is available to clinicians access the UKJ 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). Critical care units accepting international medical transfers should perform a risk assessment prior to transfer ef a patient is being transferred from a county with known HCD outbreaks or countries where there is a significant risk of specific HCDs; refer to nation	8	MERS guidance collections3,4 or generic airborne HCID guidelines, as appropriate).	met - local procedure in place, unmet - no local procedure	2=Fully met	
Critical care units accepting international medical transfers should perform a risk assessment prior to transfer if a patient is being transferred from a curvity with known HCDD outbreaks or countries where there is a significant risk of specific HCDs. (refer to national met - hocal procedure in place, unmet - no local procedure 2=Fully met	9	notified and advice sought, including guidance on obtaining appropriate diagnostic clinical spectramens, b) Local clinicars should laise 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.		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	met - local procedure in place, unmet - no local procedure	2=Fully met	

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				
	Unit managers and senior clinical staff should develop plans and checklists for scenarios such as: a) supply chain disruption (road/fuel			
1	crisis, extreme weather, industrial action or civil disturbance), b) Infrastructure failures (intermittent power cuts or 'brownouts', failure of	met / unmet	2=Fully met	
1	water or heating), c) interruption of normal staffing patterns (e.g. transport disruption, school closures). Checklists should include, for	met / unmet	z=ruily met	
	example, which drugs and consumables would run out first if supplies are disrupted.			
2	Plans should also include options for: a) Unit evacuation, both internally and externally to other sites in the event of major infrastructure		4 Destially met	Limited options
2	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
2	As lack of critical care capacity is frequently the bottleneck in other surge-events, managers and clinicians should have identified areas		2=Fully met	
3	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	z=ruily met	
	augmented migher care areas, or upgrading Lever 2 critical care areas to permit mechanical ventilitation and Lever 3 care.			
4	If increased activity is anticipated, the increase in requirement for consumables should be quantified using the concept of 'days of supply'	met - within plan , unmet - not in plan	2=Fully met	Hospital plan
4	(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.	mot - within plan, unmot - not in plan	z=ruily met	riuspital pian
-		and with the stars of the stars	0.5.0	
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

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 comoleted in collaboration with members of Inis 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 memb 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, 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			RECOMMENDATION		
		Not Met	Partly Met	Fully Met	Not Met	Partly Met	Ful Me	
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%	339	
1.3	Level 2 and 3 Physical Facilities	0%	0%	50%	0%	13%	509	
1.4	Clinical Information Systems	0%	0%	100%	90%	10%	0%	
1.5 1.6	Clinical Equipment Cardiothoracic Critical Care	19%	6%	75%	0% 0%	0% 0%	<b>100</b>	
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		0.501	100/				
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%	09	
2.10	Psychologists	0%	0%	100%	8%	58%	33	
2.11	Healthcare Scientists Specialising in Critical Care	4004	4.00/	0.001	2004	0.001		
2.12 2.13	Support Staff Smaller Remote and Rural Critical Care Units	10%	10%	80%	20%	20%	60	
3 3.1	CRITICAL CARE SERVICES: PROCESS	0.97	070/	6.49/	0%	0%	0	
3.1	Admissions, Discharge and Handover	9%	27%	64%	0%		09	
3.2	Capacity Management	14%	29%	57%		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	
	Interaction with Other Services: Microbiology, Pathology, Liaison Psychiatry and Radiology	17%	17%	67%	38%	0%	63	
3.6 3.7	Rehabilitation	0%	57% 50%	43%	14%	29%	57	
3.7	Intensive Care Follow Up	50%		0%	91%	<mark>9%</mark>	09	
3.0	The Patient and Relative Perspective	14%	<mark>14%</mark> 0%	71%	30%	0%	70	
3.10	Staff Support Inter and Intra Hospital Transfer of Critically III Patients	11% 13%	25%	89% 63%	13% 8%	13% 8%	75 85	
3.10	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%	09	
4	CRITICAL CARE SERVICES: CLINICAL CARE	0%	10%	90%	50%	25%	25	
4.1	Respiratory Support	0%	10%	0%	29%	25%	43	
4.3	Weaning from Prolonged Mechanical Ventilation and Long-Term Home Ventilation Services	0%	0%	100%	0%	0%	43 80	
4.5	Renal Support	070	0%				00	
11		0%	200/	Q ∩ 0/	200/	∩0/	70	
4.4	Gastrointestinal Support and Nutrition	0%	20%	80%	30%	0%	70 67	
4.5	Liver Support				22%	11%	67	
4.5 4.6	Liver Support Cardiovascular Support	17%	83%	0%	22% 33%	<mark>11%</mark> 0%	67 67	
4.5 4.6 4.7	Liver Support Cardiovascular Support Echocardiography and Ultrasound	17% 70%	<mark>83%</mark> 0%	0% 30%	22% 33% 33%	11% 0% 33%	67 67 33	
4.5 4.6 4.7 4.8	Liver Support Cardiovascular Support Echocardiography and Ultrasound Neurological Support	17%	83%	0%	22% 33%	<mark>11%</mark> 0%	67 67 33	
4.5 4.6 4.7 4.8 4.9	Liver Support Cardiovascular Support Echocardiography and Ultrasound Neurological Support Burns	17% 70% 14%	83% 0% 0%	0% 30% 86%	22% 33% 33%	11% 0% 33%	67 67 33	
4.5 4.6 4.7 4.8 4.9 4.10	Liver Support Cardiovascular Support Echocardiography and Ultrasound Neurological Support Burns Care of the Critically III Pregnant (or Recently Pregnant) Woman	17% 70%	<mark>83%</mark> 0%	0% 30%	22% 33% 33%	11% 0% 33%	67 67 33	
4.5 4.6 4.7 4.8 4.9	Liver Support Cardiovascular Support Echocardiography and Ultrasound Neurological Support Burns	17% 70% 14%	83% 0% 0%	0% 30% 86%	22% 33% 33%	11% 0% 33%	67 67	
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Section 1	CRITICAL CARE SERVICES: STRUCTURE	Level description	Choose level	Comments
1.1	Levels of Critical Care			
STANDARDS	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	Perpetents admined to a critical care or in most de included in a national clinical additivogramme in which Levels of Care classification must not be used in isolation to decide upon a patient's requirements.	met not met	2+Fully met	
RECOMMENDATIONS			2 Martinette to Unit	
	None.		3=Not applicable to Unit	
1.2	Outcomes			
STANDARDS				
STANDARDS	Critical care units must hold multi-professional clinical governance meetings, including analysis of mortality and mortidity.	met - comprehensive programe with multprofessional 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. Critical care units should participate in a programme of hospital-acquired infection surveillance to monitor and benchmark rates of catheter-related bloodstream	met / not met	2=Fully met	
4	Critical care of this should participate in a programme or nosphare-copied intection savemance or motion and denominant rates or campeler resided bootstream infections, antimicrobial use and frequency of multi-resistant infections, egi 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 relation to intensive care admission and refutual. Units should develop a consistent approach to patient centred decision-making, evaluating burdens and benefits of admission to intensive care, and be able to	National measure met - all admissions audited and reviewed, partially met, some audit evidence of this process, not met - no audit		
2	Units should overop a consistent approach to patient-centred obscion-making, virulating ourden's and behavits of admission to intensive care, and be able to demonstrate this through the audit of ore-admission consultation, acreed cellins of theraov, and time-imited treatment trials. Longer-term mortality should be collected on all patients admitted to critical care.	met - al admissionia audated and reviewed, partially met, some audit evidence of this process, not met - no audit information / no review of admissions met - collected on all patients, partially met - intermittant audit / review, not met - not reviewed	2=Fully met 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. All new build units must comply with HBN 04-02.	met / not met met / not met / not applicable	2=Fully met 3=Not applicable to Unit	
3	An text data data into a compty with men Genz. Medicines and fluid storage must compty with HBN 00-03.	met / not met / not appicable met / not met		Pharmacy to confirm
	1			
RECOMMENDATIONS		met - time line and evidence to suugest procress, partially met - timeline hut no evidence of monroese, portmet - on	2-E-th met	
1 2	Existing units that do not comply should have a timeline to establish when national standards will be met. Large units should be divided into smaller units (e.g. 8-10 beds) to facilitate clinical care.	net - time ine and evidence to suugest progress, partially met - timeline but no evidence of progress, not met - no timeline / not acelcable if standards met methot met	2=Fully 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. Critical care units should incomposate sufficient storage for medicines (including informated and controlled drugs). IV fluids (including regal redacement) and enternal	met, partially met, not met, not applicable	3=Not applicable to Unit	
5	Critical care units should incorporate sufficient strange for medicines (including enfogenated and controlled drugs), IV fluids (including realing integrations) and estimated in the strange of the stra	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 embanking on a new build to share emeriences and learning the considered include extendial poice and natural light learls, colour and decretation schemes, involve and direity needs, and staff and vicion	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 statil and usites areas. Consideration should also be given to the patient's recovery and rehabilitation needs, including the potential for long-stay patients to spend periods satisfa Critical care units should be inspected as part of the pare-review process, including the review of the building and facilities. Research who concerns or Critical care units should be inspected as part of the pare-review process, including the review of the building and facilities. Research who concerns or critical care units should be impected as part of the pare-review process, including the review of the building and facilities. Research who concerns or critical care units should be impected as part of the pare-review process.	met, partially met, not met, not applicable	1=Partially met	
8	Endation of the another imposed as part of the poet retrieve process, including the retrieve of the balance and the including and the incl	met - peer reviewed, feedback included, partially met - peer review, no feedback, not met - no peer review National/regional measure	2+Fully met	
	т выех о токих тых очно, дожные альбы се докахолко су соот орезволят селто у чезного вла солтакалоника.	Hande Berregeliner instalanse		
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 Toolish. Thiss: ideal in the usker interoperability-toolish. CIS procuments and customisation must involve a multidisciplinary collaboration of all stakeholders who would typically use, maintain and develop the system. This must		3+Not applicable to Unit	
2	include input from end users (including representatives of all clinical staff groups), procurement officers, clinical engineering, the CCIO (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	3=Not applicable to Unit	
		met = no documented BCP		
4	mass no comprome patient station in any way. There in this due a pocksion to ensure that station in the control many interpretation and a station of the control of the pocksion of the pocksion of the pocksion of the mass that a station of the control of the pocksion of the pocksion of the mass that a station of the control of the pocksion of the po	met = no documented BCP Met = workstation (or every bedpace plus additional workstations for mobile staff, partially met = insufficient mobile workstations, not met = absence of workstation at every bedpace (even if mobile stations available) or absence of any mobile workstations.	3=Not applicable to Unit	
	When patter data management pattern (PDMD) or electronic patient record (PPH) spatient are used, there must be access to a declared evolution compart at the bot bug case. A particular patient record (PPH) spatient are used, there must be access to a declared or land declared on access and an ad net basis. The CC must have been patient been patient or patient patient patient patient patient patient patient patient patient patient the CC must have been patient patient patient patient patient patient patient	red = no documented BCP Me = workstation for every bodypace pius additional workstations for mobile stalf, partially met = insufficient mobile workstations, not met = absence of workstation at every bedypace (even if mobile stations available) or absence of any mobile workstations.		
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 alled staff on warc	red = no documented BCP Me = workstation for every bodypace pius additional workstations for mobile stalf, partially met = insufficient mobile workstations, not met = absence of workstation at every bedypace (even if mobile stations available) or absence of any mobile workstations.	3=Not applicable to Unit	
5	When patter data management systems (PDMG) or electronic galient moral (EPM) system are used, here must be access to a declarad evolutation compart at each bed space. A however, the patter can be predicted as the system of the space can be predicted, musting and alled staff or ware mands and on an affance basis. The CS must have not implementation and cogniting training programments to apport at latel for ware organized and the space basis.	mel – no documentel BCP – tele – socializato in en very observa plas additional workstations for mobile suff, partially met – inauficient mobile de – socializato in en very observa d'universation al every tedepois (even Fincible suffice analabile) or docume of any mobile workstations. Met – training provided to all staff requiring ti including new statems, x00% on first day of before.		
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STANDARDS			
1	Consultants, nursing, resident medical, healthcare professional and pharmacy staffing must adhere to the standards outlined in the relevant staffing chapters of GPICS. 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	met / not met	3-Not applicable to Unit
2	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. 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	met / not met	3-Not applicable to Unit
4	resident team must be trained in Cardiac Surgery Advanced Life Succort (CALS) and be carable of emergency chest re-opening 24/7. Postoperative care pathways must be guided by appropriate protocols and delivered by trained personnel in a Level 3 clinical environment that complex with national	met / not met	3-Not applicable to Unit
5	To append the particular particular and a gradient of appendix and protocol and a particular particular and a particular and	met / not met	3-Not applicable to Unit
6	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 cardiofhoracic critical care unit, supported by sufficient pharmacy technical staff. 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	met / not met	3-Not applicable to Unit
10	ICNARC ARCtIC (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	No		
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. The cardiothoracic critical care unit should have in place agreed clirical criteria for the appropriate case-mix and arrangements for escalation to a general critical care	met = clear written protocol, partially met = occurs in practice but referen/accepter dependent, not met = escalation	3-Not applicable to Unit
3	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 aternative to medical staff in the cardiothoracic critical care unit. 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	Statement	
5	period	met / not met	3=Not applicable to Unit
6	Perfusion services should be readily available. Cardiothoracic anaesthetists and cardiothoracic surgeons should be integrated into the multidisciplinary nature of each cardiothoracic critical care unit and take an active	met / not met	3=Not applicable to Unit
7	Cardiobracic anaesthetists and cardiobracic surgeons should be integrated into the multidsciptinary nature of each cardiobracic 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
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1.7	Neurocritical Care*		
	*NOT Applicable if non neurocritical care		
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STANDARDS	*NOT Applicable if non-insurcontical care		
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1 2 3 4 6 7 8 9 10 10 11 1 2 2 3 4 5 6 6	Consultaris, narrang resister medical, teathcare professional and planmacy staffing nertices and early platters mut adhere to the same standards outlined in the resister of the same second to inscription for the program of the same standards outlined in the resister of the same standards outlined in the same standards outlined and the same standards outlined in the resister of the same standards outlined in the same standards outlined and the same standards outlined in the resister of the same standards outlined in the same standards outlined and the same standards outlined in the resister of the same standards outlined in the outlined and the same standards outlined in the resister of the same standards outlined in the outline standards outlined in the resister of the same standards outlined in the resister of the resister outlined in the resister of the same standards outlined in the resister of the same standards outlined in the resister outlined in the resource outlined in the resource outline in the resoure o	net - al available, partially - some available big net - formally agreed and added pathways in place, partially net - done but not monitored pathway, not met - met - all pathways agreed and added pathways in place, partially net - done but not monitored pathway, not met - met - total access mendiately once mady for discharge from acute come, partially met - have access to but discharge addeds - shift for scores densets - not met - no access of debts - 4 week to access neuron whether met - total access mendiately once mady for discharge from acute come, partially met - have access to but discharge addeds - shift for scores densets - not met - no access of debts - 4 week to access neuron whether met - all access and prove many for discharge from acute come, partially met - have access to but discharge addeds - shift for score debters - not met - no access of debts - 4 week to access neuron whether met - and access and prove to facilitation discussed, not met (must allow local discusse professional latitude to NOT here from accessing to facilitation discussed, not met (must allow local discusse professional latitude to met - neuronbab conclustion for demonstration met - neuronbab conclustion from acute comes a suble local referencessanity during critical care stary, met - neuronbab conclustion from week after neurons a suble solen. met - neuronbab conclustion in the acute and met - no acoust allong. met - neuronbab conclustion the acute data - no acoust allong. met - neuronbab conclustion with acute data - no acoust allong. met - neuronbab conclustion with acute data - no acoust allong.	S-Mar applicable to Unit S-Mar applicable to Unit S-Mar applicable Unit S-Mar applicable Unit S-Mar applicable Unit S-Mar applicable to Unit

