Trust-wide Document

NHS
Great Western Hospitals
NHS Foundation Trust

Critical Care Unit (CCU) (all patients) Admission and Discharge Policy

(Critical Care Unit refers to the combined Intensive Care Unit and Higher dependency Unit)

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Status	LIVE		
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees involved in the admission, discharge and transfer of patients on the Critical Care Unit.		
Special Cases	None		
Accountable Director	Medical Director		
Author/originator – Any Comments on this document should be addressed to the author	Consultant in Intensive Care		
Division and Department	Surgery, Women's & Children's (SW&C). Department of Critical Care.		
Implementation Lead	Consultant Intensivist / Matron for Critical Care		
If developed in partnership with another agency ratification details of the relevant agency	N/A		
Regulatory Position	Picsociety.uk (Ref 3)		
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Contents

1 Introduction & Purpose

1.1 Introduction & Purpose

This document sets out the Great Western Hospitals NHS Foundation Trust (the Trust) policy regarding the admission and discharge of both adult and child patients from the Department of Critical Care (Level 3 – Intensive Care patients; Level 2 – High Dependency patients)at the Great Western Hospital (GWH).

This document is underpinned by the Faculty of Intensive Care Medicine and Intensive Care Society document "Guidelines for the Provision of Intensive Care Services" Edition 2 (June 2019) (Ref 1) Department of Health document EL-96-20, "Guidelines on admission to and discharge from Intensive Care and High Dependency Units", March 1996 (Ref 2) and National Framework Document "Comprehensive Critical Care: A review of Adult Critical Care Services (Ref 3). It should be noted that both of these guidance's have been archived yet the standards remain the underpinning guidance for critical care across the United Kingdom.

1.1.1 Definition of Levels of Care

National Framework Document "Comprehensive Critical Care: A review of Adult Critical Care Services - (Ref 1) defines levels of care as the following:

- Level 0: Patients whose needs can be met through normal ward care in an acute hospital.
- Level 1: Patients at risk of their condition deteriorating, or recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.
- Level 2: Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care or those 'stepping down' from Level 3 care.
- Level 3: Patients requiring advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

Clinical judgement should be used to determine which level of care would be most appropriate based on the criteria given above. Although a lower level of care will usually require a lower nurse-to-patient ratio or reduced critical care support, this may not apply in all circumstances, and the aim should be flexibility in the provision of employee resources to meet the needs of the patient. The level of care assigned to a patient will influence, but not determine, staffing requirements.
It is important to note that Levels of Care classification (particularly for Level 2) is wider than the presence or absence of organ failure per se.
GPICS (Ref 1) represents best practice, and every reasonable opportunity to work within these guidelines should be taken, however there may be circumstances when the GWH is experiencing acute escalation whereby the Unit may have to admit patients that are not always level 2 or 3. The unit may also be required to discharge patient/s to a general GWH ward, or appropriate area (e.g. theatre recovery), if an admission for a critically ill patient requires critical care even when out of hours.

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

CQC	Care Quality Commission
Department of Critical Care	Unit providing ICU and HDU care
EIA	Equality Impact Assessment

GPICS	Guidelines for the Provision of Intensive Care Services
GWH	Great Western Hospital
HDU	High Dependency Unit
ICNARC	Intensive Care National Audit and Research Council
ICU	Intensive Care Unit (Previously called ITU Intensive Therapy Unit)
NHS	National Health Service
PICU	Paediatric Intensive Care Unit
TEP	Treatment Escalation Plan
WATCh	Wales and West Acute Transport for Children

2 Main Document Requirements

2.1 Referral

2.1.1 Who Can Refer a Patient to the Critical Care Unit?

Any consultant or appropriately experienced member of a Consultant's team may refer patients to critical care services. GPICS (ref GPICS) recommends consultant to consultant referral, though it is recognised that this is not always possible and that the priority should be to minimise delays to definitive treatment. Referring and receiving consultants must be directly involved in the process.

In addition, nursing or allied health professional employees, or members of the outreach team, may need to alert critical care medical employees directly in circumstances of unusual urgency. In these cases the referring team must always be alerted in parallel and are expected to attend.

The referring team shall maintain responsibility for the patient up to admission to Intensive Care, and shall remain responsible for on-going management if admission is refused or deferred.

No Unit in the Network shall accept a patient for transfer from any department (wards/theatres/Emergency Department (ED)) of another hospital unless they have been referred to the critical care team of the referring hospital and assessed as suitable.

2.1.2 How to Refer

Ideally the ward consultant should contact (phone/bleep) the Intensive Care consultant via switchboard. Patients can also be referred by bleeping the on call doctor (bleep 1747 or Dect phone 7112) or bleeping the Outreach team (bleep 1778). The Critical Care team shall review the patient according to clinical urgency. Patient requirement for admission is based on the level of care required as set out in section 1.1.1 of this document

2.1.3 Response to Referral

During the critical care review to establish if the patient can be admitted care of the patient continues to be provided by the referring team.

Review of the patient may result in one of several outcomes as follows:

- Decision to admit.
- Decision for Active Level 1 (Ward) Management and Review section - 2.3.4 of this document.
- Substantive Decision not to Admit section - 2.3.7 of this document.

2.1.4 Standards

- The decision to admit to the critical care unit and the management plan must be discussed with the duty consultant in Intensive Care Medicine.

- 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.
- 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 within 12 hours of admission to critical care.

Transfer to other critical care units for non-clinical reasons must be avoided where possible.

2.2 Admission

2.2.1 Criteria for Adult Critical Care Unit Admission

Criteria for Admission to the Critical Care Unit:

- Patient has a reversible acute condition and is appropriate for advanced intervention.
- That this is consistent with the patient's wishes (or in their best interests in the event of lack of capacity).
- Patient needs level 2 or level 3 care (see definitions in 1.1.1), or is likely to need such care in the near future, and would be at risk if he or she remains in a general ward area.
- Post-operative monitoring in the high-risk patients, including but not exclusive to emergency laparotomies and major elective surgery in the co-morbid patient.
- The severity and time course of the patient's condition is such that further management of the acute illness, or simple fluid and oxygen resuscitation measures on the general ward, are unlikely to improve the patient's condition or to reduce the need for admission.

Adult patients are admitted to critical care areas for advanced life support and monitoring, during active treatment of an underlying clinical condition. The clinical condition which has resulted in the patient needing critical care should be identifiable, acute and potentially reversible.

A patient's previously expressed (spoken or written) preference for or against intensive care must be taken into account. If a valid advance directive refusing Intensive Care admission is in place then this must be respected. If a Treatment Escalation Plan (TEP) (Ref 5) is in place this should be used to guide decision making. The role of relatives or others close to the patient in the case of an incapacitated patient is to represent their understanding of what the patient would wish. Capacity assessments should be completed in line with the Trust Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (Ref 12).

Admission for critical care is only appropriate if the patient can be reasonably expected to survive and receive sustained benefit in quality of life. An increasing requirement for organ support is not in itself a reason to admit a patient who is suffering their final illness, and who has no apparent avenue of recovery.

Even when there is an acute reversible component, the patient's chronic health status (impairment of organ systems or physiological reserve) may significantly affect the patient's ability to survive and benefit from an intensive care episode. This requires careful assessment, but should not be prejudiced by age, disability or ethnicity.

Patients who are referred because they are confused and difficult to manage, or for other expedient reasons other than critical illness should be reviewed on a case by case basis. These admissions should only be considered when there is considerable spare capacity to facilitate their admission and care in the Department of Critical Care. The Intensive Care consultant on call will make the final decision about such admissions.

2.2.2 Criteria for Child Admission to the Department of Critical Care

Children should be referred to Critical Care Unit the same way as described above. However, the Critical Care area at the GWH is an adult unit and there is national agreement (Ref 3) that critically ill children should be cared for in specialised Paediatric Intensive Care Units (PICU). The Trust's regional centre is at Bristol. Children are only to be admitted to the unit for stabilisation prior to transfer to PICU.

Critically ill children should be discussed with the Paediatric Consultant on call, the Intensive Care consultant on call and the Wales and West Acute transport for children (WATCh) service prior to any decisions about admission or transfer.

In exceptional circumstances, namely that WATCh are unable to retrieve the child and the children's unit are unable to safely care for the child, the child may be admitted to the Department of Critical Care. Discussion with the Paediatric Consultant on call, the Intensive Care Consultant on call, the nurse in charge of the Children's unit, the nurse in charge of Intensive Care and WATCh will be needed to determine where and how the child can be cared for most safely. When these circumstances are happening an incident form must be completed.