	CRITICAL CARE SERVICES: WORKFORCE			
2.1	Medical Staffing			
STANDARDS				
1	r clow o designe o becente el clower designe el activitación de la construcción de sino designe o becente el construcción de sino	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	2=Fully met	
	activities will be exclusively in ICM and the Consultant will not be responsible for a second speciality at the same time."	met = anything else Met = daytime consultants work blocks of 3 or more days, with job planned handover time, partially met = blocks		
2	consulant work patients must deriver continuity of care.	of <3 days or days themselves divded but with clear handover, not met = anything else	2=Fully met	
3		Fully met = 7 days a week, partially met = 5 days per week	2=Fully met	
4	All shell had a sub-track to the sub-track to the basis basis basis and the All solution of the sub-track basis from the sub-track to the	Fully met = 7 days a week, partially met = 5 days per week	2=Fully met	
5	a doctor or ACCP with advanced airway skills.	Met / not met	2=Fully met	
6		Met / not met	1=Partially met	No Lead Consultant
7	must be able to attend within 30 minutes. A smar number or units that remain statled overnight by an anaestnetic consultant without daytime iCM sessions, by a necessity dictated	Met / not met	2=Fully met	
8	of the and other while the Orderal Andread and the a constraint in inclusive out of inclusion of antice 247, enter by robat	Met / not met	3=Not applicable to Unit	
9	The ward round must have dairy input from hursing, microbiology, pharmacy and physiomerapy and regular input from detellos, speech	Met = >95% of days 2 ward rounds occur, partially met = 90-95%, not met = <90% Met - all met 7 days per week, partially met - ( define missing groups ) or only 5 days per week, not met - not	2=Fully met	
10	and language therapy, occupational therapy and clinical psychology to assist decision making. The nurse in charge should be present in	Achieved Met = staff confirm rota is resilient, partially met = staff believe rota has features that are unsustainable in the long	1=Partially met	
11	Rotas for consultants and resident staff must be cognisant of fatigue and the risk of burnout.	term, not met = failed rota requiring regular locum cover	2=Fully met	
MMENDATIONS				
1		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			
FANDARDS				
1		met 98% of the time or not met	2=Fully met	
2	Each designed attingtion one will must have as identified lead sums who has morell connectivity for the suming elements of the service	met 98% of the time or not met	2=Fully met	
3	e.g. a Band 8a Matron.	met / not met met = supernumerarv nurse does not have their own patient >99% of time, partially met = supernumerarv nurse	2=Fully met	
4	the supervisory clinical coordinator role on duty 24/7 in critical care units. Units with fewer than six beds may consider having a	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	
	Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory	to care tor their own patient >5% shifts Met = unit >11 beds always has second supernumerary nurse avaialble, Partially = available >60% shifts, not met		
5	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.	wer = unit >11 beds aways has second supernumerary hurse available, Pantally = available >60% shins, hot mer, = 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 pr	met - 1.0 per 75, partially met 1.0 per 100, unmet - no educator or less than 1.0 per 100	2=Fully met	
	nursino staff.	Met = always provided until competence achieved, partially = provided but may have own patient before full		
7	specialist competence. c	competencies completed, Not met = anything else	2=Fully met	
8		met or not met	2=Fully met	
9		Met = >95% of shifts, partially =90-95% shifts, not <90%	1=Partially met	
10	In addition to loadership competencies the load superimption forms are superimption for this supercent for the added one unit must meet	met or not met	2=Fully met	
11	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	
MMENDATIONS	Step 1 of National Competencies for Adult Critical Care Nurses should commence when a nurse with no previous experience of the			
1	specialty begins working in Intensive Care Medicine.	met / not met	2=Fully met	
2		met / not met	2=Fully met	
3	Additional Clinical Nurse Educators will be required for larger units, i.e. 1.0 WTE for approximately 75 staff. Clinical Nurse Educators	National measure		Fully met with 2 post reg co
4	Additional calinical robust poddatos win be required to naive robust of the non-approximately 75 sain. Calinical robust poddatos should be service robust of a post-registration intensive care sward and be in possession of a post-registration teaching gualification.	See above	3=Not applicable to Unit	
5		met / not met	1=Partially met	
	The Best Practice Principles to Apply When Considering Moving Critical Care Nursing Staff to a Different and Unfamiliar Clinical Care			
6	effects on staff morale, recruitment and retention should be considered, particularly when this is recurrent. Executive Directors of Nursing	met - policy in place, partially met - no policy but followed, not met - no policy and not followed	2=Fully met	
7	should ske requisite stops to minimise this. Supernumerary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive care nursino.	met / not met	1=Partially met	Woking towards
7	Supernumerary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive	met / not met	1=Partially met	Woking towards
2.3	Supernumerary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive	met / rot met	1=Partially met	Woking towards
	Superrumenary clinical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive care runsing.	met / rot met	1=Partially met	Woking towards
	Supernumenary cirical coordinators should have completed Step 4 competencies in addition to their post-registration award in interview of the state	met / rot met	1=Partially met	Woking towards
2.3	Supernumenary cirical coordinators should have completed Step 4 competencies in addition to heir past-registration award in interview of Workforce, Induction & Training of Medical and Numing Staff Each critical care unit must have a decicated supernumenary Cirical Nurse Educator (1 WTE per approximately 75 staff), responsible for Each critical care unit must have a decicated supernumenary Cirical Nurse Educator (1 WTE per approximately 75 staff), responsible for controlling the education and training and CPD Intervex Ktr Interview care nursing staff and pre-registration suddets.	met / not met	1=Partially met 2=Fully met	Woking towards
2.3	Supernumenary circleal coordinators should have completed Step 4 competencies in addition to their post-registration award in interview of Workforce, Induction & Training of Medical and Nursing Staff Each ontion care with must have a dedicated appendimensity (Chicra Nurse Extension (1 WTE per approximately 75 staft), responsible for additional care with must have a dedicated appendimensity (Chicra Nurse Extension (1 WTE per approximately 75 staft), responsible for additional care with must have a dedicated appendimensity (Chicra Nurse Extension (1 WTE per approximately 75 staft), responsible for All nursing staff appointed to interview care must be functioned apprived for additional staff.			Woking towards
2.3 FANDARDS	Supernumerary cirical coordinators should have completed Step 4 competencies in addition to their post-registration award in intensive post-registration award post-registration award in intensive post-registration award po	See above 22.6	2=Fully met	Woking towards
2.3 TANDARDS 1 2	Supernumeary cirical coordinators should have completed Step 4 competencies in addition to her post-registration award in interview process running.  Workforce, Induction & Training of Medical and Nursing Staff  Each critical care unit must have a dedicated supernumeary Cirical Nurse Educator (1 WTE per approximately 75 staff, responsible for coordinating the education and training and CPD transversk for interview care nursing staff and pre-registration advects.  All nursing staff appointed to interview care must be advected by a critical in staff.  All registration staff and competencies assess for starter they can advect on a critical in staff.  All registrate staff and competencies assess for starter they can advect on a critical in staff.  All registrate staff and competency Framework tor Adult  All registrate competency in intervie care must be winking towards Step 1 of the National Competency Framework for Adult  All registrate competency in intervie care must be winking towards Step 1 of the National Competency Framework tor Adult  All registrate competency in intervie care must be winking towards Step 1 of the National Competency Framework tor Adult  All registrate competency in intervie care must be winking towards Step 1 of the National Competency Framework tor Adult  All registrate care advectors advecto	See above 2.2.6 See above 2.2.7	2=Fully met	Woking towards
2.3 TANDARDS 1 2	Supernumenary cirical coordnators should have completed Step 4 competencies in addition to their post-registration award in intensive care nursing. Workforce, Induction & Training of Medical and Nursing Staff Each critical care unit must have a dedicated supernumenary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for coordnating the education and training and CPD traineverk for intensive care nursing staff and pre-registration students. All nutring staff appointed to timensive care must be allocated a period of supernumenary practice to allow adequate time for registration All registrat nurses commencing in intensive care must be working towards Stap 1 of the National Competency Framework for Adult Nares en Critical Care. Animium of 50% of registered nursing staff must be in possession of a post-registration award in intensive care nursing. Where direct care is augmented using non-registered staff, appropriate training and competence assessment must be provided.	See above 2.2.6 See above 2.2.7 See above 2.2.1 - recommendation	2=Fully met	Woking towards
2.3 TANDARDS 1 2 3 4	Supernumeary circleal coordinators should have completed Step 4 competencies in addition to their past-registration award in interview of the number of the state	See above 2.2.6 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.8	2=Fully met 2=Fully met 2=Fully met 2=Fully met	Woking towards
2.3 TANDARDS 1 2 3 4 5	Supernumeary circleal coordinators should have completed Step 4 competencies in addition to heir post-registration award in interview process numbers of the state of the sta	See above 2.2.8 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.8 See above 2.2.11	2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met	Waking towards
2.3 TANDARDS 1 2 3 4	Supermunerary circuit conductors should have completed Step 4 competencies in addition to their post-registration award in intensive gradient and straining of Medical and Nursing Staff           Workforce, Induction & Training of Medical and Nursing Staff           Each critical care unit must have a dedicated supernumenary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for gradient and straining and CPD Itameters (bit Intensive care nursing staff and preventional instance).           Read-critical care unit must have a dedicated supernumenary Clinical Nurse Educator (1 WTE per approximately 75 staff), responsible for gradient and competencies assesses to ensure they can staffy care for a device base.           All registered nurses commencing in intensive care multi-to work for addition to the start of	See above 2.2.6 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.8	2=Fully met 2=Fully met 2=Fully met 2=Fully met	Waking towards
2.3 TANDARDS 1 2 3 4 5	Supernumenary cirical coordnators should have completed Step 4 competencies in addition to their past-registration award in intensive care number. Workforce, Induction & Training of Medical and Numing Staff Each critical care unit must have a dedicated supernumenary Cirical Nurse Educator (1 WTE per approximately 75 staff), responsible for coordnating the education and harming and CPD harmever. Ko inference care number using and opported to thereine care number and complete staff apported to thereine care must be addicated a period of supernumenary practice to allow advectate. All negated nurses commencing in intensive care must be avoid on goal staff and pre-registration students. All registration commencing in intensive care must be avoid provided to a post-registration word in intensive care number. Where direct care is augmented using non-registered supportstaff, appropriate training and completence assessment must be provided. All non-consultant medical staff commencing a post in the critical care unit have a consultant-direct departmenting fuelds, but is not initiately programm. The must be appropriated training and completence assessment must be provided. All non-consultant medical staff commencing a post in the critical care unit nurs. Where direct care is augmented using non-registered support staff, appropriate training and completence assessment must be provided. All non-consultant medical staff commencing a post in the critical care unit nurs. There direct care is augmented using non-registered and opport staff, appropriate training and completence assessment must be provided in the critical dates, and must have bar to intende to the port must be provided and opport staff, appropriate training and completence assessment must be and provide to the port of must be available on the don't staff and the critical care and must have bar to appropriate the staff assessment and the rest and and representational staff assessment and the rest and and reposited supernum tand thave bar to porton staff	See above 2.2.8 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.8 See above 2.2.11	2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met	Woking towards
2.3 TANDARDS 1 2 3 4 5	Supernumerary circleal coordinators should have completed Step 4 competencies in addition to their past-registration award in interview of the number of the state of the stat	See above 2.2.8 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.8 See above 2.2.11	2=Fuly met 2=Fuly met 2=Fuly met 2=Fuly met	Woking towards
2.3 1 1 2 3 4 5 5 6 6 7	Supernumerary circuit accorduators should have completed Step 4 competencies in addition to their post-registration award in intensive in Workforce, Induction & Training of Medical and Nursing Staff  Each critical control and the should be added a should be added and the should be added and	See above 22.8 See above 22.7 See above 22.1 · recommendation See above 22.8 See above 22.8 See above 22.11 met - infoudes all elements, partially met - some elements, not met - no identifiable written programme. met - meets all elements, partially met - some elements met, not met - no regular teaching	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Partially met	Waking towards
2.3 TANDARDS 1 1 2 3 4 4 5 6 7 8 8	Supernumerary chiral coordinators should have completed Step 4 competencies in addition to their past-registration award in intensive in the set of the se	See above 2.2.8 See above 2.2.7 See above 2.2.1 • recommendation See above 2.2.8 See above 2.2.8 See above 2.2.11 met - infoudes all elements, partially met - some elements, not met - no identifiable written programme. met - meets all elements, partially met - some elements met, not met - no regular teaching met - meets all elements, partially met - some elements met, not met - no meetings as described	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Partially met 2-Fully met	Waking towards
23 TANDARDS 1 2 3 4 5 5 6 6 7	Supernumerary cirical coordnators should have completed Step 4 competencies in addition to their past-registration award in intensive of care number.  Workforce, Induction & Training of Medical and Numing Staff Esch critical care unit must have a dedicated supernumerary Clinical Nume Educator (1 WTE per approximately 75 staft), responsible for coordnating the education and training and CPD trainiveck for intensive care number and provegatation sudders. An number grant appointed to Intensive care must be adviced as period of supernumerary practice to allow advectate the registration advects. An intensive care must be a dedicated supernumerary Clinical Nume Educator (1 WTE per approximately 75 staft), responsible for coordnating the education and training and CPD trainiveck for intensive care number and prove equations sudders. An intensive care must be available to the submit of the supernumerary practice to allow advectate. The registration commercing in intensive care must be avoid to supernumerary practice to allow advectate for Advatt Names in Critical Care. Names in Critical Care. Names in Critical Care. Comparison of Stor of registreem number grant the bit submit grant of a post-registration award in intensive care number with a format policite of programm. The must be provided and prove that for photometry and and competence assessment must be provided. All non-consultant medical staff commercing a post in the critical care unt number to avoid advate, and must have the intensity of a devices and of programmers in terms the advation of the dorts, in Advance, and the submit and the prove submit advation to the unit, who access ad departmential guidelines of the clinical care unt number to advate that and the clinical and the number of the submit and the clinical and a departmential duckets, on the links, built, the submit advated to the total and the submit of the dorts, and the submit and the submit and advate the advate to advate that the submit and the submit and the submit an	See above 22.8 See above 22.7 See above 22.1 · recommendation See above 22.8 See above 22.8 See above 22.11 met - infoudes all elements, partially met - some elements, not met - no identifiable written programme. met - meets all elements, partially met - some elements met, not met - no regular teaching	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Partially met	Waking towards
2.3 1 1 2 3 4 5 6 7 8	Supernumerary cirical coordinators should have completed Step 4 competencies in addition to their past-registration award in intensive (completency) and completencies in addition to their past-registration award in intensive (completency) and completencies (completencies) (completencies) and completencies (completencies) (completencies) and completencies (completencies) (complete	See above 2.2.8 See above 2.2.7 See above 2.2.1 • recommendation See above 2.2.8 See above 2.2.8 See above 2.2.11 met - infoudes all elements, partially met - some elements, not met - no identifiable written programme. met - meets all elements, partially met - some elements met, not met - no regular teaching met - meets all elements, partially met - some elements met, not met - no meetings as described	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 1-Partially met 2-Fully met	Waking towards
23 TANDARDS 1 2 3 4 5 6 7 7 8 8 9	Supernumerary chiral coordinators should have completed Step 4 competencies in addition to their past-registration award in intensive in a second state of the second	See above 2.2.8 See above 2.2.7 See above 2.2.1 • recommendation See above 2.2.8 See above 2.2.11 met - infoudes all elements, partially met - some elements, not met - no identifiable written programme. met - meets all elements, partially met - some elements met, not met - no regular teaching met - meets all elements, partially met - some elements met, not met - no regular teaching met - meets all elements, partially met - some elements met, not met - no meetings as described met - 0.25 PA per trainee, partially met less than 0.25 per trainee, not met, no time allocated.	2-Fully met	Waking towards
2.3 TANDARDS 1 2 3 4 5 6 7 7 8 9 9 10	Supernumerary circical coordinators should have completed Step 4 competencies in addition to her pest-registration award in interview of the second state of the secon	See above 2.2.6 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.1 - recommendation See above 2.2.8 See above 2.2.11 met - indicudes all elements, partially met - some elements, not met - no identifiable written programme. ret - meets all elements, partially met - some elements met, not met - no regular teaching ret - meets all elements, partially met - some elements met, not met - no meetings as described ret - roz 25 PA per trainee, partially met less than 0.25 per trainee, not met, no time allocated. ret / not met	2-Fully met 1-Partially met 1-Partially met	
23 TANDARDS 1 2 3 4 5 6 7 6 7 8 9 10 11	Supernumerary chiral coordinators should have completed Step 4 competencies in addition to their past-registration award in intensive in a second state of the second	See above 2.2.6 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.1 - recommendation See above 2.2.8 See above 2.2.11 met - indicudes all elements, partially met - some elements, not met - no identifiable written programme. ret - meets all elements, partially met - some elements met, not met - no regular teaching ret - meets all elements, partially met - some elements met, not met - no meetings as described ret - roz 25 PA per trainee, partially met less than 0.25 per trainee, not met, no time allocated. ret / not met	2-Fully met 1-Partially met 1-Partially met	
23 TANDARDS 1 2 3 4 5 5 6 7 7 8 9 9 10	Supernumerary cirical coordinators should have completed Step 4 competencies in addition to their past-registration award in interview of the number of the state	See above 2.2.6 See above 2.2.7 See above 2.2.1 - recommendation See above 2.2.1 - recommendation See above 2.2.8 See above 2.2.11 met - indicudes all elements, partially met - some elements, not met - no identifiable written programme. ret - meets all elements, partially met - some elements met, not met - no regular teaching ret - meets all elements, partially met - some elements met, not met - no meetings as described ret - roz 25 PA per trainee, partially met less than 0.25 per trainee, not met, no time allocated. ret / not met	2-Fully met 1-Partially met 1-Partially met	
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	An ACCP who entered a training post after 5 November 2017 should successfully complete an ACCP specific two-year Postgraduate			
2	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.	d 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/hot 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 (Mondav-Fridav) 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	met / not met	0=Not met	
5	least Advanced Stage II (excellence level) in adult critical care pharmacy. Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so	met / not met	0=Not met	
6	Advanced Stage II must have access to an Advanced Stage II (excellence-level) intensive care pharmacist for advice and referrals. As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays). Attend = dips	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	into ward round(s) as appropriate and discusses issues 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	Met = service continues as usual during annual leave, Partially = some cover but not normal service, Not met = no	2-Eully met	
2	required (20% minimum is recommended).	cover or on call type cover only	2=Fully met 0=Not met	
	Intensive care pharmacists should undergo an independent, recognised process to verify competence level. Senior specialist intensive care pharmacist support should, preferably, be provided within the organisation but may be provided from a	met / not met		
3	A peer-o-peer practitioner visit should occur at least once a year to ensure training issues are identified and to help maintain the	met / not met / not applicable	1=Partially met	
4	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 brieflings or operational and patient safety	met / not met	2=Fully met	
2	briefings. The critical care MDT must have an identifiable lead physiotherapist who will be accountable for clinical service delivery, provide training	met / not met	2=Fully met	
3	and mentorship to junior staff, and oversee clinical governance and quality assurance. All physiotherapy staff must receive appropriate competency-based training to ensure delivery of high-quality physiotherapy intervention	met / not met met / not met	2=Fully met	
	within critical care. This training must include staff who are not critical care specialists but are involved in out of hours/on-call cover. Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care, ensuring		-	
4	regional by Jaiming markets and professional quidelines and standards. Respiratory physiotherapy must be available to critical care patients 24 hours a day and seven days a week. This includes the provision of	met - fully meet standard 7 days per week , partially met - meet standard 5 day per week, not met	2=Fully met	
5	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 disclosed and the second secon	met - 85% patients, partially met 75-85% of patients, not met <75% of patients or no audit data	2=Fully met	100% of patients assessed on same/fi
7	Intensive care. This should include the collaborative setting of individualised, patient-centred rehabilitation posits. 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 cilicical need and rehabilitation plan for an individual patient. Rehabilitation	met - 7 days per week, partially met 5 days per week,	1=Partially met	No regular OT input into ITU patients.
	plans should be updated accordingly.			
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
RECOMMENDATIONS				
	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	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 <		
1	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	0.5 per four level 3 beds	0=Not met	WGH has up to 6 ITU patients for the
2	physiotherapist to four ICU Level 3 beds 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	Statement	2 - r ony mex	While Band 4 Tec staff exist in other s
3	physiotherapy or multidisciplinary workforce. Competency/capability frameworks should be in place encompassing all Agenda for Change (AIC) bands applicable to the local service.	Statement		while band 4 rec starrexist in other s
4	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 cu
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 PI
7	The intensive care physiotherapy service or, where appropriate, as part of the MDT, should have robust and evidence-based clinical quidelines/standard operating procedures surrounding airway clearance interventions and specialist rehabilitation interventions including	met / not met	0=Not met	No local policy as no dedicated ITU PI
	early mobilisation of patients in intensive care. The lead physiotherapict, or appropriate density, should participate in all relevant local (and where appropriate, regional) intensive care.			·····
8	operational delivery, governance and quality improvement groups. This may include governance meetings, service improvement work- streams, morbidity and montality review meetings, business continuity meetings, operational or clinical management meetings. This	met / not met	1=Partially met	Attend as able, many of these meeting
	should also include active participation/collaboration with their regional Critical Care Operational Delivery Network.			
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	met / not met	2=Fully met	
	individualised, patient-centred rehabilitation goals and a holistic rehabilitation approach should be taken across a 24-hour period. Physiotherapists should play a key collaborative role in the coordination and delivery of ventilation and tracheostomy weaning plans,			
10	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	1=Partially met	
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		Physiotherapy service heavily involved
			2=Fully met	Physiotherapy service heavily involved
12	Where a local intensive care follow-up clinic/services exists, a physiotherapist should contribute to this service.	met / not met		
12	Where a local intensive care follow-up cliniciservices exists, a physiotherapist should contribute to this service.		2=Fully met	
12	Where a local intensive care follow-up clinic/services exists, a physiotherapist should contribute to this service.		2=Fully met	
			2=Fully met	
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2.7			2=Fully met	
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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	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.	devices only, not met = no access (apart from simple white boards/paper) 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, partialy 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 handeover process) or not met	0=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 referals 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
2.9	Occupational Therapists			
STANDARDS 1		met = 5 day a week access, partially met = < 5 days/week, not met = no service or on call service from other	0=Not met	
	Critical care units must have access to occupational therapy services 5 days a week during working hours. Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, access 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	depts only		
2	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	On times when have inreached to cri
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. The critical care team should include a service coupational therapist with sufficient experience to contribute to and develop rehabilitation.	met / not met	0=Not met	
3	programmes that address the complex functional, cognitive and psychosocial needs of the patient cohort. Occupational therapy staff on the critical care unit should be able to assess and provide non-pharmacological treatment for those patients	met / not met met (OT involved in management of delirium in ICU) partially = involved but no routine review of patients with	0=Not met	
	who present with delirium. Occupational therapists should be involved in intensive care follow-up clinics to assess and facilitate appropriate referrals rehabilitation or	delirium or not met		
5	Occeptational the applies should be involved in intensive care roution up units to assess and lacinate appropriate relevant enablication of specialist services and to address any long-term physical and non-physical impairment affecting occupational performance.	met /not met	0=Not met	
2.10				
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 definium guideline detailing non pharmalogical stratergies. Not met	2=Fully met	
RECOMMENDATIONS				
1	Psychologists should ensure that delinium is accurately assessed by nurses using a validated instrument, and that when delinium is detected, risk factors are reviewed and corrected by the MDT. They should advise on non-pharmacological strategies to prevent and	met / not met	2=Fully met	
2	reduce definition at the ward level (by improving the environment) and patient level (to facilitate orientation and engagement). 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	and blocks blocks and environment. This can be believed in behavior via minimum frames, MICE 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 care6 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,	met/not met	1=Partially met	
	and to have those feelinos validated and normalised. All patients found to be at risk of psychological morbidity (following the short assessment) should receive a comprehensive assessment	met = 75% assessed before discharge, partially met = 50-75% or assessed after discharge from ICU, not met =		
6	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.	niet = 75% assessed before discharge, paruary niet = 0075% or assessed alter discharge rion (CO, not niet = 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/hot 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	met = always available at FU clinic, partially = available by referral, not met = not available	3=Not applicable to Unit	
	As part of the critical care unit MU1, the psychologist should provide: a) i framing for staff to increase knowledge and understanding of psychological reactions, delifium, environmental stressors and psychological outcomes of critical liness, b) Consultation with the multidisciplinary team on communication, sleep, effects of sedation, anxiety, stress, mood, delirium, family issues and holistic care plans,			
10	(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	Met = all elements, partially = some, not = none (could be split)	2=Fully met	
	also need bereavement succorf if their family member dies in the critical care unit. 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) Talored evidence-based interventions for persisting morbidity such as			
11	regarding psychological support for intensive care patients, b) I alorde dividence-based interventions for presisting morbially 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	Met = all elements, partially = some, not = none (could be split)	2=Fully met	
	services, or commendations of 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	men – un chernema, paraziny – donne, not – none (court die apary		
	community. Employers have a duty of care to support staff working in a stressful environment such as intensive care, where burnout is highly			
12	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	Met = routinely available, partially = some ad hoc staff support, not = no staff support	1=Partially met	
	coaching sessions for senior managers. To develop this coordinated service for patients, families, and staff, critical care units should employ a senior HCPC-registered			
13	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/hot met	1=Partially met	
2.11	Healthcare Scientists Specialising in Critical Care			
STANDARDS				
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	metrios met	3=Not applicable to Unit	
	standards set by the Medicines and Healthcare Products Regulatory Agency (MHRA) and the International Organisation for Standardisation (ISO) standard (22870.2016). Critical Care Scientists voluntarily registered with the Health and Care Professions Council (HCPC) must meet the Standard of			
3	Proficiency and comply with the Standards of Conduct, Performance and Ethics. Critical care units receiving trainee healthcare scientists for training in intensive care must comply with the requirements for training set for	met = are registered and comply / not met met / not met	3=Not applicable to Unit	
4	them by the National School of Healthcare Scientist (NSHCS).	inter me 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	methot met	3=Not applicable to Unit	
2	registered with the HCPC. The Critical Care Scientiste should work collaboratively to be a dynamic member of the multidisciplinary team assistion in the provision of	methot met met = embedded in dept, partially = available but not embedded, not	3=Not applicable to Unit	
	high quality, patient-centred care within the critical care environment. The Critical Care Scientists should draw on specialist knowledge to provide advice to medical, nursing and wider multidisciplinary team			
3	working in a critical care setting about the safe and effective use of medical devices used within the critical care environment, including monitoring, disposition 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. The Critical Care Scientists should provide effective management and support for medical devices, including advising on optimal clinical	met / not met	3=Not applicable to Unit	
5	The Critical Care Scientists should provide effective management and support for metocal devices, including advising on optimal clinical settings and troubleshooting, resulting in focused, efficient and high-quality care. The Critical Care Scientists should contribute to the educational needs of the multidisciplinary team, including delivering training,	met = evidence eg logs or equipment testing available / partially = happens but no evidence, not met	3=Not applicable to Unit	
6	mentorship and educational support. The Critical Care Scientists should demonstrate flexibility and adaptability to work across diverse pathways of patient care and clinical	met = evidence of involvement in teaching and training / not met Statement	3=Not applicable to Unit	
8	services that are both routine and highly specialised. The Critical Care Scientists should work safely and effectively within their scope of practice and ensure they do not practise in areas	met/not met	3=Not applicable to Unit	
9	where they are not prolicient. As part of the multidisciplinary team, the Critical Care Scientists should contribute to the strategic direction, planning and delivery of critical care services	metrocomes met (ideally evidence eg attend dept meetings)/ not met	3=Not applicable to Unit	
10	critical care services. 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.	methot met	3=Not applicable to Unit	
	The second se			•
2.12	Support Staff			
STANDARDS				1
1	All support staff must have clearly identifiable roles with specific competencies.	met / not met	2=Fully met	
2	All support staff must have a period of induction and supernumerary status.	met / not met	2=Fully met	
3 4	All support staff must be appropriately trained, competent and familiar with the use of equipment.	met / not met	2=Fully met	
5	All support staff must be included within the intensive care team and be updated on key unit issues and developments. Support staff roles must be clearly identifiable to colleagues, patients and visitors to the department, either by uniform and/or name	met / not met met / not met	2=Fully met	
6	badges. Intensive care areas must develop healthcare support worker roles to assist registered nurses in delivering direct patient care and in	met / not met met / not met	2=Fully met	
7	maintaining patient safety. Healthcare support workers must complete the Care Certificate and adhere to the Code of Conduct for healthcare support workers.	met / not met met / not met	0=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	2=Fully met	
9	collection. 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	

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 dedicated time allotted to a suitable member of start 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	met = full cover wiht 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 relevent 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 ioint 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	met = formal arrangements with SLA in place / not met	3=Not applicable to Unit	
	devise and support remote and rural training posts in critical care.			