While the child is in the adult Critical Care area the following must occur (Ref 3):

- A registered children's nurse must be available to support the care of the child and to review the child at least every 12 hours.
- Discussion with the WATCh team about the child's condition prior to admission and regularly during their stay on the General Intensive Care Unit.
- Agreement by a local paediatrician to the child being moved to the Intensive Care Unit.
- Availability of a local paediatrician for advice.
- Review of the child by a senior member of the paediatric team at least every 12 hours during their stay on the General Intensive Care Unit.
- 24 hour access for parents to visit their child.

Children will generally be discharged from the Critical Care Unit to PICU and will be retrieved by WATCh. However, if the child's condition stabilises to such a degree that the Critical Care team and the Paediatric team are in agreement that the child can be safely cared for in the GWH Children's Unit then they will be discharged to the Children's Unit as soon as possible and ideally within four hours of the decision to discharge.

2.3 Action for Admission to the Department of Critical Care

The patient is to be admitted to the Department of Critical Care as soon as a bed is available. Appropriate bed management steps are taken to free a bed space if none are available.

2.3.1 Decision for Active Level 1 (Ward) Management and Review

2.3.1.1 Criteria for Ward Management and Review

- Patient has a reversible acute condition and is appropriate for advanced intervention as discussed in section 2.2.1.
- Patient does not clinically need level 2 or level 3 facilities at present but may do later.
- Patient can be safely monitored on an acute general ward at present.
- Patient would benefit from simple resuscitation and basic organ support in an acute ward setting with advice from the critical care team (level 1).
- Patient would benefit from further investigation and management of underlying acute condition in an acute ward setting.

2.4 Action for Ward Management and Review

These measures may render level 2 or level 3 care unnecessary if carried out promptly. It is not in any patient's best interests to undergo an avoidable Intensive Care admission.

The referring team has full responsibility for ensuring that such measures are adequately executed. The Critical Care team input shall be advisory and may include bedside training or interventional support at their discretion/as per patient requirement.

The Critical Care team shall maintain active review at agreed intervals, either via direct review by Unit clinicians or via the Outreach team. The patient shall be urgently reviewed with a view to admission if their condition deteriorates.

2.4.1 Substantive Decision not to Admit to the Department of Critical Care

Criteria for Decision not to Admit to the Critical Care Unit:

- If a patient is suffering his or her final illness – the clinical deterioration and organ failure for which he or she has been referred is not amenable to treatment of an underlying acute problem; or any such acute problem has already progressed beyond reasonable hope of recovery.
- Patient's co-morbidity and poor physiological reserve make the prospect of significant and sustained recovery minimal.
- Patient refuses admission, either by previous stated wish or on discussion with critical care and referring team.

2.4.2 Action when not Admitting to Department of Critical Care

Decision shall be discussed between referring team, critical care team, and relatives. The role of the relatives is to represent the anticipated wishes of the patient, rather than to make an active end of life decision. Where there is dissent, discussion should be referred to consultant level. Initial discussion may take place at junior or senior trainee level but in principle, trainee critical care team members should not refuse admission without senior discussion.

The intensive care consultant is the final gatekeeper for critical care admission.

No referring employees may order or force an admission which has been refused by the critical care team after discussion at consultant level. A second opinion may be sought from both sides if consensus is not reached. In cases of extreme dissent the Unit lead clinician, respective clinical directors and risk management team should be consulted.

Critical care employees shall render assistance and advice on palliative or other supportive care of patients that they have agreed are not suitable for Critical Care Unit care and support. However, final responsibility for ongoing management shall rest with the referring team.

The patient's resuscitation status should be reviewed under the Trust's Resuscitation Policy (Ref 9) as a logical and integrated part of critical care discussion.