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. Unplanned admissions to the critical care unit must occur within four hours of making the decision to admit.	< 85% met, 75-85 partially met, < 75% or no data not met 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 7a	Transfer to other critical care units for non-clinical reasons must be avoided where possible. Consultant in Intensive Care Medicine-led ward rounds must occur twice a day (including weekends and national holidays).	met = non clinical transfer <0.5% of admissions, partially met < 1%, not met >1% of admissions < 85% met, 75-85 partially met, < 75% or no data not met	2=Fully 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	2=Fully met	
9	Discharge from critical care to a general ward must occur within furu hours of the decision and must occur between 07:00hrs and 21:59hrs. There must be a standardised handover procedure for medical, nursing and AMP staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation preception.	met = >80%, partially = 60-80%, not <60% met / not met	1=Partially met 0=Not met	
10	a formalised transfer process. This must include their structured rehabilitation prescription. 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	1=Partially met	
		+		
RECOMMENDATIONS	None			
	IWIE			I
3.2	Capacity Management			
STANDARDS	1			
STANDARDS	Hospital management teams must optimise the use of critical care capacity at all times. The admission and discharge of critical care patients must be prioritized such that patients requiring critical care support are admitted without datas (within four hours after decision to	>90% admitted within 4 hours, 85-90% admitted within 4 hours, < 85% admitted within 4 hours or not		
1	palients 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.	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 duy consultant and the duty runse in charge of the critical care unit. Under no circumstances should clinical decisions be overriden by non-nicitical coerational 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. Hospital boards must demonstrate regular oversight of the use of critical care escalation and the provision of intensive care outside of the	met / not met	2=Fully met	
4	Hospital locaris must demonstrate regular oversignt or the use or critical care escalation and me provision or intensive care outside or the critical care unit. Escalation plans must balance risks of non-clinical transfer against risk of care outside of the critical care unit.	met / not met met / not met	0=Not met 2=Fully met	
6	Escalation plans must differentiate between escalation during 'normal' operation and escalation during major incidents or pandemic scenarios.	met / not met	1=Partially met	consultant to consultant discussion
7	Regional Intensive Care Networks must have escalation plans documented and agreed at medical director and chief executive level to allow the duvi intensive care consultants and duvi nurses in charoe to coordinate the usane of intensive care beds across the network. Regional pandemic escalation plans must include trigger levels for agreed critical care admission criteria and thresholds for restriction of	met / not met / not applicable	3=Not applicable to Unit	Mutual aid document
8	planned activity to assist neighbouring critical care units Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units	met / not met / not applicable met / not met / not applicable	3=Not applicable to Unit 3=Not applicable to Unit	HB escalation plan
10	to include escalation and, if required, prioritisation of transfers over local elective activity. 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 met / not met / not applicable	3=Not applicable to Unit	
11	requiany. 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			
RECOMMENDATIONS	Critical care units should determine the emergency capacity they require to meet Standard 1 locally, based on their admission and occurancy data. The capacity to core with the predicted emergency workload can then be managed by ensuring an annormate number.	met / not met	1=Partially met	
2	occupancy data. The capacity to cope with the predicted emergency workload can then be managed by ensuring an appropriate number of bods available for semenency admissions before accession elective admissions. Acute hospitals will require at least one ortical care bed per 35 acute hospital beds, hospitals undertaking a large amount of complex	met / not met met = 1:35 or greater, partially 1:45-1:35	2=Fully met	
3	major surgical procedures are likely to need significantly more than this. 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	medical patients only
4	When using alternative areas of the hospital to provide critical care capacity, here 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. Decisions to proceed with major elective surgery should take into account current occupancy, provision de mergency capacity over the	met = immediate access to ICU resident / registrar /nurse in charge for advice + twice daily consultant ward round	2=Fully met	Significant pressure on staffing
6	next 24 hours and, at times of regional network escalation, the emergency capacity in neighbouring units. Critical care units may find it useful to develop a statistical model locally that provides predictable data on the number of emergency	met / not met	1=Partially met	
b	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	met / not met	2-Fully met	
	process. 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 (NEVIS-2) is the recommended for call	met / not met	2#Pully liter	HB policy
2	excisionant's anone's registrant durity plant la voir no years, more excised builty Willing double (vertred sy or no economicand or using systems as the more efficient and deficitive. Using a common score ensures that staff operate the same language across the patient pathway and enhances the benefits of an early warring system. As part of a multi-trigger system, other triggers such as unite output acute kicking injury alerts, cause for concern and patient/carer Calif Concern, should be considered as they will enhance the	met / not met	2=Fully met	
	acute kidney injury alerts, cause for concern and patient/carer <i>Call for Concern</i> , should be considered as they will enhance the recoanition of the deteriorating patient.			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 threapies and service clinical involvement. It should define the speed and urgency of response, including a clear secalation policy to ensure that an appropriate the staff of the second se	met / not met	2=Fully met	
	response always occurs and is available 24/7. Each organisation should ensure patients receive care from appropriately trained critical care outreach, rapid response or equivalent			Health Board policy and Critical Care Outreach
2	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	met 24/7, partially met daytime only or 5 days per week, not met - less than this frequency	2=Fully met	
	hnonital 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			Health Board policy and Critical Care Outreach
3	in hospital5. 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. Organizations should aim to deliver Comprehensive Critical Care Outreach as outlined by the seven core elements and have an	met / not met		RESUS TEAM
4	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 6a	All patients should be reviewed by the CCO team (or equivalent) following discharge from the critical care unit to the ward. All CCO teams should participate in the National Critical Care Outreach Activity Outcome Dataset.	Met - < 85%, partialy met 85-75%, unmet > 75% or no data	2=Fully met 1=Partially met	
	Each organisation should develop audit tools to assess utilisation of their track and trigger and graded response system with clear	met / not met		Data recorded but not recorted nationally at present as not a overarchinobody
6b	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 C6502 and must be fed back to healthcare organisation Boards and Critical Care Networks where referent.	met / not met	1=Partially met	RESUS /RRAILS 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. There should be regular review of service provision to facilitate proactive approaches in order to match service configuration against local demands and activity. Three should be reflected in the operational policy. There should be a nominated lead of service at nealthcare	met / not met	2=Fully met	
7b	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	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 solicy	2=Fully met	
2	to minimise the risk of infection. Infection control procedures must be documented and agreed by the multi-professional team.	daily checklist or no audit. not met = no policy 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. Clearning of the environment must be undertaken by trained staff and subject to audit and quality control, with particular attention to high-	Handwashing audit - Met - < 95%, partilly met 95-86%, unmet > 85% met = policy in place with regular audit data and systematic reports, partially = policies in place but only	2=Fully met	
5	contact surfaces. Duties of cleaning and nursing staff, in cleaning specific surfaces, should be clearly defined. There must be surveillance systems in place for audit and feedback of nosocomial infection, reporting to the national scheme where	met – policy in place with regular audit data and systematic reports, partially – policies in place but only ad hoc audits, not met – anywhing else met - supply data to ICCQIP ( or equivalent) , partially met - locally monitored, not met - not regularly	2=Fully met	credits for cleaning
6	applicable, for example, reporting central venous catheter-related bloodstream infection to the Public Health England Infection in Critical Care Quality Improvement Programme ICCQIP). The principles of antibiotic stewardship must be adhered to in consultation with the microbiology team.	monitored met = vocumented dany consumment microbrologist input at reast or OK addit data against trass stewardship programme -85% compliance, partially = -85% (some units exempt from audits because of		
	1	and preserve and a preserve and a second reacting more available of		
RECOMMENDATIONS	Dationale school does assessed for exercises of 1000A			
1	Patients should be screened for carriage of MRSA and/or carbapenemase-producing organisms according to locally determined prioritisation. Sensitivity of risk factor allocrithms is cenerally low and universal screening is prefarable in highly endemic regions. Patients with MRSA carriage or infection should receive topical suppression to reduce shedding and, if possible, single-room isolation.	met - done > 95% of the time , partially met 85-95% of the time, unmet - <85% or no data or not done met / unmet	2=Fully met 2=Fully met	
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 / unmet met / not met	2=Fully met	In accordance with hb policy
4	Design of new units should include inflection control specialists as part of the planning term. 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 inflections.	met / not met / not applicable	3=Not applicable to Unit	
5	resistant infections. 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 imetabled microbiology rounds during the week. The microbiologist will advice on the choice and duration of artimicrobial chemidentear or in accordance with local formulates as a surt of antibiotic teamsrathio.	met / not met	2=Fully met	
6	Intection control nursing staff or intensive care nurses with intection 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	met / not met	2=Fully met	
7	prevenue or expected infertion infloader, doubling privately and notification and resultant manufacture and prevenue or a second prevenue of the second or t	met = formal audit and review process in plance / unmet	2=Fully met	not available at weekends
	· · · · · · · · · · · · · · · · · · ·			
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	0=Not met	202
2	There must be local antimicrobial prescribing guidelines in accordance with the principles of antimicrobial stewardship. Clear protocols must be in place for management of massive haemorrhage including the role of laboratory services.	met / not met	2=Fully met	hb policy
	procession of the pace of menegative of the solve had not the solution of the of the of the of the of the solve of the solution of the s	met / not met	2=Fully met	hb protocol
3	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				
6	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 nermanently recorded record covering the entirety of the investigation of There must be sever-day availability of radiology services, appropriate to the specialize being cared for, to allow timely investigation of	met / not met met = full service 7/7, partially = 7/7 service but some elements not always available (eg 7/7 reporting	2=Fully met	
	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.	but interventional service only daytimes), unmet = <7/7 service	1=Partially met	not always available
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	
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. All point of care laboratory devices used to assist clinical decision making should be subject to appropriate quality assurance	met / not met met - fully centralised lab standard QA process in place with audit evidence, partially - some QA	2=Fully met	
4	Per point or care rabitatory devices use to assist clinical decision making should be soupled to appropriate quary assistance mechanisms, agreed by laboratory and end users. Clear protocols for access to radiology services that are not available on site (e.g. interventional radiology, MRI in ventilated patients)	process with intermittent audit, unmet = no laboratory standard QA process	2=Fully met 0=Not met	
6	should be available. Liaison psychiatry services should be available in all acute hospitals with a single point of referral. Emergency mental health referrals	met / not met met = available and meets time criteria, partially = available but not <1h <24h, not met = not available	0=Not met	
	should be seen within one hour of referral and urgent mental healthcare referrals within 24 hours of referral (within the liaison team's usual operation hours). Patients who have sell-harmed, irrespective of the apparent motivation, should have a comprehensive psychosocial assessment. This	met = available and meets time critena, partially = available but not <td></td> <td></td>		
7	should generally be the responsibility of the liaison psychiatry service and should not be delayed until after medical treatment is complete unless life-savins treatment is necessarv, or he patient is unconscious or otherwise incasalyed or being assessed. Liaison professionals should be available to advise on issues around mental capacity and there should be working arrangements detailing	met / not met	0=Not met	patients must be medically fit for crisis team assessment
8	Labori protestonais sincia de avaracire o avvise or issues around menar capacity and mere sincia de working analigements detaining 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 sconer) and a	> 85% of patients - met , 75-86% partially met, < 75% ( or no data ) unmet	1=Partially met	
2	rehabilitation olan outlined by all relevant heraov professions as clinically indicated. 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 meed and rehabilitation plan for an individual patient. Rehabilitation	all rehab needs met 7 days a week = met, all rehab needs met 5 days per week = partially met, rehab	1-Partially met	
	inspectivy appropriate to each interacy, in order to meet into minica meet and maintainable pair to all interview particular abane chevid he material annotation annotation and the sat daily, and when changes or fluctuations in behaviour occur; in the event of a positive All patients must be screened for delinium at least daily, and when changes or fluctuations in behaviour occur; in the event of a positive delinium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors	needs not met consistently = unmet		
3	delirium screen, family should be informed, strategies to facilitate patient orientation implemented and medical review of risk factors completed. 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	2=Fully met	
4	Patients which instructionally intra the communities and are at fisk of morbidly 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,	> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	2=Fully met	
5		> 85% of patients - met , 75-85% partially met, < 75% ( or no data ) unmet	1=Partially met	
6	Adults at risk of poor quality recovery must have an individualised rehabilitation plan documented in their formal handower 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 inabilitation lash individ cours as soon as feasible and acontoriate.	> 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				
RECOMMENDATIONS 1	Physiotherapy services should provide assessment and intervention for both acute respiratory and physical rehabilitation seven days per water consistent should be mode for other therapic residue to be provided as needed at waterpole.	met 7 days a week = met, met 5 days per week = partially met, not met consistently = unmet	1=Partially met	
2	week: provision should be made for other therapy services to be provided as needed at weekends. Specialist rehabilitation co-ordinator roles should be considered to facilitate the oversight of the rehabilitation pathway for patients, and to	met = rehab coordinator (eg senior nurse); partially met = has other roles, unmet = doens't exist	0=Not met	
3	ensure that assessments, meterats and documentation are completed and transferred to engoing services and teams. The relic of themps support workers or inhabitation assistants should be concidered as part of the rehabilitation team; these roles may be uni-professional or multi-professional in nature and recruited from running or allied health backgrounds. These may enable enhanced delivers, and incared efficience or inhabitations are delivers and are paration schebilition to ho dail work of folgering direferences.	Statement		
4	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 accrossive namino of these roles. Rehabilitation culcomes should be monitored and progression made using outcome measures appropriate for the stage of recovery.	met = rehab progression monitoring assessments in place inc after leaving ICU (eg CPAT), partially =	1+Partially met	
5	individual therapy, and dependent on local resources (including personnel, coupement, and finance). The rehabilitation plane that forme part of the bandware of crase on discharge from critical case should address all relevant domains for	on icu only, unmet = no progression monitoring met / not met	1=Partially met 2=Fully met	
6	Individual national previous hump are voltamente una dei soutrage main concernante anno autoratari recommentario. Individual national includino, Juni na metricata lo, chevical, functional, functional, considar solida solidati To facilitate the rehabilitation component of the formal handwer of care on discharge from critical care to a general wark, weekly multidisciplinary trababilitation wark rounds should be led by a senior member of the critical care multiprecisional and association and result in an multidisciplinary trababilitation wark rounds should be led by a senior member of the critical care multiprecisional team and result in an	met / not met	2=Fully met	
7	Indication of the second second second second second second maintenance of the second se second second sec	met / not met	2=Fully met	
	easily by all team members. For high-risk/complex patients, capturing the experience for the patient and family in a manner that they can reflect upon and engage			
8	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 discussed for granulating and the second	met / not met	0=Not met	
	a resource for specific balletits.			
RECOMMENDATIONS		Γ		
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. The follow-up programme should ensure the delivery of structured and supported self-directed rehabilitation to all patients at critical care.	met = all patients, partially = selected patients, unmet = none	0=Not met	
3	discharge and at hospital discharge. 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	met = all patients, partially = selected patients, unmet = none met = all acorooriate patients, partially = selected patients limited by capacity not need, unmet = none	0=Not met	
4	up ream should include an intersive care consolinating measure care rouse, clinical psychologist, physical explosit, debuar and occurational thermalist according to the individual patient's needs. Selection of patients for follow up should be based on length of stay (more than three days) or at increased risk (e.g. following	met = an appropriate patents, partiany = selected patents innied by capacity not need, unnex = note met / not met	0=Not met	
5			0=Not met	
5	anaphysiss, or cost-parfurm interave care). Self-election of patients should also be incidented. Follow up should write actively seeking common physical sequelae, such as wateries, weight loss and sexual dysfunction, and the consequences of critical care universities of performed and rationalised with input from pharmacy if required. Review of current medication should be performed and rationalised with input from pharmacy if required.	met / not met met / not met	0=Not met	
	analyhaw, or podcadrum interse care). Set leaded or potents should also be located. To follow a phodul more activity seleng common phycel aspecials, which was welves, weight loss and sexual dystunction, and the cansequences of orbital care universitial procedure (a g. hanhoristom). Review of current modulant hould be performed and introlucion with input from pharmacy if required. Psychological sequelaes (such as away, depression, regimmers and poler/samitatis there disorder) should be sough via screening Psychological sequelaes (such as away, depression, regimmers and poler/samitatis there disorder) should be sough via screening throad by the sough Openession Sale (MUS), and UK Pert Transfer Strees Syndrome (KI PESS +1), fince and be	met / not met Met = screening process in place for psychological seq for all patients, partially = for selected patients,		
6	anaphysiss, or cost-parfurm interave care). Self-election of patients should also be incidented. Follow up should write actively seeking common physical sequelae, such as wateries, weight loss and sexual dysfunction, and the consequences of critical care universities of performed and rationalised with input from pharmacy if required. Review of current medication should be performed and rationalised with input from pharmacy if required.	met / not met Met = screening process in place for psychological seq for all patients, partially = for selected patients, unmet = no screening	0=Not met	
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6 7 8 9	anaphanos no podradnim minoso cello. Self-loadekor of patenti should ato be fonctiano. International analysis and a second self-self-self-self-self-self-self-self-	mel / not met Me – ucrowning process in place for paythological seq for all patients, partially – for adjected patients, met-refersal from cinic / not met - referral via GP met / not met	0=Not met 0=Not met 0=Not met 0=Not met	Established pre covid but not sustained diring
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6	All staff must have opportunities for personal development reviews including annual appraisals. All staff working in critical care must be able to access the Freedom to Speak Up Guardian.	met - > 85% of staff appraised / PDP done, Partially met 75-85% not met < 76% of staff	2=Fully met	
7	Staff must be provided with adequate resources consistent with other GPICS standards to deliver their job mile e.g. adequate staffing	met / not met	0=Not met	Not specifically with thius title but regular meetings to encourage feedback
8	ratios, access to facilities for nutrition and hydration, adequate equipment. Staff rostering must comply with Health and Safety Executive recommendations for sleep and rest.	Statement 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	
10		HIEL/ HOK THEN	2 - r uny mar	Space available Could be larger
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	0=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	met / not met	1=Partially met	
6	a a Schwartz Create Rounds dehiefen fillowing medical energencies) All staff should have ergonomic clinical work areas with appropriate access to light and control of noise.	met / not met	2=Fully met	Reinvicorate processes already set up
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 III Patients			
STANDARDS	Transfer to other critical care units for non-clinical reasons must be avoided where possible.			
1	Parasen o une cinical care une to noncumular reasons must be avoided where possible. Appropriate equipment must be available to undertake a safe transfer and to manage complications/adverse events which may occur		0=Not met	
2	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 undercone 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	met / not met	2=Fully met	
5	record A named intensive care consultant must take overall responsibility for the decision to transfer a patient and the level of support required,	met / not met	2-Fully met	
6	but does not necessarily have to undertake the transfer. 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 borning. This must be around prior to the transfer being undertaken	met / not met	2=Fully met	
8	hospital. This must be agreed prior to the transfer being undertaken. Where patients have completed specialist care and orgoing 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.	Percentge occuring within 48 hours of decision. Met > 85%, partally met 75-85%, not met < 75% of the time or no data collected.	1=Partially met	
	The second se			-
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	meet scandard and no no has assessment met = documented 95%, partially met 80-95%, unmet <80% or no data or not a consultnat decision	2=Fully met	
	documented. An adeouately stocked and regularly checked, dedicated transfer bag should be available for use during all patient transfers. This bag			
3	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, it sealed with a tag, then a daily check that the seal is unbroken. The	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	
	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. The activity and should be documented at approximate interpatie while in transit. Where portable, action should be taken to remark			Supported by operating theatre
4	The patient's vial signs should be documented at appropriate intervals while in transit. Where possible, action should be taken to remedy any physiological deterioration during the transfer. Standardised transfer documentation should be completed for all intensive care patient transfers. Transfer documentation should be	met = audit evidence of obs or transfer forms, unmet = no evidence	2=Fully met	
5	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 atmassfer, 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. There should be a clear agreed escalation process for any delayed transfer across an operational delivery network geographical area.	met = 95%, partially = 80-95%, unmet <80% documented	2=Fully met	
11	The definition of 'delay' will vary according to the reason for the transfer. For patients being transferred from a specialist critical care unit	met / not met	2-Fully met	
	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. Appropriate infection control precautions, including isolation, must be made available for patients with known high-risk infections or who			
12	Appropriate intection control precautions, including isolation, must be made available for patients winn known high-risk intections of 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	Order for delay a patient transfer. Similarly, isolation racinities must be available for immunocompromised patients who require ment. Critical care units should have an agreement with their local ambulance providers in relation to the contracted transport provision for		6.5.H	
13	intensive care services, and to ensure these standards are met throuchout the entire patient pathway. There should be a system for monitoring the quality of inter hospital transfers and governance arrangements which includes capture of	met / not met met - well established processes, data avaiable, partially met - reviewed, limited data available, not met.	2=Fully met	
15	numbers, indication for transfer, incidents, delayed transfers and outcomes. Audit measures and learning should be widely shared. There should be standardised network wide transfer documentation and training programmes.	rarely undertaken or not at all met = both / partially met = one or the other / not met = neither	2-r ony mar	
		The event of the other		
16	Consideration should be given to the formation of specialist transfer teams, as these may reduce the incidence of adverse events and	Statement		
16	Consideration should be given to the formation of specialitis 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		
16 3.11	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		
		Slatenort		
	Care at the End of Life	Statement		
3.11	Care at the End of Life Decision making summaring one at the end of life, including the intitionate for any decisions, must be documented clearly and communicated to patients and heri lowed ones. The latter being of patinular relevance I patients lack capacity (below).	Satement met - 98% whicks documentation, partially - 55 98% documented but gaps found in documentation on audit, unma - 45% or major failings in what is documented	2-Fully met	
3.11 STANDARDS	Care at the End of Life Constant and the indication of the analysis of the ana	Statement met = 99% with clear documentation, partially = 95 99% documented but gaps found in documentation on audit, unmet = -99% or major failings in what is documented met / not met	2=Fully met	
3.11 STANDARDS 1 2	Care as the End of Life Constant and the send of the including is a prioritized for any decisions main to documented death yield communicated to particular, and the local care. The latter bring of particular releases of galaxies that any decision main any decision of the send of the including is a prioritized release of galaxies. The latter bring of particular releases of galaxies and the particular decision of the send of the including is a prioritized release of galaxies. The latter bring of particular releases of galaxies and the particular sendences with exception of the send of galaxies of the theory is a sendence of the sendence of the release is being a capacity for 2000 (MCA 2000). England and Wates, b) Adults with bringped/ Act (2000). Scottler, d) and Capacity, Act (1000) releases the theory is a sendence of the sendence of the release is being a capacity of the sendence of the release of t	on audit, unmet = <39% or major failings in what is documented met / not met	2=Fully met	
3.11 STANDARDS 1 2 3	Care as the End of Life Constant making announcing parts at the send of the including the prioritize for my decisions making announcing game at the send of the including the prioritize for my decisions and prime to one cans. The latter brain of particular relevance of games to be done	on audit, unnet = -09% or major failings in what is documented met / not met met / not met	2=Fully met	
3.11 STANDARDS 1 2	Care at the End of Life  Decision making sumounding care at the end of life, including the intrionate for any decisions, must be documented clearly and communicated to patients and their load ones. The latter being of particular relevance I patients lack capacity (below). Decision making sumounding end at their load ones. The latter being of particular relevance I patients lack capacity (below). Decision making sumounding end at their load ones. The latter being of particular relevance at the hospitoly At COMS. Sociation, of Decision making sumounding end at their capacity (below). Decision making sumounding end at their capacity (below). Decision makes the strend Case Taxes the End of Life. Case Paratice in Decision Makino. Decision makes the strend case Taxes and their capacity (below). Consideration must be names at whether args and charation can be direred to every dring patient, and where appropriate the constalist ture-capacity due to contains.	on audit, unmet – d9% or major failings in what is documented met / not met met / not met met - condected with audit data on referral rates reviewed quarterly, partially = considered but no audit data or - 47% referral rate, unmet - not doce.	2=Fully met	
3.11 STANDARDS 1 2 3	Care as the End of Life Constant making announcing parts at the send of the including the prioritize for my decisions making announcing game at the send of the including the prioritize for my decisions and prime to one cans. The latter brain of particular relevance of games to be done	on audit, unmet – d9% or major failings in what is documented met / not met met / not met met - condected with audit data on referral rates reviewed quarterly, partially = considered but no audit data or - 47% referral rate, unmet - not doce.	2=Fully met	
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3.11 STANDARDS 1 2 3	Can as the End of Life  Constraints and an end of the including is a strainted for any decisions, must be documented dearly and communicate by straints, and the load case. This later this of constraints are made to be addressed of the including is a straint and and the including and and the straints. The dear bend case. This later this of constraints are made to be addressed of the including and and the straints are dearby and constraints and the load case. This later this are documents and any effections of the straints and the load case. This later this are document and any effective straints are done of the straints and the straints are done of the straints and the straints and the straints and the straints are done of the straints are done of the straints and the straints are and the straints and the straints are associated and the straints are associated as the shore are approximated and the straints are associated as the shore are approximated as the shore are approximated and the straints are associated as the shore are approximated as the shore are associated as the shore are associated as the shore are approximated as the shore are approximated as the shore are associated as the shore are associated as the shore are approximated as the shore are approximated as the shore are approximated as the shore are associated as the shore are associated as the shore are associated as the shore are approximated as the shore are associated as the shore are associated as the shore are associated as th	on audit, menner = <0% or major failings in what is documented met / not met met / not met met / not met met - considered with audit data on referral mass reviewed quarterly, partially = considered but no audit data or <0% referral mets, unnet = not doce Statement	2-Fully met 2-Fully met 2-Fully met	
3.11 STANDARDS 1 2 3 4 5	Care at the End of Life Central methods of the send of the including the previousle for any decisions, must be documented dearly and communicated to statement and the location. The latter brings of particular releases of Life Section making and the send of Life Section making and the section of Life Section Sect	on audit, unmet – d9% or major failings in what is documented met / not met met / not met met - condected with audit data on referral rates reviewed quarterly, partially = considered but no audit data or - 47% referral rate, unmet - not doce.	2=Fully met	
3.11 STANDARDS 1 2 3 4 5	Care at the End of Life Decision making sumounding care at the end of the, including the rationale for any decision, must be documented clearly and communicated to patients and ben fored ones. The latter being of patiential are documented clearly and communicated to patients and ben fored ones. The latter being of patiential are documented clearly and protestion and patients and patients and patients and patients and communicated patients and communicated patients and patients and patients and patients are done and patients and Capacity (et al. Menia Capacity (et al. Care). Show the state of the documented clearly and protestion of any document bene of the disk of a patient and the patients and capacity (et al. Care). To add the disk of a patient and the patients and the add the disk of the disk of a patient and the add the disk of any document on the offend of the disk of any document of the transmission of a make site or the disk of advantance can be offend to every dyng patient, and where appropriate the transmission of the patients and the advantance of the patient patient patients and the advantance of the disk of the disk of the disk of the patient patients and the advantance of the patient patients and the advantance of the transmitted or advantance of the patient patient patients and the advantance of the patient patients and the advantance of the transmitted or advantance of the transmitted or advantance of the patient patient patient patient patients and the advantance of the transmitted or advantance of the transmitted or advantance of	on audit, menner = <0% or major failings in what is documented met / not met met / not met met / not met met - considered with audit data on referral mass reviewed quarterly, partially = considered but no audit data or <0% referral mets, unnet = not doce Statement	2-Fully met 2-Fully met 2-Fully met	
2.11 STANDARDS 1 2 3 4 5 5 RECOMMENDATIONS 1 2	Care at the End of Life Decision making surrounding care at the end of the, including the rationale for any decision, must be documented clearly and communicated to parken as do far found on the life of the parket of particular releases of parkets lack documented clearly and communicated to parket as a life and capacity (Hotel). The life of parket of the parket of the parket of the parket of parket of the parket of parket of the par	on audit, manne - d0%, or major fallings in what is documented met / not met met / not met met - considered with audit data on referral rates reviewed quarterly, partially - considered but no audit data or CVD% referral rate, unmet - not doce Statement net / not met met / not met	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met	
3.11 STANDARDS 1 2 3 4 5 5 PRECOMMENDATIONS 1	Cere as the End of Life  Center making sensending general the send of the including the priorities for any deviations, must be documented damity and communication to advance the deviation of the including the priorities for any deviations, must be documented advanty and communication to advance the deviation of the deviation of the advance of the deviation of t	on audit, manne - <0% or major failings in what is documented met / not met met / not met met / not met met / not met met / not met	2-Fully met 2-Fully met 2-Fully met	Cely 100 Consultant
STANDARDS           1           2           3           4           5           1           2           3           4           5           1           2           3           1           2           3           3	Cere as the End of Life Decision making extramologic grant at the end of life, including the intervel for any decision, must be decontented for any decision. Decision making extramologic grant at the end of life, including the intervel for any decision. Decision making extramologic grant at the end of life, including the intervel is accordance with reference assisted regression of the decision for the decision. Decision making extramologic grant at the end of life, accordance with reference assisted regression of the decision for the decision. Decision making extramologic grant at the end of life accordance with reference assisted regression of the decision. Decision making extramologic grant at the end of life accordance with reference assisted regression. Decision for the decision of the decision making extramologic and the end of life accordance with professional guadance. Decision factors are been to share the origin and the context. Decision factor assisted by decision of the decision o	on audit, manne - d0%, or major fallings in what is documented met / not met met / not met met - considered with audit data on referral rates reviewed quarterly, partially - considered but no audit data or CVD% referral rate, unmet - not done Statement net / not met met / not met	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 0-fully met	Cely 1 ICU Consultant
2.11 STANDARDS 1 2 3 4 5 5 RECOMMENDATIONS 1 2	Cons at the End of Life Decision making anomating grant at the end of life, including is an introduct for any decisions, must be deconstrained for any decisions and the end of life. This later is an introduct for any decisions and the end of life. This later is an introduct for any decisions and the end of life. This later is an introduct for any decisions and the end of life. This later is an introduct for any decisions and the end of life. This later is an introduct for any decisions and the end of life and the end of life. This later is an introduct for any decisions and the end of life and the end of life and the end of life and the end of life. This later is any decision and the grant making requirements and decision making barriers in the end of life and the end of life	on audit, ment = <0% or major failings in whit is documented met / not met met / not met met / not met net / not met met / not met met / not met met - 7 days par week, partially met 5 days par week,	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met	Cety 1 GJ Consultant
STANDARDS           1           2           3           4           5           1           2           3           4           5           1           2           3           1           2           3           3	Cen at the End of Life Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and comparison to patients and that of advances. This team being of patients are discussed patients and sequence (tables) and comparison of the patient of the discuss. This team being of patients are discussed patients and sequence (tables) and Capacity A (tables). This team being of patients are discussed as a patient of the patient of the discussed	on audit, maint = <00% or major failings in whit is documented met / not met met / not met / not met met / not met / n	2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 0-fully met	Cely 1 ICU Consulant
Σ11           STANDARDS           1           2           3           4           5           1           2           3           4           5           1           2           3           4           5           4           5           4           5	Cen as the End of Life  Decision making surrounding once at the end of life, including the tradicular relevance of guidentia and performance of the end of the including the end of the e	on audit, maint = <00% or major failings in whit is documented met / not met met / not met	2-Fuly met	Cely 1 K3 Consultant
211 STANDARDS 1 2 3 4 5 1 RECOMMENDATIONS 1 2 3 4	Cen as the End of Life Center making encounting general the end of the including the previousle for any devicines, must be documented device yield communication is address and the load center. The latter brings of parallalue references of general latter documents and general general terms of the documents and terms of the documents of the documents and terms of the documents of the documents and terms of the documents of the documents and terms of t	on audit, manne - c950, or major failings in whit is documented met / not met met / not met met - considered with audit data on referral rates reviewed quarterly, partially - considered but no audit data or 2010; inferral tile, umet - not done Statement met / not met met / not met met / not met met - fost met met - or days par week, partially met 5 days par week, met - systematic documentation used 39%, partially 90-95%, or no systematic documentation, unmet no evidence	2-Fuly met 2-Fuly met 2-Fuly met 2-Fuly met 0-Net met 2-Fuly met 2-Fuly met	Cety 1 ICU Consultant
3.11           1           2           3           4           5           1           2           3           4           5           1           2           3           4           5           6	Create the End of Life Decision making summaring care at the end of this, including the rationale for any decisions, must be documented clearly and Decision making summaring and of the care [EdG] must be performed in accordance with interant standary requires to and protestion and any personnel of the care [EdG] must be performed in accordance with interant standary requires to and protestion and accordance (EdG) must be performed in accordance with interant standary requires to and protestion and accordance (EdG) must be performed in accordance with interant standary requires to and protestion and accordance (EdG) must be performed in accordance with interant standary requires to and protestion of stant by cardiorapping of a transmitted for the max between the protestion of particle (Construction) and construction making allowed (EdG) standard be construction Decision native protection and accordance (EdG) must be performed in accordance with protestional partners. Construction must be advected to change in there construction on the protection on guiders revealed to access whether they are improving or deterioration, and of the possibility that they may be dying. Best partners protection making maximum accordance (EdG) activates the thereare a standard or dependent on the maximum reveal to access whether they are improving or deterioration, and of the possibility that they may be dying. Best partners protection making making chances. Provide data base in informed. Decision making emission for access the end of Be should, whereare possible, hothe partners data chances in the protection or pulses the antimeter or access the accession of the first data chances are marked as accession partners and	on audit, ment = <00% or major failings in whit is documented met / not met met - objer week, partially met 5 days per week, met = systematic documentation used 90%, partially 90-80% or no systematic documentation, unnet no exforce	>Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met 2-Fully met	Cely 1EU Consultant
Σ11           STANDARDS           1           2           3           4           5           1           2           3           4           5           1           2           3           4           5           4           5           4           5	Circle at the End of Life Decision making sustainability data at the end of file, including the intribute for any decision, must be documented deally and Decision making sustainability and at the end of file, including the intribute for any decision, must be documented of deally and Decision making sustainability and of the care (FLAC) must be performed in accordance with relevant asstudyr requirements and protession adjustance. The second End Color Mark 2000, End Star de Mark	or audit, ment = <0% or major failings in whit is documented met / not met met - 7 days par week, partially met 5 days par week, met = systematic documentation used 90%, partially 90-90%, or no systematic documentation, unmet no met / not met met - notice documentation used 90%, partially 90-90%, or no systematic documentation, unmet no met / not met	2-Fuly met	Cedy 1 IGU Consultant
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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	
	unicar care unis interiore appropriate.			
3.13				
3.13	Legal Aspects of Capacity and Decision Making			
STANDARDS				
	Units must have regular, minuted, multidisciplinary team meetings to review cases where dispute have or may have arisen.			
1		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 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 aroups.	Statement		
4	Independent Mental Capacity Advocates (IMCA) should be consulted (in England and Wales) when a patient is 'unbefiniended'. 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 them is clinicitia about hest interests between the medical team and family.	Statement		

	CRITICAL CARE SERVICES: CLINICAL CARE	Level description	Level	Comments
4.1	Respiratory Support			
STANDARDS				
	Units must have access to sufficient modern invasive and non-invasive ventilators which will support pressure/olume ventilation, ittration of inspired oxygen concentration, support spontaneous ventilation and allow application of PEEP. Pulse oximetyr, capnography, ECG, blood pressure monitoring and ventilator alarms must be used for all ventilated patients	met / not met	2=Fully met	
-	Pulse ownetry, capnography, EUG, blood pressure monitoring and ventilatori alarms must be used for all ventilated patients whose traches is intubated. An accurate height must be measured on admission for every patient requiring invasive mechanical ventilation to calculate predicted body weath (PBW) and corresponding tracet tidal yolume to allow protective ventilation (Ronika PBW) in those with	met / not met	2=Fully met	
	ARDS or at risk of ARDS). Units must have evidence-based, written guidelines covering the use of non-invasive ventilation, the management of ARDS,	met / not met met - guidelines for all and review date within last 3 years , partially met - one or more guidelines missing	2=Fully met	
5	prevention of ventilator-associated one-umonia and wearing from ventilation (including the use of sectation). Referral pathways for patients with severe but potentially reversible acute hypoxaemic respiratory failure must be in place with Regional Extra corported Membrane Oxygenation-capable (ECMO) Centres.	or not reviewed within the last 3 years, not met - limited ouidlines and / or older than 3 years 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. Units must have immediate access to point-of-care testing to enable arterial blood gas analysis.	met / not met mer veo macrane or una or warar easy use, war a backup warar o nars or una or yr macrane, panaary = single ABG machine with backup machine 5-30 minutes away or 24/7 on call repairs within 30 mins, unmet	2=Fully met 2=Fully met	
		angle also introduce that backup interacting of the set	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	Tidal volume (mUkg PBW), plateau airway pressures and cumulative fluid balance should be monitored and recorded daily in all			
1	patients requiring invasive ventilation. Audit of compliance with ARDS, ventilator associated pneumonia and weaning guidelines should be undertaken quarterly.	met - all recorded daily, partially met - one / two not recorded daily, not met - more than two not recorded met / not met	2=Fully met 0=Not met	
3	Units should have standardised systems to monitor VAP rates and antibiotic resistance patterns. There is insufficient evidence at present to inform clinicians about the role of Extracorporeal Carbon Dioxide Removal (ECCO2R)	met / not met	1=Partially met	
4	in acute hypothesis 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			
	1			
STANDARDS	Level 3 units must have access to a regional home ventilation and weaning unit. Arrangements must be in place to which extinue memory extincts with generic efficiencies of feature inductions for tendence of arms estimate with some from	met / not met	1-Partially met	
2	collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex warains problems to the Realonal Centre Uhits must had multi-professional clinical governance meetings, including analysis of mostality and mobidity.	met / not met	1=Partially met	
RECOMMENDATIONS	Patients with potential weaning problems should be identified at an early stage of admission. Most will have significant		6 Euto -	
1	respiratory or neurological co-morbidiles. Patients with slowly deteriorating neurological conditions are at particular risk of wearing failure. Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing Patients should be managed by a multi-professional intensive care team with specialist expertise and experience in managing	met / not met	2=Fully met	
2	patients with weaning problems and consisting of senior medical, nursing, physiotherapy, speech and language therapy, and dietitian members. These patients should be managed in a consistent manner by the use of structured weaning plans, including sedation	met = full MDT routinely used, partial = 1-2 MDT professions not routinely involved met protocols in place and audided, partiality met = protocols in place but not audited, not met = no	1=Partially met	
4	management, based on agreed protocols. Early mobilitation and rehabilitation as likely to prevent weaning delay and failure. Units should have protocols in place and resources to croxide these services as described in the section of this document on rehabilitation (Chapter 3.8). The use of non-invisive ventillation (NV) as a bridge to synthancous breahing incluid be considered in selective groups.	protocols in place/not reviewed in last 2 years met / not met	2=Fully met	
5	The use of non-invasive verification (NV) as a bridge to spontaneous breaking should be considered in selective groups. Resources and skill in NVI should be available in all units manaina patient with chronion euromuscular Early discussion with regional cloralicitary verification services should occur in any patient with chronic neuromuscular impairment, and in those requiring more than 2 citarys or evaluation. Regional weaking centres should defer advice to referring	met / not met	2=Fully met 0=Not met	
	units to assist with weaning . The transfer of some patients with weaning delay and failure should be discussed with regional weaning/home-ventilation	met / not met / NA if no regional weaning service met / not met / NA if no regional weaning service	0=Not met	
	centres and protocols should be in place to aid these decisions.			
4.3	Renal Support			
	тыпа заррот			
STANDARDS	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	
	Unitial care units must make the necessary lactilities and expensive to provide acute NK1 for patients with Ak1 on a 247 basis. Patients receiving acute RRT, where the cause of AK1 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. Acute RRT for patients with progressive or severe AKI must be started before the onset of life-threatening complications	met / not met	2-Fully met	
4	associated with renal dvsfunction.	met / not met	2=Fully met	
RECOMMENDATIONS				
	The decision to initiate RRT should be based on the condition and prognosis of the patient as a whole, and not no isolated urea or creatinine values as per Kidney Diseases Improving Global Outcomes (KDIGO) recommendations and the NICE guideline. Where life-threatening complications of AKI occur, such as intractable hyperkialsemia, RRT should be started emergently unless	met / not met	2=Fully met	
2	a decision has been made not to escalate therapy. Patients with end-stage renal failure who are not in a renal unit/dialysis centre and require urgent RRT may require critical care	met / not met	2=Fully met	
	admission. In such cases, there should be close liaison with the regional renal service regarding transfer and vascular access. Continuous and intermittent RRT should be considered as complementary therapies for AVI. The choice of therapy should be based on patient status, expertise of the clinical stati 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	citrate anticoagulation should be available Met/unmet	2=Fully met	
7	using regional citrate anticoagulation for CRRT rather than heparin in patients who do not have contraindications for citrate.			
	using regional citrate anticoagulation for CRRT raher than heparin in patients who do not have contraindications for citrate. Bicarbonate, rather than lactate should be used as a buffer in dialysate and replacement fluid for acute RRT. Dwa doising may need advance whencer RRT is stated or the RRT recreation is altered. Close collaboration with an	met / Partially met = daily prescription chart but compliance not audited / not met		
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	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. Links should be made with regional centre provideo transiunular introhenatic nortoxystemic shurd (TIPSS) for natients with	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. Units that manage patients with liver failure should have 24-hour access to both diagnostic and therapeutic upper GI endoscopy	met / not met met = both, unmet if not available or no intervention available	2=Fully met	
10	service. 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.		2=Fully met	
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4.6	Cardiovascular Support			
STANDARDS				
1	Electrocardiography, chest X-Ray and transfloracic echocardiography (includes focused echo) although expertise may not be in unit and could be provided by other speciality 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. Protocols for immediate transfer to a facility able to provide percutaneous revascularisation of patients presenting a myocardial	met / not met	0-Not met	
5	Process of immediate fails and in a subject of provide percuraments in the subject of patients presenting a myocardial infarction must be in place. The intensive care team must facilitate the implementation of national standards, guidelines and pathways pertaining to the	met / not met met / not met	1=Partially met	
6	patients with a cardiac disease, to be delivered in addition to the other organ support being provided. 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 cardicthoracic surgical unit.	met / not met	1-Partially met	
	de galdeo in consolitation won a rocal cardidogist and the specialist cardidonation surgical dim.		1 1	
RECOMMENDATIONS	A validated method for advanced haemodynamic assessment with a skilled operator in both the practical use of the device and			
2	A variated mentor or avariate need of avariate assessment with a same operator in our ne practical use of the device and interpreting the data it provides should be available at all times. An intra-aortic balloon pump should be available (in consultation with local/regional cardiology team). This may require transfer	met / not met met / not met	2=Fully met 0=Not met	
3	to another centre. Local protocols in the use of vasoactive drugs should be in place, although there is little evidence to support the use of any	met / not met	2=Fully met	
	single agent in practice.		1	
4.7	Echocardiography and Ultrasound			
STANDARDS				
STANDARDS	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. Ultrascound equipment must be readily available, serviced regularly and up to date. There must be sufficient equipment to	met / not met met-immediate availability (ie on unit) of ultrasound machine for vascular access and raoid access of	0=Not met	
5	Ultrasound equipment must be readity available, serviced regularity 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 reoured 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 exholung ultrasound / partially = not all elements eg only 1 machine on a large unit / not all scrobe types/ not met	2=Fully met	
6	Infection control measures must be adhered to at all times. The disinfection and storage of transcessophageal echocardiography probes must follow national guidelines. A record must be	met / not met	2=Fully met	
7	retained in order to identify and track patients after device usage in the event of future complication/infection. All images must be securely stored for quality assurance purposes with appropriate data governance. Reliance on the	met / not met / not applicable ( no TOE) met = all images are stored, reviewed by trained echo specialist and uploaded to PACS, partial = uploaded	2=Fully met 0=Not met	
8	ultrasound machine storage capacity is not a secure method. Whenever scans are performed to inform clinical decision making, a structured report must be generated and stored in the	but not reviewed or reviewed but non centralised storage, unmet = images not safely archived in PACS met = structured report and audited, with > 90% compliance, partially met reported but not structured, not	0=Not met	
10	patient record. Training scan reports must not be stored in the patient record unless someone suitably trained verifies the document first.	audited or < 90% compliance . not met = < 50% reported/documented in notes 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	Transcesciphageal 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	
ECOMMENDATIONS				
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. Individuals should not report scans beyond their level of accreditation, but should participate in a training programme, leading to	met / not met met / not met	3=Not applicable to Unit 3=Not applicable to Unit	
6	more advanced accreditation. 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	met / not met	3=Not applicable to Unit	
7	department, as appropriate. Reports should be net wire tocused nature or the investigation and the clinical context. Scans undertaken as part of training should not be archived before they have been verified by a trainer. Regional networks and electronic image transfer systems should be created to allow for prompt access to review scans by a	met / not met	3=Not applicable to Unit	
8	specialist with Level 2 accreditation, or equivalent, when this is required. Consideration should be given to the development of fully qualified physiologists with dedicated intensive care commitment and	met / not met / not applicable	3=Not applicable to Unit	
9	experience under joint supervision to deliver echocardiography services within intensive care. Regular replacement of ultrascound equipment is required to ensure it remains up to date. Normal guidance states that electrical equipment is replaced every seven years, however ultrascound equipment may need to be updated more frequently to keep up	met / not met	0=Not met	
	experience under joint supervision to deliver echocardography services within intensive care. Regular replacement of ultrasound equipments in required to exure it remains up octan. Normal guidance states that electrical equipments is replaced every seven years, however ultrasound equipment may need to be updated more frequently to keep up with technological advances.	met / not met		
	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	met / not met		
9 4.8	Regular replacement of ultrasound equipment is required to ensure it remains up to date. Normal guidance states that electrical expirament is registed every server years, however ultrasound equipment may need to be updated more frequently to keep up with technological advances.	net / not met		
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STANDARDS				
	Any critical care unit that admits antenatal women over 20 weeks' gestation must have rapid access to obstetric and paediatric			
1	services able to attend in an emergency. There must be a clear plan and equipment immediately available for performing a peri 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 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	prenamt women admitted to critical care at least once in event twenty-four hour period. 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 serior neonatologist or paediatriciam 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	met / not met	3-Not applicable to Unit	
5	anaesthesia). Breast feeding (including the use of breast pumps) must be encouraged and supported in all post-natal women admitted to	met / not met	3-Not applicable to Unit	
6	critical care. Women who require care that falls outside Enhanced Maternal Care (EMC) must be referred as soon as possible to the general	met / not met	3-Not applicable to Unit	
7	critical care service. The route of escalation to critical care services must be clearly defined. 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	
	THE AMENDATION CONTINUES TO THE INCLUSING SHEET & SOURCE AT A SUBJECT AND THE UNIT AND STREET IN BOUL			
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	considered for transfer to a realonal or sucra-realonal initical care unit with experience in MCC. Physical contact between a mother and her baby should be maintained during post-inatal critical illness, even if the mother is unconscious. This contact and other events of the admission should be recorded in a critical care dary which can be used in	met / not met	3=Not applicable to Unit	
3	psychological rehabilitation after critical care or in bereavement counseling. 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 form a critical activity and provide a strategies and activity of the strategies of the strategies and the	met / not met	3-Not applicable to Unit	
4	which includes inou from a clinician with experience in critical are follow-ue. Recognition of EMC should be incorporated into midwifery pre & post registration curricula and feature in obstetric, anaesthetic and critical case training programmers.	Statement		
5	and critical care transp programmes. Healthcare professionals locking 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	Obstetic 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. MCC quality inductors should be monitored, using data reported through the IDMRC Case Mix Programme and the Scottish MCC quality inductors should be monitored, using data reported through the IDMRC Case Mix Programme and the Scottish MCC quality inductors should be monitored, using data reported through the IDMRC Case Mix Programme and the Scottish MCC quality inductors should be monitored, using data reported through the IDMRC Case Mix Programme and the Scottish MCC quality inductors should be monitored.	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 III Child in an Adult Critical Care Unit			
STANDARDS				
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	met / not met	3-Not applicable to Unit	
1	unavailable, or when there is an expected short duration of critical care e.o. an older child with overdose or alcohol excess. Admission must be discussed and agreed by the local consultant in Intensive Care Medicine, local consultant paediatrician and	met / not met met / not met	3=Not applicable to Unit 3=Not applicable to Unit	
3	the consultant in caediatric Intensive Care Medicine (this may be the regional paediatric transport team consultant). A nominated lead intensive care consultant and lead nurse in the adult critical care unit must be responsible for intensive care	met / not met	3=Not applicable to Unit	
4	An adduct critical care unit that may provide care for critically ill children must have an appropriately equipped area for providing adduct critical care unit that may provide care for critically ill children must have an appropriately equipped area for providing adduct in the second s	met / not met	3-Not applicable to Unit	
5	basediatric critical care. 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	met / not met	3-Not applicable to Unit	
6	provided by anesthetists of notes plasma plasma in the apport and advanced many managements. Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer of critically ill children and the provision of	met / not met	3-Not applicable to Unit	
	paediatric critical care must be available. Escalation, end of life and organ donation decisions must be discussed in collaboration with the regional consultant in			
7	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 number adults.	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		F		
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 III 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	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/kp PBW.	compliance < 90%, un met = no quideline or compliance < 50% met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 90% un met = no quideline 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 delinium using a validated method such as the Confusion Assessment Method for the ICU (CAM-ICU) or the Intensive Care Delinium Screening Checklist (ICDSC).	met / not met	2-Fully met	
7	Method for the ICul (CMM-ICul) or the Intensities Care Delinium Screening Checklist (ICDSC). Howeling intensical catheties must be inspected ability for evidence of infection using a suitable scoring system e.g. Visual Infusion Philebitis 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% met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or	2=Fully met	
8	The continued need for indwelling catheters (intravascular or urinary) must be considered daily. Monitoring of invasively ventilated patients must include continuous waveform capnography.	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. 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 met / not met	2=Fully met	
10	and maintenance, and Peripheral Venous Cannula (PVC) insertion and maintenance.	HIRA F INA HIRA		
RECOMMENDATIONS				
1	For patients without ARDS, a tidal volume of 4-8 mis/kg PBW and a peak/plateau pressure (depending on mode) of below 30 cmH20 should be targeted.	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or compliance < 00%, up met = no guideline or compliance < 60%.	2=Fully met	
2	cmH20 should be targeted. A ventilated patient care bundle should be in place with appropriate mechanisms for ensuring adherence.	compliance < 90%, un met = no guideline or compliance < 50% 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	met / not met	2=Fully met	
7	nutrients)). All sedated patients should have sedation levels monitored hourly using a scoring system such as the Riker Sedation-Agitation	met = guideline and audit data to show compliance > 90%, partially met = guideline but no audit or	1=Partially met	
8	Scale or the Richmond Agitation-Sedation Scale to ensure sedation is minimised. Noise levels and patient interventions should be minimised overnight to facilitate natural sleep.	compliance < 90%, un met = no guideline or compliance < 50% 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	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	paratimeter and applied for the mark and modely, tachaneses arome, marmanic chain signal with detection activations, or active centering syndromes. Critical care units should consider standardisation of drug concentrations in line with FICMICS guidance.	compliance < 90%, un met = no guideline or compliance < 50% met / not met	2-Fully met	
10	Chinal care units should consider standardisation of drug concentrations in line with FICAWICS guidance.	Inter / nov. Inter	2-r ony mex	

	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 standards.	met / not met or not applicable	2=Fully met	
2	Critical care units should participate in research networks, which are organised at Local Clinical Research Network (LCRN) 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. Critical care units participating in research should provide information to patients, relatives, and surrogate decision-makers (SDMs)	met / not met or not applicable met / not met or not applicable	2=Fully met	
5	about oncoine research, for example through posters, leaflets, or within generic intensive care information resources. 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		F		
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. Critical care units must participate in a National Audit Programme for Adult Critical Care, such as the Scottish Intensive Care Society	met / not met met / not met	1=Partially met 2=Fully met	
	Audit Group (SICSAG) or Intensive Care National Audit and Research Centre (ICNARC) programmes. Critical care units must have a surveillance system in place for audit and feedback of nosocomial infection, for example, catheter- related bacterateria and other blood stream infections renorded to the patiental exchere where anolicable. Critical care units should			
3	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 (ICCQIP) and Scottish nosocomial infections in ICU audit eronamme.	met / not met	0-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 admisisons - met <2% partially met, 2-4% not met>4%	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 lob plans of all intensive area streff (medical quartien nohmacistic healthcan encloseionals and and cillar staff)	met/ unmet	0=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	met / unmet	1=Partially met	
3	Isilow reconsised quality improvement methodology. 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	Audits 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.	Inter - rooust data contection and reestock for som local and hasonal austr, partially met - rooust data collection and feedback for national audit only, not met - no robust systems for data collection or 	0=Not met	
5	Ortical Care Networks should have a formal, multi-professional, pee-review programme in place for the units in their jurication. Peer reviews should be based on published national standards, but are likely on their areas that are agreed locativ, All ortical care with must measure and report their delayed discharge, out of hours discharges, non-chinal transfers and	met / not met / not applicable Met - submit all data to ICNARC / SICSAG data tools, patially met - one or more data submissions	2=Fully met	
6	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.	missing, not met - poor data compliance with ICNARC / SICSAG	z-Funy mitt	l
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	met / not met	2=Fully met	
2	Inst be the clinical lead or clinical director for critical care. 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 reports to incidents. Units should also learn from things that go well, a process described in	met / not met	2=Fully met	
3	excellence reporting. Units must hold regular structured multidisciplinary clinical governance meetings, where they discuss unit morbidity and mortality, inclusion all deaths critical incidents and near misses. A written record of actions taken and lessons learnt should be kent and a	met - meets full standard with minimum of quarterly meetings, partially met - meets standard but less	0-Not met	
	including all deaths, critical incidents and near misses. A written record of actions taken and lessons learns should be kept and a trendy and reliable methods for dissemiation of shared learning should be in place. There should be dear structures in place for dissemination lindings to staff, and deficiencies in care should lead to measurable chance. Regular feedback must be obtained from service users and staff about the quality of care delivered, for example by the use of safety	than quarterly, unmet - doesnt meet the standards met - undertake critical care led staff safety and relative surveys at least once a year, partially met is		
4	surveys and relatives' questionnaires. Critical care units must participate in a mortality review programme using appropriate methodology to maximise learning and	The set undertable chicks can be needed as a safety and relative surveys at reads once a year, partially net is less frequently or only one group surveyed. Not met = no patient or staff survey met = mortality review process that includes all deaths in ICU. / not met	0=Not met	
6	improvements in care. Appropriate actions must be taken whenever preventable factors are found. 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 compliments). Staff must also be able to easily access important information to inform patient care (for example information about medications and unit policies)	met / not met	2=Fully met	
8	whenever needed. Staff who have to conduct reviews of patient safety incidents, root cause analysis and appreciative enquiry must be trained in the	met / not met	2=Fully met	
•	management of these processes so that the reviews are conducted sensitively and constructively. Similarly, effective quality morevement requires staff that are trained in ouality increvement methodoloov. Each unit must have local safety standards for invasive procedures (including tracheostomy, bronchoscopy, central line and chest	met / not met	2#Pully liter	
9	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 stately briefing and time out, and a sign out and debriefing. An example of this process	met / not met	2=Fully met	Critical care LocSSIP in place
10	is the NHS Enoland Safety standards for invasive procedures. 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	Intensive care staff should work with other clinical teams in the hospital with respect to joint learning from morbidity and mortality		0-Not met	
2	Inview and ensuring best practice around handovers of care. Units should regularly review guidelines from professional organisations and other sources of evidence to ensure that the unit complex with best practice. These evidence sources should be translated into comprehensive locally agreed guidelines or Standard	met - done quarterly, partially met, done annually, not met, not done - use comments box met - annual review, partially met, 1-2 yearly review, not met - less than 2 yearly / not reviewed	1=Partially met	
3	Compared with read-placed. These detectes advected and be unsingled minor comparement reading agreed gradientical detection of the service. Such KPIs may be generic and The unit should identify key performance indicators (KPIs) that describe outcomes of their service. Such KPIs may be generic and common to more units, such as complication rates, e.g. delinium rates, pain scores or pressure scores. Alternatively, these may be unit the second score of the secon	met / not met	0=Not met	
4	cominan or most rains; sourd as companiadon raits; egi, deminant raits; juan sourdis to pressure sours. Aremanny, errise many oe ean specific, for example raites of energiency threatodown on cardiac critica are units. Staff should be recognised as the key resource in intensive care. A fully engaged, nell-individed well-trained and well-led worldrore is essential to allow excellence in inticical care to fource its. Staff should be resonantion from appraisal, staff	Met = all staff wellbeing criteria stated are monitored, partially met = some criteria are monitored, not	1=Partially met	
4	feedback and exit interviews should all be monitored to ensure staff welfare. Units should work with other units within their network, and nationally, to share learning, disseminate best practice, quality	met = none of criteria are monitored.	1=Partially met	
5	improvement and for benchmarking and peer review purposes. The governance of critical care units is rightly audited by outside agencies, including intensive care networks. The external responsibility for the oversight of governance arrangements varies between the devolved nations.	met = Units participate in Network led program to share best practice and QI/ not met	2-Fully met	Follow up national & WICIS 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	0=Not met	
5.4	Critical Care Networks			
	*These may not be applicable for countries which do not have networks			
STANDARDS	Critical care ODNs must support the activity of provider healthcare organisations in service redesign and delivery of the			
1	commissioned pathway, quality improvements, innovation and standardisation of clinical practice. They provide a mechanism for peer review and benchmarking self-assessment in the network. Collical care ODNe must summar commissioners in the delivery of their commissioning functions, through creating and delivering	met / not met / not applicable	2=Fully met	
2	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 improvement.	met / not met / not applicable	3-Not applicable to Unit	
3	Critical care ODNs must support delivery of a resilient critical care service within a geographical area to meet emergency			
	preparedness requirements. Each provider of adult critical care must engage, contribute and participate in activities of their local critical care ODN and will	met / not met / not applicable	2-Fully met	
4	preparatives requirements. Each provider of adult child call are insut 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 0.1% COUNt top site, but (SegueBage).	met / not met / not applicable met / not met / not applicable	2-Fully met	Unsure of funding
4	preparedness requirements. Each provider of adductricical 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 0.1% CQUIN top site, but may be supplemented by local agreements made in conjunction with keys takeholdres through the ODN ExecutiveOversight			Unsure of funding
	programments requirements. Each provider of add trickic alter emust 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 0.1% COLINI to gites, but may be supplemented by local agreements made in conjunction with key stakeholders hrough the ODNE texeutive/Densight Group.Beand. The interestic care team in provider organizations must engage, contribute and participate in a critical care ODN, including audit	met / not met / not applicable	2=Fully met	Unsure of funding
5	programmers requirements. Each provider dark for contrast encode of section and participant is advanced that load include and approximately advanced to the section of the section and the se	met / not met / not applicable	2=Fully met	Unsure of funding
5	programment requirements. Each provider data citical are must engage, contribute and participate in activities of their local critical care GNN and will care be applied indiced of the local ODN through a nationally agreed mechanism. The is carried by ODN Excluding the table of counciliarial framments and the local agreement mechanism of council on the local schedule and the ODN Excluding work where the framment of the local agreement mechanism of council on the local schedule and participate in a critical care ODN, including audit and where care team in provider organisations must engage, contribute and participate in a critical care ODN, including audit and where care team in provider organisations must engage, contribute and participate in a critical care ODN, including audit arbitry, provider and quality provident agrocesses.	mel / not mel / not applicable mel / not mel / not applicable	2=Fully met	Unsure of funding
5 RECOMMENDATIONS 1 2	programments resultments. Exception of the second	met / not met / not applicable	2=Fully met	Unsure of funding
5 RECOMMENDATIONS 1 2 3	programments resultments. Each provider data discuttaria et rocal ONE-provider and a participande na in advalland of data (local critical area COM and area taba) provider data discuttaria et rocal ONE-provider is automality adjaced and in advalland of data (local critical area COM) and and provide adjaced and and and and and and and and and an	md / not me / not applicable md / not me / not applicable not / not me / not applicable md / not me / not applicable md / not me / not applicable md / not me / not applicable	2=Fully met	Unave of funding
5 RECOMMENDATIONS 1 2	programments resultments. Each provider data due that in most engage, controller and participate in a statistical of and load order are CON and all tables provider data due that in most engage, controller and participate in a statistical of and load order are CON and all from Blanch. The intensis can stars in provider organisations must engage, controlse and participate in a critical care CON, including audit and the intensis can stars in provider organisations must engage, controlse and participate in a critical care CON, including audit and the intensis can stars in provider organisations must engage, controlse and participate in a critical care CON, including audit and the intensis care stars in provider organisations must engage, controlse and participate in a critical care CON, including audit additist, pare review and quality incomment providers agringers for the sharing of best practice and increadings. CONs should all organisation of participate in a critical care CON, including audit additist agrin engage of the sharing of best practice and increadings. CONs should all organisation of participates in a sharing best practice and increadings. CONs should all organisation of participates in the sharing of best practice and increadings. The attempt of the sharing of best practice and increadings. CONs should be the dentes of engineeries improvements to marken participate care, existing the destine of additional engineeries interprocess through callations of destine and incluse and antimized. CONs should be the comparison of advices. The all allow for more load destined and critical are units, and engineerised improvements. The should appear he wide hospital physics, to include destination of advices, whith magnetismized or equilary and effectiveness through callations of advices. The should be allowed to the comparison of advices advices and participates in the should be adviced of advices are units, and ensite in hospitate and the communities. CONs should cone an experiment and does no	met / not met / not applicable	2=Fully met	Unave of funding
5 RECOMMENDATIONS 1 2 3 4 5	programments resultments. Each provider data disc in derived CAPP of the standard participant in statistical of derived view of any CAP set all the statistical data disc in the statistical data data data data data data data da	me / not me / not applicable med / not me / not applicable	2=Fully met	Unsure of funding
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5 RECOMMENDATIONS 1 2 3 4 5	programments resultments. Exception of the second of the second ONE second sec	me / not me / not applicable med / not me / not applicable	2=Fully met	Unsure of lunding
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RECOMMENDATIONS			
	These recommendations may not be applicable to those units outside of England and Wales		
1	Collection of all 34 fields in CCMDS is recommended. This should be done by dedicated trained personnel.	met / not met	3-Not applicable to Unit
2	There should be clinical oversight of the CCMDS data entry/data submission to ensure accuracy of data.	met / not met	3-Not applicable to Unit
		met / not met	3-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	3-Not applicable to Unit
5	A lead commissioner should be identified with a commissioning forum for each critical care service.	met / not met	3-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. 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	Met or unmet	2=Fully met	
2	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 As
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. Units must have a major incident plan in place which allows for the transfer in of multiple critical care patients from a neighbouring	met / not met / not applicable	3=Not applicable to Unit	
6	hospital's critical care unit should it need to carry out an emergency evacuation. Any problem with oxygen cylinders and associated equipment must be reported immediately to both the medical gas supplier and the	Met / unmet Met / unmet	2=Fully met 2=Fully met	Major Incident plans in place, along with Business Continuity plans. Activity 18 m
8	Medicines and Healthcare products Regulatory Authority (MHRA). All staff must undergo regular training in free 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 exinguishers within their unit and which type to use in the event of a fire. Medicai and serior nursing staff must also know the	met = > 90% of staff compliant , partially met > 75%,, not met < 75%	2=Fully met	
9	The examplashed what there use and what there is used to be in the events of a mice, we used an able what and what also have the location of the medical ass plottings what off values in their unit, how to operate them and the implications of doing so. 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 A
RECOMMENDATIONS	Evacuation policies should include liaison with the Bronze (Operational), Silver (Tactical) and Gold (Strategic) commanders in conjunction with the environ fire officer on scene. Timice of execution is convict if execution occurs to early then patients may be		1=Partielly met	Fire evaruation plan discusses I intern with boshing fire
2	conjunction with the serior fire officer on scene. Timing of evacuation is crucial: if evacuation occurs to 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. Local fire evacuation policies should be tested regularly, ideally as part of a simulation scenario. Evacuation at night should also be reactined.	Met - tested annually , partially met tested daytime only and / or less than annually, unmet, not tested in the last 2 years	1=Partially met 0=Not met	Fire evacuation plan discusses Liaison with hospital fire response team.Patient Fire evacuation exercises have been requested from the fire team. Current Co
3	practised. 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.	the last 2 years 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 il 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. Laison with	met / not met / not applicable	3=Not applicable to Unit	Local BCP and Major Incident plans apply
	neighbouring units and local ambulance services at an early stage is advised.			
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 venilated capacity and to maintain this for up to 96 hours. All norminated supporting hospitals with Level 3 critical care capability must be prepared to double their normal capacity for Level 3 beds	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 Met - plans in place to do this - partially met - plans in place but dont meet this standard ( comments box	0=Not met 0=Not met	innadequaute logistics to double capacity
3	for general use and to support the decant of patients from other receiving hospitals. All hospitals with intensive care capacity must have in place plans to support the retrieval or transfer of patients; supporting hospitals	here) unmet - no plans in place to meet this standard Met / unmet		Inadequate logistics to double capacity Network call
4	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. All hospitals must have an evacuation and shelter plan that includes evacuation and shelter of highly dependent patients, including but		1=Partially met	
5	not exclusively intensive care patients, should the intensive care areas become unusable for any reason. All hospitals must have a lock down plan that includes all intensive care areas, preventing unauthorised access.	Met / unmet	2=Fully met	Patients will be taken to Theatres/Recovery or the day surgery unit depending 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.		2=Fully met	Business Continuity plans in place.Dedicated Pschologist working in Critical Ca
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	
DECOMPENDATION OF				
RECOMMENDATIONS	Intensive care leads should work closely with the Healthcare Organisation Emergency Preparedness, Resilience and Response (EPRR), the descent devices of the standard closely benefit execution or made exactly close	met / ummet	0=Not met	
2	Intensive care should have access to emergency planning and response training including strategic/crisis leadership. Intensive care service staff should participate in the local and regional multidisciplinary exercises including 'table top' and 'live' exercises	met / unmet met / unmet - within the last 2 years	0=Not met	
	to further refine local and regional plans and communication routes between organisations and networks. Intensive care leads should work with their EPRR team to facilitate exercises in the evacuation of very dependent patients from any part of their benefits. This repeated include area intendent used of the leads are used as a function of the strength of the depine.		0=Not met	
4	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. Intensive care staff should be prepared to take a central leadership role in any major incident and should be prepared to send teams	met / unmet - within the last 2 years		
5	forward' to the Emergency Department, as well as any preoperative hold areas and recovery. The plan to double the number of intensive care beds should include an inventory of where equipment is to come from, where the beds	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	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. Advance consideration of staff workforce requirements, including mutual aid from colleagues in neighbouring hospitals should form part	met / unmet	0=Not met	Inadequate logistics to double capacity
7	Advance consideration or start workforce requirements, including mutual allo from colleagues in neighbouring nospitals should form part of the intensive care service planning. Staff welfare should be actively supported during an incident and critical care staff access to informal, immediate debrief or later formal	met / unmet	2=Fully met	
9	counseiling. 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 - plan in place , unmet - no plan in place met - within plan , unmet - not in plan	2=Fully met 0=Not met	
6.3	High Consequences Infectious Diseases: Initial Isolation and Management			
STANDARDS				
1	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	A second dense in Association (Second Marillan 1997)			
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. A clinical area where critically ill patients with suspected high consequence infectious diseases may be isolated, either within the unit or	met / unmet	2=Fully met	
2	A unit all area where charany in patients with subjection in an observation in the measurement of the source of th	met / unmet	2=Fully met	
3	single use where possible. Training should be provided on a regular basis to ensure critical care staff are familiar with using and safely removing the PPE provided.	met - within a plan to do so, unmet - no plan met - annual fit testing done unmet - not annual fit testing	2=Fully met 2=Fully met	
5	This should incorporate annual fit testing of respiratory protective equipment (e.g. FFP3 masks). 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 - winnan in testing oone unmet - no plan 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 independent is reacting with local properties.	met - local procedure in place, unmet - no local procedure	0=Not met	
8	undernament, in receiption with Cean Documes. Patients with suspected airborne HCDs should be risk assessed according to national guidelines where they exist (disease-specific e.g. MERS guidance collections3.4 or generic airborne HCD guidelines, as appropriate). Following recognition of a patient with a suspected HCDI: a) local infectious disease and/or microbiology and virology services should	met - local procedure in place, unmet - no local procedure	2=Fully met	
9	be notified and advice sought, including guidance on obtaining appropriate diagnostic clinical specimens, b) Local clinicans should liaise with the imported Fever Service (note this service is available to clinicans 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 quidance (disease-specific or generic HCID quidance).	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 serior clinical staff should develop plans and checklists for scenarios such as: a) supply chain disruption (road/uel crisis, extreme weather, industrial action or civil disturbance), b) Infrastructure fallures (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 no un of trist if supplemented.	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 optiming theatres, recovery and augmented higher care areas, or upgrading Level 2 critical care areas to permit mechanical ventilation and Level 3 care.		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	

# **Critical Care Activity Data Review**

Contents Background	2
Temporary Service change:	2
Critical Care Admissions	2
Bronglais Hospital admissions August 2018 to July 2023	2
Glangwili Hospital admissions August 2018 to July 2023	2
Prince Philip Hospital admissions August 2018 to July 2023	3
Withybush Hospital (High Dependency Unit) admissions August 2018 to July 2023	3
Withybush Hospital (Intensive Care) admissions August 2018 to July 2023	3
HDdHB Critical Care admissions August 2018 to July 2023	3
Breakdown of admissions by levels of care by hospital	ł
Bronglais Hospital by level 2018 - 2023	ł
Glangwili Hospital by level 2018 - 2023	ł
Prince Philip Hospital by level 2018 - 2023	5
Withybush Hospital (Intensive Care) by level 2018 - 2023	5
Hywel Dda by level 2018 - 2023	5
Admissions by source – Overview	5

#### 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.

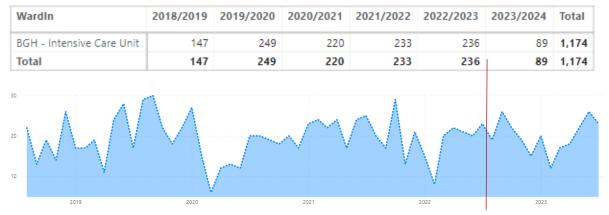
#### Temporary Service change:

On 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.

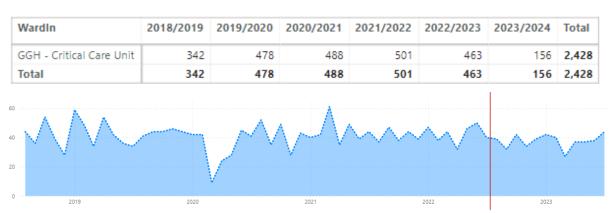
This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

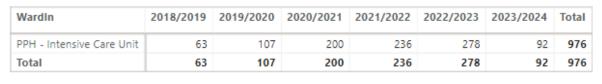
### **Critical Care Admissions**

#### Bronglais Hospital admissions August 2018 to July 2023

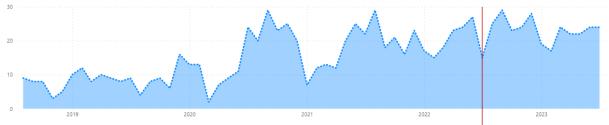


#### Glangwili Hospital admissions August 2018 to July 2023



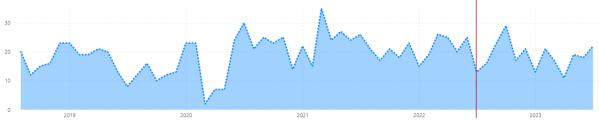


## Prince Philip Hospital admissions August 2018 to July 2023



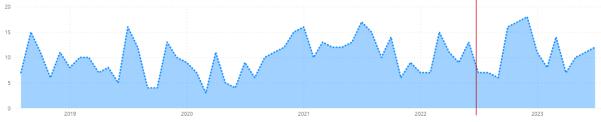
Withybush Hospital (High Dependency Unit) admissions August 2018 to July 2023

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
Total	147	173	248	261	240	70	1,139



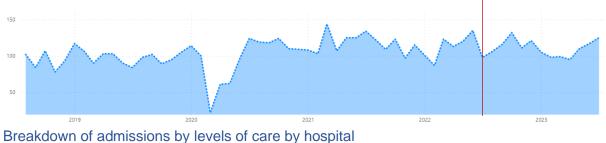
Withybush Hospital (Intensive Care) admissions August 2018 to July 2023

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
Total	78	98	122	137	137	40	612



HDdHB Critical Care admissions August 2018 to July 2023

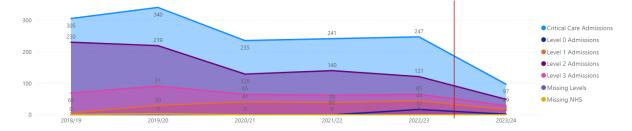
WardIn	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
BGH - Intensive Care Unit	147	249	220	233	236	89	1,174
GGH - Critical Care Unit	342	478	488	501	463	156	2,428
PPH - Intensive Care Unit	63	107	200	236	278	92	976
WGH - High Dependency Unit	147	173	248	261	240	70	1,139
WGH - Intensive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



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.

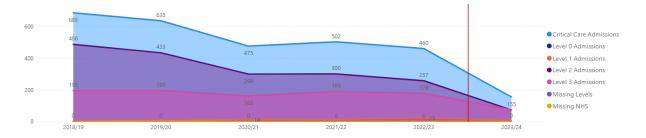
Metric	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Critical Care Admissions	305	340	235	241	247	97	1465
Level 0 Admissions	0	0	0	0	17	2	19
Level 1 Admissions	6	30	41	39	44	17	177
Level 2 Admissions	230	219	129	140	121	49	888
Level 3 Admissions	69	91	65	62	65	29	381
Missing Levels	0	0	0	0	0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

## Bronglais Hospital by level 2018 - 2023



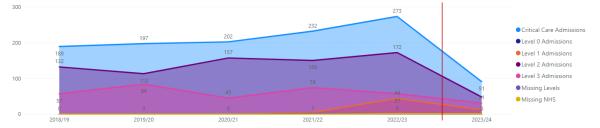
## Glangwili Hospital by level 2018 - 2023

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



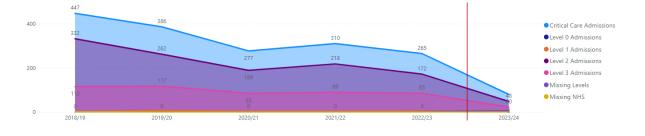
# Prince Philip Hospital by level 2018 - 2023

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



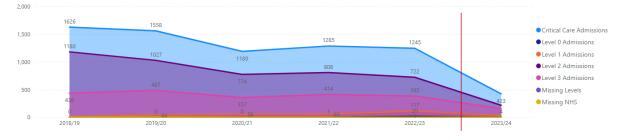
# Withybush Hospital (Intensive Care) by level 2018 - 2023

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



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

# Hywel Dda by level 2018 - 2023



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.

	A&E / AMAU	(French Decar)		Internal (InPatient) Inside HDdUHB						External (Transfers) Outside of HDdUHB				
	AGE / AMAU	(Front Door)			Internal (InPatient	) Inside HDdUF	B		Exte	rnal (Transfers	) Outside of HDdu	нв		
Site	Emergency	%	Ward	%	Theatre	%	Other routes	%	Critical Care Units	%	Another Hospital	%		
ronglais Hospital	379	36%	197	19%	428	41%	40	4%	7	1%	1	0.1%		
langwili Hospital	637	32%	557	28%	621	31%	47	2%	142	7%	10	0.5%		
rince Philip Hospital	184	20%	395	42%	299	32%	6	1%	45	5%	2	0.2%		
Vithybush Hospital	477	41%	367	31%	308	26%	0	0%	19	2%	0	0.0%		
otals	1677	32%	1516	29%	1656	32%	93	2%	213	4%	13	0.3%		
Frand Total	16	77			32	35			226					
	-								-					
			HD	dUHB - Admissi	on Routes Analys	is (as at 1st Au	gust 2019 - 31st Ju	ily 2023)						
	A&E / AMAU	(Front Door)		Internal (InPatient)					External (Transfers)					
fotal %	32	32% 63%					4%							

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

# **Critical Care Incident Data Review**

Contents Background	3
Incidents	
All sites (1st August 2018 – 31st March 2021)	4
All sites (1st April 2021 – 31st July 2023)	4
By Location (1st August 2018 – 31st March 2021)	5
By Location (1st April 2021 – 31st July 2023)	
By Severity/Level (1st August 2018 – 31st March 2021)	6
By Severity/Level (1st April 2021 – 31st July 2023)	6
By Type (1st August 2018 – 31st March 2021)	7
By Type (1st April 2021 – 31st July 2023)	8
Bronglais Hospital (1st August 2018 – 31st March 2021)	9
By Severity/Level	9
Bronglais Hospital (1st April 2021 – 31st July 2023)	9
By Severity/Level	9
Bronglais Hospital (1st August 2018 – 31st March 2021)	10
Ву Туре	10
Bronglais Hospital (1st April 2021 – 31st July 2023)	11
Ву Туре	11
Withybush Hospital (1st August 2018 – 31st March 2021)	12
By Severity/Level	12
Withybush Hospital (1st April 2021 – 31st July 2023)	12
By Severity/Level	12
Withybush Hospital (1st August 2018 – 31st March 2021)	13
Ву Туре	13
Withybush Hospital (1st April 2021 – 31st July 2023)	14
Ву Туре	14
Glangwili Hospital (1st August 2018 – 31st March 2021)	
By Severity/Level	
Glangwili Hospital (1st April 2021 – 31st July 2023)	15
By Severity/Level	
Glangwili Hospital (1st August 2018 – 31st March 2021)	
Glangwili Hospital (1st April 2021 – 31st July 2023)	
Ву Туре	
Prince Philip Hospital (1st August 2018 – 31st March 2021)	
By Severity/Level	18

Prince Philip Hospital (1st April 2021 – 31st July 2023)	
By Severity/Level	
Prince Philip Hospital (1st August 2018 – 31st March 2021)	
Ву Туре	
Prince Philip Hospital (1st April 2021 – 31st July 2023)	
Ву Туре	19

## 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



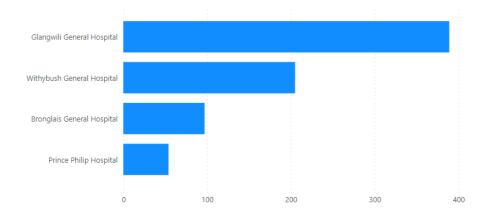
							Au	Se	0	No	De	
							g	р	ct	V	С	201
							18	18	18	18	18	8
							28	23	27	21	14	113
						J						
Ja	Fe	Ma	Ар	Ма	Ju	ul	Au	Se	0	No	De	
n	b	r	r	у	n	1	g	р	ct	V	С	201
19	19	19	19	19	19	9	19	19	19	19	19	9
						2						
29	23	40	20	31	25	9	28	21	22	22	15	305
						J						
Ja	Fe	Ма	Ар	Ма	Ju	ul	Au	Se	0	No	De	
n	b	r	r	У	n	2	g	р	ct	V	С	202
20	20	20	20	20	20	0	20	20	20	20	20	0
						2						
22	21	15	13	13	20	2	25	21	24	24	19	239
Ja	Fe	Ма										
n	b	r										202
21	21	21										1
38	31	19										88
			•									122
												E

40 20 0 Jul 2021 Jan 2022 Jul 2022 Jan 2023 Jul 2023

			Ap r 21	Ма у 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	Ма у 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	Ма у 23	Ju n 23	J ul 2 3						202 3
29	13	26	18	28	27	2 4						165 <b>702</b>

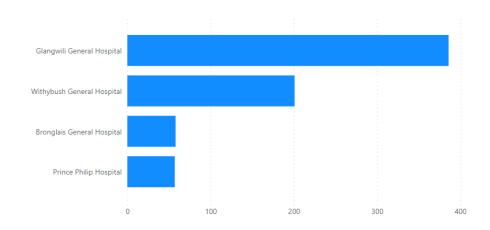
All sites (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

5



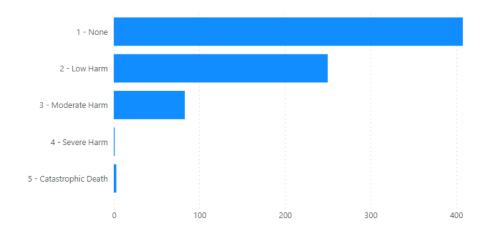
#### By Location (1st August 2018 – 31st March 2021)

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



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

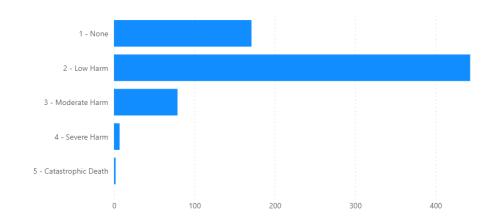
Primary Location	Count
Glangwili General Hospital	386
Withybush General Hospital	201
Bronglais General Hospital	58
Prince Philip Hospital	57



By Severity/Level (1st August 2018 – 31st March 2021)	)
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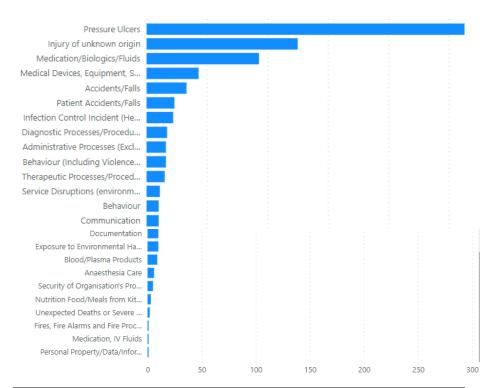
Severity	Count
1 - None	408
2 – Low Harm	250
3 – Moderate Harm	83
4 – Severe Harm	1
5 – Catastrophic Death	5

#### 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

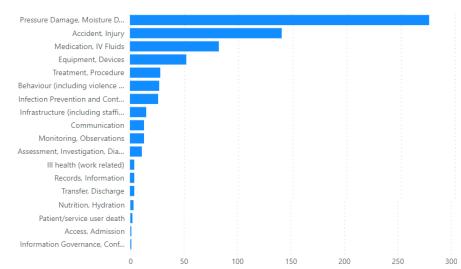
#### By Type (1st August 2018 – 31st March 2021)



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

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

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

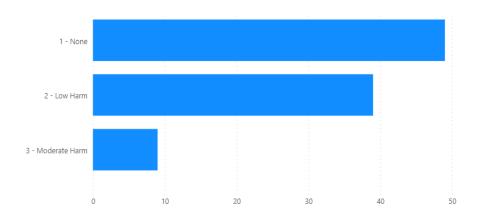


Incident type tier one	Count
Pressure Damage, Moisture Damage	276
Accident injury	140
Medication IV fluids	82
Equipment, Devices	52
Treatment, Procedure	28
Behaviour (including violence and aggression)	27
Infection prevention control	26
Infrastructure (including staffing, facilities, environment)	15
Monitoring & Observation	13
Communication	13
Assessment, investigation, diagnosis	2
III 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)

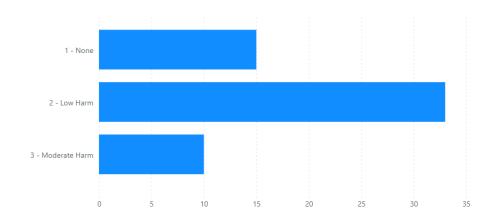
#### By Severity/Level



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)

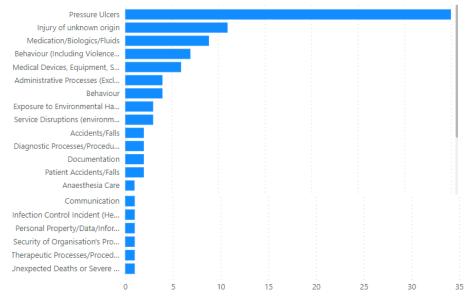
#### By Severity/Level



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)

#### Ву Туре

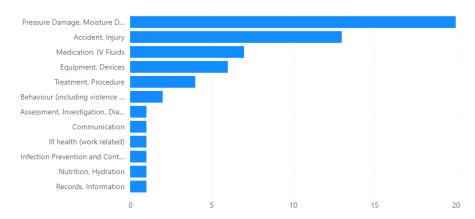


Incident type tier one	Count
Pressure ulcers	35
Injury of know origin	11
Medication/Biologics/Fluids	9
Behaviour including violence & aggression	7
Medical devices. Equipment, supplies	6
Exposure to Environmental Hazards	3
Administrative Processes (Excluding Documentation)	4
Behaviour	4
Service Disruptions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

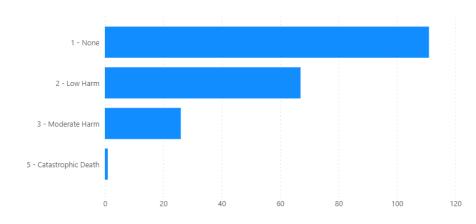
#### Ву Туре



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
III 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)

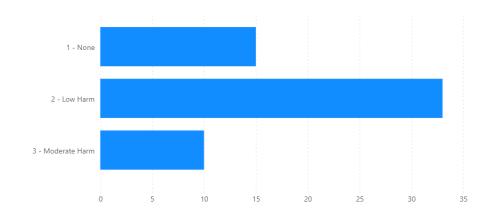
#### By Severity/Level



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

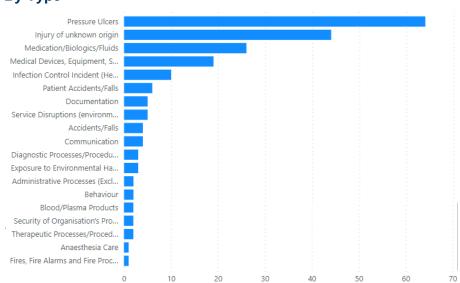
#### Withybush Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

#### 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)



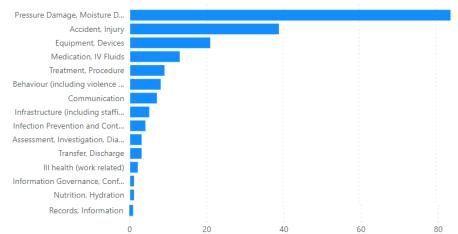
Incident type tier one	Count
Pressure Ulcers	64
Injury of unknow origin	44
Medication/Biologics/Fluid	26
Medical devices. Equipment, supplies	19
Infection Control Incident (Healthcare Associated	
Infection)	10
Patient accidents/falls	6
Documentation	5
Service disruption (environment, infrastructure,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

#### Ву Туре

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

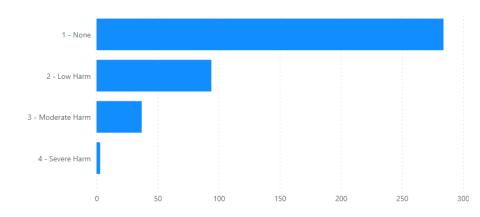
#### Ву Туре



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
III 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)

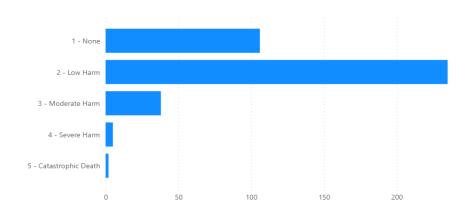
#### By Severity/Level



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)

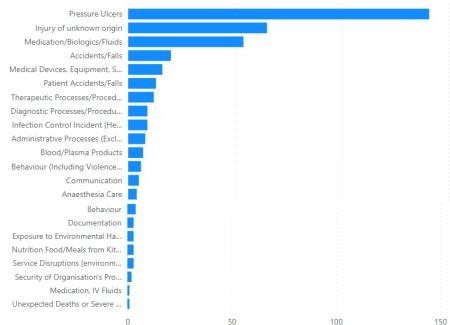
#### By Severity/Level



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)

#### Ву Туре

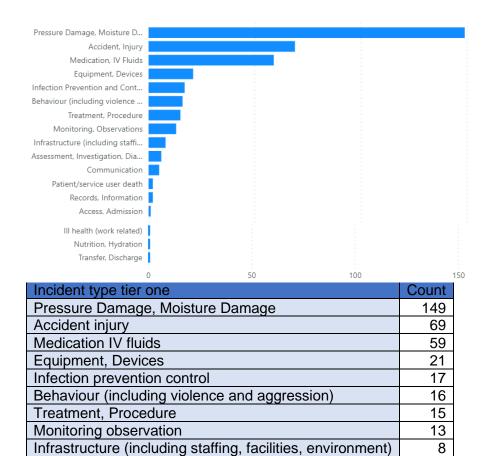


	ő	50	100		154
Incident type ti	er one			Count	
Pressure Ulce	rs			141	
Injury of unkno	ow origin			65	
Medication/Bio	ologics/Fluid			54	
Accidents/falls				20	
Medical device	es. Equipment, s	supplies		16	
Patient accide	nts/falls			13	

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

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

#### Ву Туре



6

2

2

Assessment, investigation, diagnosis

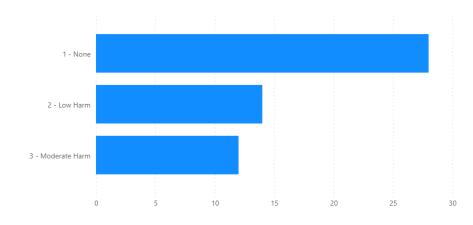
Patient/service user death

Records, Information

Access admission	1
III 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)

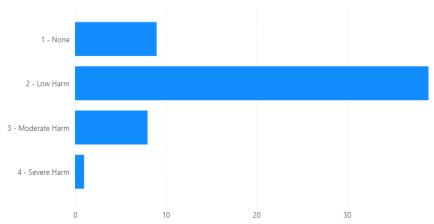
#### By Severity/Level



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

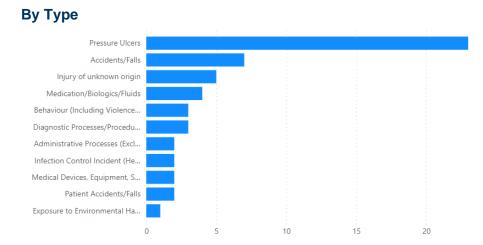
#### Prince Philip Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)

#### **By Severity/Level**



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

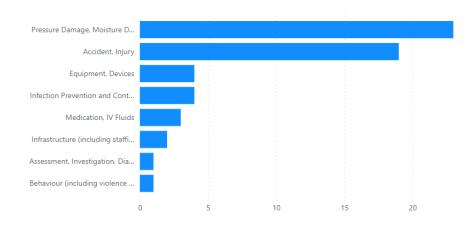
#### Prince Philip Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



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

Background	2
Complaints	3
All sites (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	3
All sites (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023	3
By Location (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	
By Location (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	
By Grading (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	
By Grading (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	
By Type (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	
By Type (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	6
Bronglais Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	7
By Grading	7
Bronglais Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	
By Grading	
Bronglais Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	
Ву Туре	
Bronglais Hospital (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	
Ву Туре	
By Grading	9
Withybush Hospital (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	9
By Grading Withybush Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	9
Withybush Hospital (1" August 2018 – $31$ " March 2021)	10
By Type	10
Withybush Hospital (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	10
By Type Glangwili Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	10
Giangwill Hospital (1° August 2018 – 31° March 2021)	11
By Grading Glangwili Hospital (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	11
By Grading	11
Glangwili Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	
By Type	
Glangwili Hospital (1 <sup>st</sup> April 2021 — 31 <sup>st</sup> July 2023)	12
<b>Glangwili Hospital (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)</b> By Type	12
Prince Philip Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	12
By Grading	
Prince Philip Hospital (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	13
By Grading	
Prince Philip Hospital (1 <sup>st</sup> August 2018 – 31 <sup>st</sup> March 2021)	14
By Type	
Prince Philip Hospital (1 <sup>st</sup> April 2021 – 31 <sup>st</sup> July 2023)	14
By Type	
-, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

#### 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.

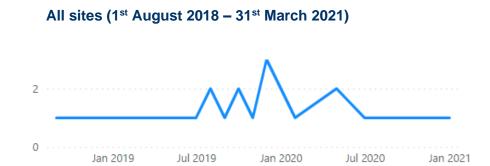
#### **Temporary Service change:**

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.

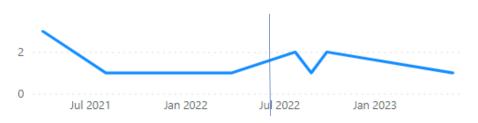
This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

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

#### Complaints



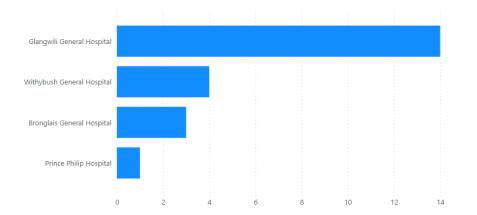
All sites (1<sup>st</sup> April 2021 – 31<sup>st</sup> July 2023)



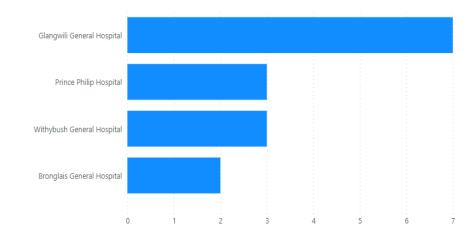
	Dec	Nov	Oct	Sep	Aug	1						
2018	18	18	18	18	18							
2	0	0	1	1	0							_
	Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan
2019	19	19	19	19	19	19	19	19	19	19	19	19
14	3	1	2	1	2	1	1	1	0	0	1	1
	Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan
2020	20	20	20	20	20	20	20	19	20	20	20	20
6	0	0	0	0	1	1	0	2	0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

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

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



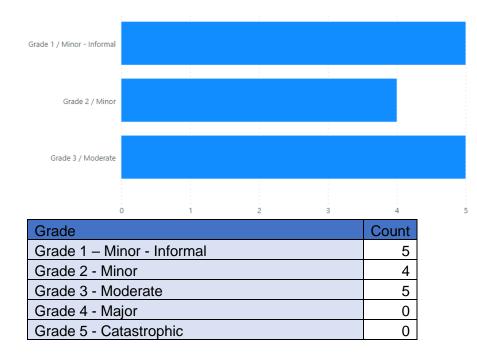
Primary Location	Count
Glangwili General Hospital	14
Prince Philip Hospital	1
Withybush General Hospital	4
Bronglais General Hospital	3



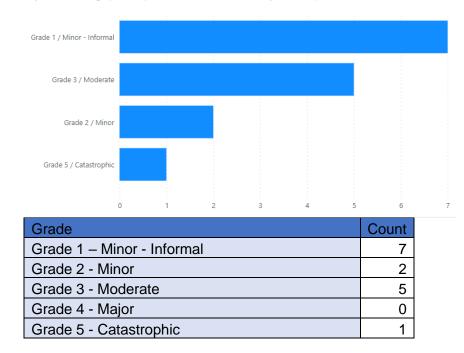
Primary Location	Count
Glangwili General	
Hospital	7
Prince Philip Hospital	3
Withybush Hospital	3
Bronglais General	
Hospital	2

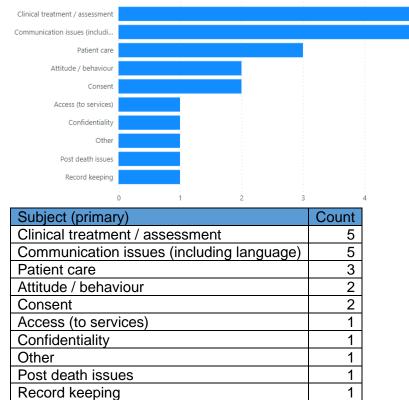
By Grading (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)

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



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



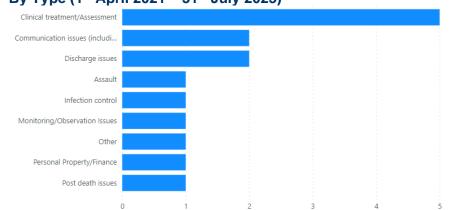


5

1

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

#### 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)



# GradeCountGrade 1 – Minor - Informal0Grade 2 - Minor1Grade 3 - Moderate2Grade 4 - Major0Grade 5 - Catastrophic0

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

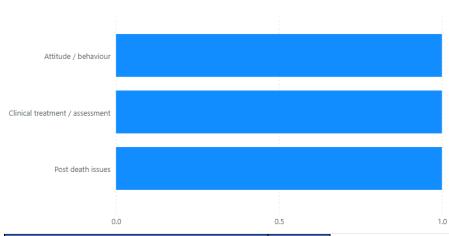
#### **By Grading**



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

#### By Grading

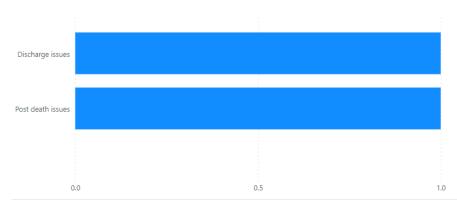
#### Bronglais Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



# Subject (primary)CountAttitude/ behaviour1Clinical Treatment / assessment1Post death treatment1

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

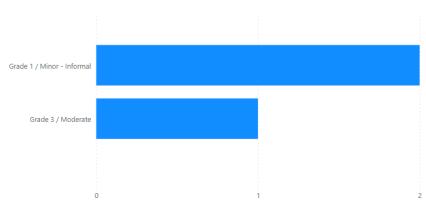
#### Ву Туре



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

#### Ву Туре

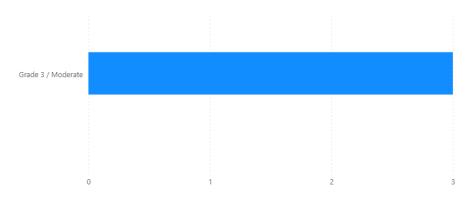
#### Withybush Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



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)

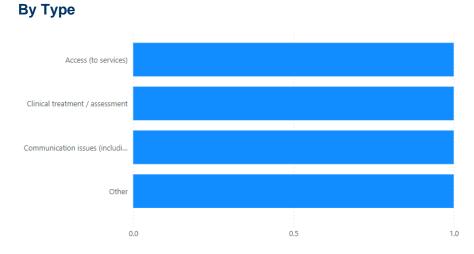
#### By Grading



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

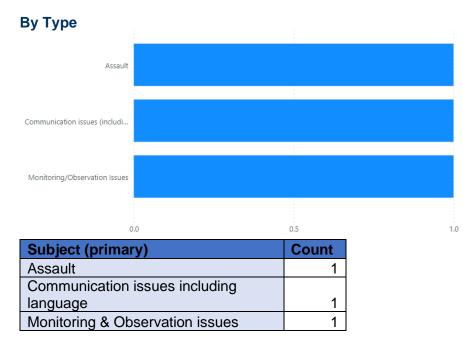
#### By Grading

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

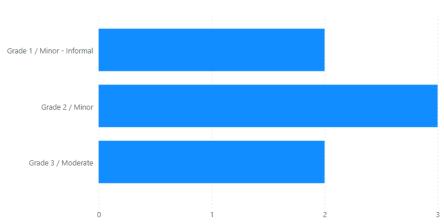


Subject (primary)	Count
Access to services	1
Clinical Treatment/Assessment	1
Communication issues inc Language	1
Other	1

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



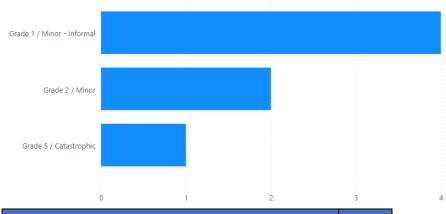
#### Glangwili Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



# GradeCountGrade 1 – Minor - Informal2Grade 2 - Minor3Grade 3 - Moderate2Grade 4 - Major0Grade 5 - Catastrophic0

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

#### **By Grading**

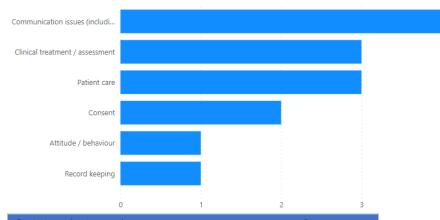


Grade	Count
Grade 1 – Minor - Informal	4
Grade 2 - Minor	2
Grade 3 - Moderate	0
Grade 4 - Major	0
Grade 5 - Catastrophic	1

#### By Grading

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

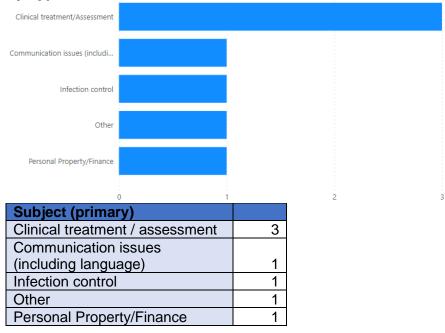
#### Ву Туре



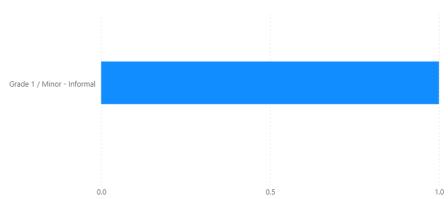
Subject (primary)	Count
Communication issues (including	
language)	4
Clinical treatment/assessment	3
Patient Care	3
Consent	2
Attitude / behaviour	1
Record Keeping	1

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

By Type



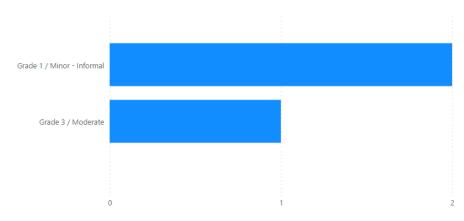
#### Prince Philip Hospital (1<sup>st</sup> August 2018 – 31<sup>st</sup> March 2021)



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)

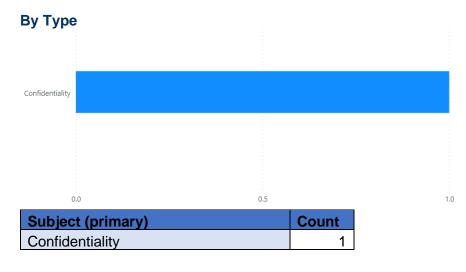
#### By Grading



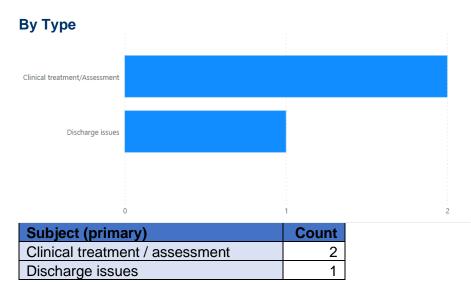
Grade	Count
Grade 1 – Minor - Informal	2
Grade 2 - Minor	0
Grade 3 - Moderate	3
Grade 4 - Major	0
Grade 5 - Catastrophic	0

#### By Grading

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



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



#### Critical Care Patient Experience Data Review

#### Contents

Background	. 2
Service Changes	
Patient Experience	. 4
All Wales Experience – Health Board Survey (1 <sup>st</sup> April 2021 to 31 <sup>st</sup> July 2023)	
Themes – 2021	5
Themes – 2022	5
Themes - 2023	5
Patient Experience	. 6
Friends and Family Test (1 <sup>st</sup> April 2021 to 31 <sup>st</sup> July 2023)	6
Themes – 2021	6
Themes – 2022	6
Themes - 2023	6
Patient Experience	. 7
Compliments (1 <sup>st</sup> April 2021 to 31 <sup>st</sup> July 2023)	7
3 Sentiments that relate to Compliment	7
3 Health Board Values that relate to Compliment	7
Themes – 2021	7
Themes – 2022	7

#### 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.

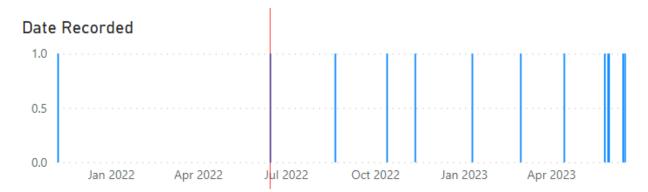
#### **Service Changes**

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.

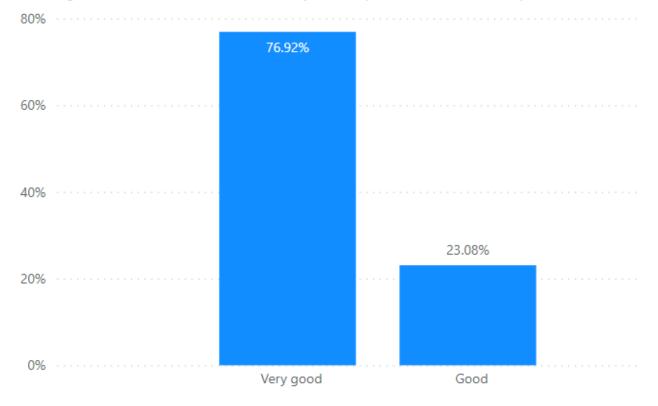
#### Patient Experience All Wales Experience – Health Board Survey (1<sup>st</sup> April 2021 to 31<sup>st</sup> July 2023)

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.



C13 - Critical Care Workforce Data



## 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 <u>not</u> 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	YES 5 Substantive 1 Locum	YES Rota covered by additional hours	YES 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	NO	No Vacancies	All have Theatre and Critical Care in job plans.
Bronglais General Hospital	YES Consultant led service	NO	NO	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)

			Location/Si	te	•	
Staff Group	Role	Bronglais General Hospital	Glangwili General Hospital	Prince Philip Hospital	Withybush General Hospital	Grand Total
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

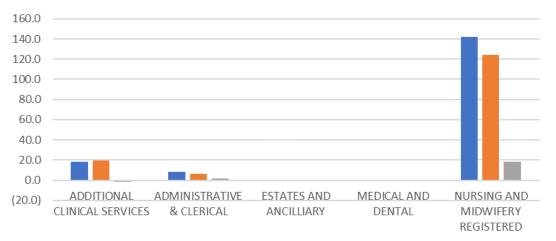
The table above shows the workforce within Critical Care by role and location as of 31<sup>st</sup> July 2023.





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

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



Budget Actual Wacancy

#### Budget overview as of 31st July 2023

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.

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 Mesaures in place	Current Risk Score	Previous Risk Score	Movement $(\downarrow, \uparrow \& \leftrightarrow)$	RAG Rating	Staff Group/ Groups affected
1363	Scheduled Care: Critical Care	There is a risk Inability to support a safe roster to maintain safe Consultant Anaesthetic cover of Critical care provision across PPH and GGH. 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. 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. Risk location, Glangwili General Hospital, Prince Philip Hospital.	Recruitment & retention, rota	Adverts out for Consultant vacancies Current staff backfill Requests with Agency for Consultant cover	9	20	Ŷ		Medical
1374		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 This is caused by 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. 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. Risk location, Bronglais General Hospital.	Roster sustainability, Recruitment issues, locum sessions.	Current staff backfill - Locum x 2, existing staff supporting as additional sessions, and Medical Bank. Staff from other sites picking up occasional shifts. Requests with MEDACs agency to support vacancies. Continue to work with MEDACs in support of temporary backfill whilst working towards sustained recruitment.	9	12	¥		Medical





# Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1663	Scheduled Care: Critical Care	There is a risk of of patients not receiving appropriate care due to insufficient skill mix in ITU BGH and lack of senior staff. This is caused by staff being off on long-term sick, maternity leave, Band 5 va cancies and on boarding. 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. This may affect patient flow due to nonurse in charge. This may affect patient flow due to nonurse in charge. This will have an effect on the Band 7 Senior sister workload whilst managing the roster/covering clinically. Junior members of the team will feel increased pressure due to the possibility of less support on a shift. The band 6 Sisters currently in work will feel pressure to cover extra shifts and may become overworked.		Band 7 Sisters covering deficits. Band 6 Sisters from ITU GGH have covered night shifts. Block booked agency nurses. Early escalation to TNS agency Consultants covering the unit made a ware when there are deficits. Site also made aware. Daily review of off duty. Appointed Band 6 secondment Appropriate staff sickness management e.g. regular contact whilst off, return to work interviews, Occupational health etc Senior nurses can provide cover when necessary	8				Nursing





# Critical Care Workforce Overview Historic picture April 2018 – April 2023

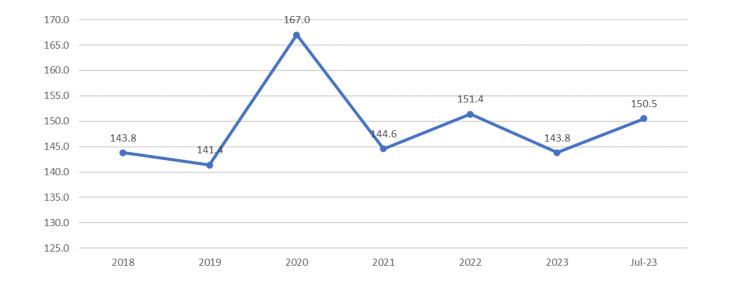




# **Historic Workforce**

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
TOTAL WTE	143.8	141.4	167.0	144.6	151.4	143.8	150.5



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.

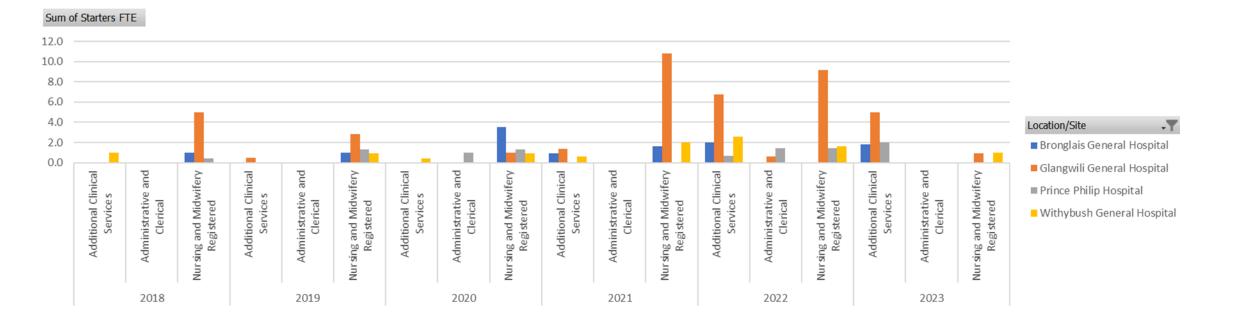
# Additional service insights

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**



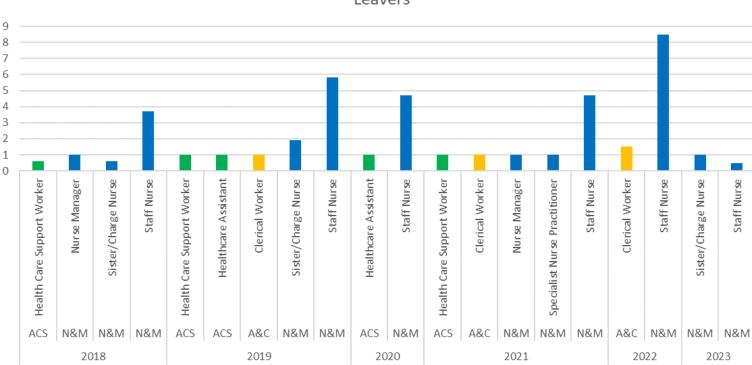
	2018	2019	2020	2021	2022	2023
Starters	7.4	6.6	8.2	17.3	26.3	10.8

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



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

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





# 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 Anaesthatist 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		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 Tel: 01554 899055

#### Form 1: Overview

1. 2.	What are you equality impact assessing?         Brief Aims and Description	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 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.	Who is involved in undertaking this EqIA?	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.	Is the Policy related to other policies/areas of work?	Intensive Care Society <u>https://ics.ac.uk/guidance.html</u> Acutely ill adults in hospital <u>https://www.nice.org.uk/guidance/cg50</u> Rehabilitation after critical illness in adults <u>Overview   Rehabilitation after critical</u> <u>illness in adults   Guidance   NICE</u> Intravenous fluid therapy in adults in hospital <u>Overview   Intravenous fluid therapy in</u> <u>adults in hospital   Guidance   NICE</u> Adult Critical Care <u>https://gettingitrightfirsttime.co.uk/medical_specialties/adult- critical-care/</u>
5.	Who will be affected by the strategy / policy / plan / procedure / service? (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.	What might help/hinder the success of the Policy?	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.

**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
Article 2 : The right to life	Х	
<b>Example</b> : The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control		
Article 3 : The right not be tortured or treated in an inhuman or degrading way	Х	
<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		
Article 5 : The right to liberty	Х	
Example: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		
Article 6 : The right to a fair trial	Х	
Example: issues of patient choice, control, empowerment and independence		
Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control	Х	
<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		
Article 11 : The right to freedom of thought, conscience and religion	Х	

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	

How will the strategy, policy, plan, procedure and/or service impact on:-	Positive	Negative	No impact	Potential position Please include un to support your	nintended view e.g. s	conseque	ences, op		s or gaps.	This sectio	on should a	also include	e evidence	Opportunities for improvement / mitigation 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			x	Population Data Year (data was collected)		ywel Dda	Universit	:y Health E	Board Pop	ulation – 2	2021 Censu	ıs		
in different				County	Carmarth	enshire	Ceredig	ion	Pembrok	eshire	Total			
ways or affect				Measure	value	percent	value	percent	value	percent	value	Percent		
one age group				Age										
and not another?				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		

Ageo	d 35 to								
49 y	ears	31,801	16.9	10,145	14.2	19,459	15.8	61,405	15.6
Ageo	d 50 to								
64 y	ears	40,905	21.8	15,256	21.3	27,335	22.2	83 <i>,</i> 496	21.8
Ageo	d 65 to								
74 y	ears	24,605	13.1	9,942	13.9	17,444	14.1	51,991	13.7
Ageo	d 75 to								
84 y	ears	15,246	8.1	6,095	8.5	10,855	8.8	32,196	8.5
Ageo	d 85								
year	's 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.

			All health board staff undertake	e equalities training a	as part of mar	ndatory competer	ncy training.	
			There is a car transport service	available for patient	s families to ι	use.		
			Hospital sites across the health	board are located cl	ose to public	transport routes a	and links.	
			All sites will have accessible toil	ets either directly in	the service a	rea or nearby.		
			Wheelchairs are widely availabl those who have difficulty walkir	•	es to be used	d by patients fami	ly where req	uired for
			When required, clinical staff wil	I support the patien	ts family actir	ng as a chaperone	for visiting.	
			On each site, staff will have according to the site sites have access to meals.	ess to facilities to pro	ovide the pati	ient with basic dri	nks and biscı	iits. Larger
			At this time no negative impact service changes.	has been identified	on age. This	will be reviewed i	n line with ar	iy proposed
Dischility		х	Population Data			r		
Disability					<b>a</b>			
Those with a physical disability,			Disabled under the Equality Act: Day-to-day activities limited a lot	Carmarthenshire	Ceredigion 6686	Pembrokeshire	Total 40463	
Those with a physical				Carmarthenshire 21255 21897	Ceredigion 6686 8951	Pembrokeshire 12522 14651	Total 40463 45499	

conditions such							
as diabetes		Patient data Patients are assessed of condition, including the to the high levels of int clinical outcomes or qu assessment, but not in	ir medical history. Th erventions provided i ality of life. Therefore	ere is potential then not in the control of the con	at patients with disa dmission to care ma	bilities may not respond ay not improve their	1
		Positive Impacts:					
		All health board staff u Dementia Awareness) t training.				-	
		Adjustments may be ne include support from of services, support from a	ccupational health for	r communication o	-	nts / families. This could Learning Disability	
		All hospital sites adhere	e to minimum accessi	bility standards.			
		Wheelchairs are widely walking.	available at hospital	entrances to be us	ed by patients fami	lies who have difficulty	
		Hospital transport has o	cars to support patien	nts family with diff	erent types of mobil	ity concerns.	
		Negative Impact					
		At this time no negative proposed service change	•	ntified on Disabili	y. This will be revie	wed in line with any	
	x	Population Data					
<b>Gender</b> <b>Reassignment</b> Consider the		Year (data was collected)	Hvwel Do	da University Heal	th Board Census Da	ta - 2021	
potential impact		County	Carmarthenshire	Ceredigion	Pembrokeshire	Total	

on individuals		Measure	value	percent	value	percent	value	percent	value	percent
who either:		Gender								
		All persons	187,897	100	71,475	100	123,360	100	382,732	100.0
•Have		Male	91,685	48.8	34,963	48.9	60,071	48.7	186,719	48.8
undergone, intend to undergo		Female	96,212	51.2	36,512	51.1	63,289	51.3	196,013	51.2
or are currently		Gender identity the								
undergoing		same as sex								
gender		registered at birth	144,924	93.2	55,874	91	95,794	93.4	296,592	92.5
reassignment.		Gender identity								
<ul> <li>Do not intend to</li> </ul>		different from sex								
undergo medical		registered at birth								
treatment but		but no specific								
wish to live in a		identity given	210	0.1	84	0.1	121	0.1	415	0.1
different gender		Trans woman	93	0.1	73	0.1	58	0.1	224	0.1
from their gender		Trans man	90	0.1	62	0.1	66	0.1	218	0.1
at birth.		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

In Carmarthenshire, 0.32% of people reported identifying with a gender different form the sex registered at birth.

In Ceredigion, 0.70% of people reported identifying with a gender different form the sex registered at birth.

In Pembrokeshire, 0.31% of people reported identifying with a gender different form the sex registered at birth.

Gender identity - Census Maps, ONS

#### **Patient Data**

• There is no available information for Critical Care patients regarding gender reassignment.

			Positive Impacts: All health board st specifically relating Negative Impact Where a patient g remain confidentia may arise where t	g to gende ender is no al however	r identity ot the sam	as part of e as was cases will	mandator	ry compete	ency traini birth, the	ng. service is c	onscious fo	or this to	Mitigation Patient confidentiality is maintained using health board guidelines regarding confidentiality.
Marriage and		х	Population Data										
Civil Partnership			Year (data was collected)		Hywel D	da Unive	rsity Heal	th Board C	Census Dat	a - 2021			
This also covers			County	Carmarth	nenshire	Ceredig	ion	Pembrok	eshire	Total			
those who are not married or			Measure	value	percent	value	percent	value	percent	value	percent		
in a civil			Marital Status	-									
partnership.			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		45.7		

					1				
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. <u>How life has changed in Carmarthenshire:</u> <u>Census 2021 (ons.gov.uk)</u>

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. <u>How life has changed in Ceredigion: Census 2021</u> (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. <u>How life has changed in Pembrokeshire: Census</u> 2021 (ons.gov.uk)

#### **Patient Data**

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

Staff Data
<b>Positive Impacts:</b> All health board staff undertake equalities training as part of mandatory competency training.
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. <u>HDUHB EQUALITIES DUTIES REPORTING - Staff In Post (nhs.wales)</u>
Negative Impact
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.

Form 3 Gathering of Evidence and Assessment of Potential Impact

y In 2021, there were 20,007 hirthe registered ecross Wales	
regnancy and       x       In 2021, there were 29,007 births registered across Wales.         Maternity and birth statistics: 2021   GOV.WALES	
Maternity and birth statistics. 2021 GOV. WALES	
Maternity covers the Patient Data	
period of 26 weeks after	
having a baby, whether Pregnant parents or those on maternity would not be a factor on admission to, and treatment	
or not they are on in, critical care departments if clinically indicated.	
Maternity Leave.	
Staff Data	
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.	
Negative Impact	
	litigation
Where a patient is pregnant this may change the course of treatment that would normally be	
	upport and
	nput would be ought from
	elevant
	pecialist
	eams, e.g.
	naternity,
ot	bstetrics etc.
x     Population Data	
Race/Ethnicity or	
Nationality	
People of a different Year	
race, nationality, colour, (data was collected) Hywel Dda University Health Board Census Data - 2021	
culture or ethnic origin Collected) Hywel Dda University Health Board Census Data - 2021	
including non-English / Welsh speakers,CountyCarmarthenshireCeredigionPembrokeshireTotalsMeasurevaluepercentvaluepercentvaluepercentvaluepercent	

m seekers and Ethnicity									
int workers. 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	74.4		200	0.5	440	0.0	1 501		
group	714	0.4	368	0.5	419	0.3	1,501	0.4	

identified as 'Mixed or multiple ethnic groups' and 0.9% as 'Other ethnic group'. <u>https://www.gov.wales/ethnic-group-national-identity-language-and-religion-wales-census-</u> <u>2021-html</u>

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

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. HDUHB EQU	
<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. Race, ethnicity or nationality is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated.	Mitigation
<b>Negative Impact:</b> Where a patient or their family are non English or Welsh speaker may be unable to communicate to staff.	The Healthboard has access to a translation service for patients who are unable to communicate in English or Welsh.
	Adjustments may be necessary to allow for appropriate communication with patients / families, for which,
	translation services are available and accessible.

gion or Belief (or	Population	Data							
- <b>belief)</b> term 'religion' udes a religious or	Year (data was collected)		Hywel D	)da Unive	ersity Heal	th Board C	Census Dat	a - 2021	
osophical belief.	County	Carmart	nenshire	Ceredig	ion	Pembrok	eshire	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 <i>,</i> 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 Not	1,127	0.6	677	0.9	746	0.6	2,550	0.7
	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'. <u>https://www.ons.gov.uk/visualisations/censusareachanges/W06000010/</u>

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'. <u>How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</u> 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'. <u>How</u> <u>life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</u>

#### 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.

HDUHB 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
Grand Total	15,586

#### **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.

	<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.	
	Negative Impact:	
	A non-English or Welsh speaker may be unable to communicate to staff.	Mitigation
		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.
		The <u>specialist</u> <u>pharmacy</u> <u>service</u> can support when managing situations where a patient is known to be unable to be administered specific drugs

		х	Population data	
Sex				
Consider whether those				
affected are mostly				
male or female and				
where it applies to both				
equally does it affect				
one differently to the				
other?				

Year (data was collected) County	Carmarth	-	da Unive Ceredig	-	th Board C Pembrok		a - 2021 Total	
Measure	value	percent	value	percent		percent		percent
Gender	value	percent	value	percent	value	percent	value	percent
All	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

	 										<b>1</b> 1	
		All other										
		gender idoptition	20	0	66	0 1	22		126	0.0		
		identities	38	0	66	0.1	32	0	136	0.0		
		Patient data										
		Sex is not a fac clinically indica		dered on	admissio	n to, and ti	reatment i	in, critical	care depar	tments if		
		Staff Data										
		As of 2020, 77. sex will affect o HDUHB EQUAL	or be affe	ected by tl	hese char	iges in the	service.		le. It is unl	ikely staff		
		Gender		Headcour	nt							
		Female		45								
		Male Grand Total		39 <b>74</b>								
				/4								
		<ul> <li>Positive Impac</li> <li>All health b Rights) as p</li> <li>There are n specific ger</li> </ul>	oard sta oart of manale and	andatory of female st	competer aff in the	ncy training service an	g. d where p	ossible, if				
		Negative Impa	ct:									
		At this time the This will be rev		-					aracteristi	c of sex.		
	x	Population dat	ta									
Sexual Orientation												
Whether a person's												
sexual attraction is												
towards their own sex,												

che opposite sex or to poth sexes. Year (data was collected)		Hywel D	da Unive	rsity Heal	th Board C	ensus Dat	a - 2021	
County	Carmarth	enshire	Ceredig	on	Pembrok	eshire	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

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 D	UTIES REPORTING -	Staff in Post			
	Sexual Orientation –	- All Staff		Headcount		
	Heterosexual or Strai			7,562	_	
	Not stated (person as	-	nrovide a	7,502	_	
	response)			1,516		
	Other			183	_	
	Not Recorded on ESR	2		2,325		
	Grand Total	<b>`</b>		11,586		
	All health board staff ( Rights) as part of man <b>Negative Impact:</b>		• •	iding Equality, Div	versity and	l Human
<b>d Forces</b> der members of	At this time there is no orientation. This will be Population data					tic of sexual
	orientation. This will b					tic of sexual
der members of rmed Forces and families, whose n needs may be rted long after they	orientation. This will b	be reviewed in line	with any prop	oosed service char	nges. Totals	tic of sexual
der members of rmed Forces and families, whose n needs may be ted long after they left the Armed s and returned to n life. Also	orientation. This will b Population data Previously served in the UK regular	be reviewed in line	with any prop	oosed service char Pembrokeshire	nges. Totals	tic of sexual
der members of rmed Forces and families, whose n needs may be ted long after they left the Armed s and returned to n life. Also der their unique iences when sing and using day-	orientation. This will be Population data Previously served in the UK regular armed forces Previously served in UK reserve armed	be reviewed in line of Carmarthenshire 5610	with any prop Ceredigion 1851	Pembrokeshire 4654	Totals 12115	tic of sexual
ler members of med Forces and amilies, whose needs may be ted long after they eft the Armed and returned to a life. Also er their unique ences when ing and using day- public and	orientation. This will be Population data Previously served in the UK regular armed forces Previously served in UK reserve armed forces Previously served in both regular and	be reviewed in line of Carmarthenshire 5610	with any prop Ceredigion 1851	Pembrokeshire 4654	Totals 12115	tic of sexual
er members of ned Forces and milies, whose needs may be ed long after they et the Armed and returned to life. Also r their unique nces when ng and using day-	orientation. This will be Population data Previously served in the UK regular armed forces Previously served in UK reserve armed forces Previously served in both regular and reserve UK armed	Carmarthenshire 5610 1334	with any prop Ceredigion 1851 537	Pembrokeshire 4654 930	Totals 12115 2801 721	tic of sexual

	-	<u> </u>										1
could be through												
'unfamiliarity with		Pat	tient Data									
civilian life, or frequent												
moves around the			impact. Arm			levant to	the decisi	on to adn	nit into crit	ical care,	and would	
country and the		not	affect treat	ment opt	ions.							
subsequent difficulties												
in maintaining support		Ne	gative Impac	ct:								
networks, for example,												
members of the Armed		Att	this time the	re is no n	egative imp	bact has l	been ident	ified unde	er the chara	acteristic	of armed	
Forces can find		for	ces. This wil	l be revie	wed in line	with any	proposed	service cl	hanges.			
accessing such goods												
and services												
challenging.'												
For a comprehensive												
guide to the Armed												
Forces Covenant Duty												
and supporting resource												
please see:												
Armed-Forces-												
Covenant-duty-												
statutory-guidance												
	Х	Pop	pulation Dat	а								
Socio-economic												
Deprivation												
Consider those on low		Info	ormation to i	inform or	n Socio-eco	nomic de	privation i	s hard to	obtain. Ho	wever, e	conomic	
income, economically		act	ivity informa	ition is av	ailable on t	he 2021	census. W	e are awa	are that the	ere are ar	eas within	
inactive, unemployed or		the	he health board footprint of considerable deprivation. The below table notes economic									
unable to work due to		act	activity within the health board footprint									
ill-health. Also consider												
people living in areas		Ye	ear (data									
known to exhibit poor			as									
economic and/or health			ollected)		Hywel D	da Unive	ersity Heal	th Board	Census Dat	a - 2021		
indicators and			ounty	Carmart	henshire	Ceredig	-	Pembrol		Totals		
individuals who are			-		1		1				n a r a a r t	
unable to access			easure	value	percent	value	percent	value	percent	value	percent	

services and facilities.	Economic									
Food / fuel poverty and	Factor									
personal or household	Total: All									
debt should also be	usual									
considered.	residents									
For a comprehensive	aged 16									
guide to the Socio	years and									
Economic Duty in Wales	over	155,487	100	<mark>61,392</mark>	100	102,551	100	<mark>319,430</mark>	100.0	
and supporting resource	Economically									
please see:	active									
https://gov.wales/more-	(excluding									
equal-wales-socio-	full-time	02.262		20.045	40.0	F4 402	F2 0	107 200		
economic-duty	students)	83,262	53.5	29,845	48.6	54,182	52.8	167,289	51.6	
	In	70.027	<b>Г</b> 1 Л	20 710		F1 C07		160 242	40 F	
	employment	79,927	51.4		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		4 -			4 9 5 9		6 9 9 9		
	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	

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).

Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

## Patient data

Socio-economic deprivation is not a factor considered on admission to, and treatment in, critical care departments if clinically indicated.

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.

## Staff Information

There is currently no data available on socio-economic status for staff.

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.

## **Negative Impact**

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.

## Mitigation

The Health Board has adopted savings schemes for staff to use, such as the Hapi app benefits for everyday discounts, the

			Leasing Car
			Scheme and
			Pool Car
			scheme,
			amongst many
			others.
			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.
	х	Population Data	Mitigation
Welsh Language			
Please note		According to Welsh Census 2022 data, it is estimated that 29.5% of people aged three or older	
opportunities for		were able to speak Welsh. This figure equates to around 900,600 people.	
persons to use the			
Welsh language and		The Health Board adopted the Welsh Language Standards in 2019 across all directorates	
treating the Welsh		including Mental Health & Learning Disabilities Services. Following on from this a Welsh	
language no less		Language Services Report is produced annually.	

Positive Impact	
In March 2021 the Bilingual Skills Policy was introduced across the health board. The main aims	
of the policy are as follows:	
• To increase the use of Welsh within the workplace.	
·	
Welsh or English, according to personal choice, and to encourage other users and providers to	
above can provide bilingual services to patients and carers.	
All service users and patients are offered a proactive service offer of Welsh language, which is	
recorded.	
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.	
	Mitigation
Negative Impact	U
	Welsh
	language
	standards
	applied to all
	health board
	staff
	Patient
	information
	available in
	<ul> <li>of the policy are as follows:</li> <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> <li>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.</li> <li>All service users and patients are offered a proactive service offer of Welsh language, which is recorded.</li> <li>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,</li> </ul>

		English and Welsh
		VV CISIT
		Welsh
		language
		speaking staff
		are available
		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.

# Form 4: Examine the Information Gathered So Far

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.

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

Socio-economic	2	-2	-4
Deprivation			
Welsh Language	1	-1	-1

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

S	Scoring Chart B: Potential Impact				
-3	High negative				
-2	Medium negative				
-1	Low negative				
0	No impact				
+1	Low positive				
+2	Medium positive				
+3	High positive				

Scoring Chart C: Impact				
-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.

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

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

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.	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.	
If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.	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.	

# Form 7 Action Plan

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

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