2.5 Admission Procedure

2.5.1 Critical Care Unit Bed State – Level 3 (Critical Care Unit)

The nurse-in-charge and the Intensive Care Consultant shall agree upon one of three operating states for level 3 (Critical Care Unit) areas:

2.5.2 Course of Action When Unit Closed to Referrals (State Black)

- If a new in-house referral is judged to be suitable for Critical Care Unit admission but there are no beds, then either the newly referred patient or a more stable patient currently in the intensive care unit shall be transferred to another hospital.
- The decision of which patient to transfer has significant ethical and medico-legal implications. The Trust has a duty of care to all its patients inside and outside of the department of Critical Care, and must triage resources accordingly. However, transferring an existing stable Critical Care Unit patient means removing them from a place of safety against that patient's own best interests.
- Therefore it is anticipated that a patient already on Critical Care Unit should be transferred out only under exceptional circumstances.
- In the case of pandemic other plans may be enacted – please reference the appropriate guidance. (COVID-19 surge; seasonal influenza pandemic)

Conversely, it may, on occasion, be unavoidably necessary to transfer a current intensive care patient. The balance of likely clinical outcomes for both patients must be carefully weighed, especially if putting a stable patient at risk for the sake of another who is unlikely to survive. Units with available beds must support any decision, once taken.

The decision shall be discussed between the Intensive Care Units and with referring medical or surgical teams and relatives of each patient involved, but the final decision of which patient to transfer rests with the Intensive Care Consultant of the referring Unit, who is responsible for both patients; no critical care team should place another Unit under unreasonable pressure to substitute referred patients.

If a patient on Critical Care Unit is transferred or discharged for the benefit of another individual or individuals, it is recommended that the reasons for transfer, together with anonymised clinical details of the other patient(s) involved, should be fully documented and archived by means of a Trust clinical incident report.

2.5.3 Successful Admission (State Green or Red): Information Flow

Upon agreement by the critical care team that the patient is suitable for admission:

- The nurse-in-charge shall be consulted before the patient is accepted, to ensure that nursing staffing levels are adequate to care for the new admission.
- If the patient is transferred directly from ED or accepted from another hospital, the relevant specialty or on-take general team shall be contacted and asked to assume responsibility for management after discharge from the Critical Care Unit.
- Relatives shall be informed of admission to the unit by Critical Care Unit employees.
- The patient's GP shall be informed of admission by telephone, letter or email.

2.6 Critical Care Unit Admissions from Outside the Hospital

2.6.1 Movement, Description, Action

Movement	Description	Action
Ward to Critical Care Unit	Patients needing current, or anticipated need for, Critical Care Unit care *and* local specialist care, referred from another hospital to a medical or surgical team outside Critical Care Unit.	Referral to critical care will be made by the local (receiving) consultant or their team. *It is the responsibility of the receiving specialty team to contact the* Critical Care Unit *medical staff and to verify bed availability before accepting the patient into the hospital.*
Ward to Critical Care Unit	Patients needing current or anticipated Critical Care Unit care *and* local specialist care (as above), referred from another hospital direct to the receiving Critical Care Unit team	Availability of beds will be confirmed but the referring hospital will then be asked to contact the appropriate specialist on-call team who, if they wish to accept the patient, will in turn make a referral to the critical care team.
Critical Care Unit to Critical Care Unit	Patients primarily requiring Critical Care Unit care and critical care expertise, referred directly from Unit to Unit. Includes repatriation of Critical Care Unit patients and non-clinical transfers due to lack of beds.	Referrals will be considered and accepted by the intensive care team. If there is an ongoing problem relating to the original cause of admission (e.g. related to surgery), the appropriate specialist team on-call should be asked to review the patient on arrival. The on-take team in the relevant speciality at time of arrival shall be responsible for care of the patient after discharge from Critical Care Unit, and will be notified as such.
Private sector to NHS: Emergency requests for critical care assistance	The Trust has a duty of care to all patients in the area, and will render all necessary assistance when clinically indicated. However, standard critical care admissions guidelines and equity of access shall be considered to apply to both NHS and private sectors. The critical care expectations and consent of private patients and their relatives shall be assessed and managed in line with those in the NHS: there can be no discrimination, either for or against private patients.	The Trust has a duty of care to all patients in the area, and will render all necessary assistance when clinically indicated. However, standard critical care admissions guidelines and equity of access shall be considered to apply to both NHS and private sectors. The critical care expectations and consent of private patients and their relatives shall be assessed and managed in line with those in the NHS: there can be no discrimination, either for or against private patients.

2.7 Coding of Critical Care Unit Bed State

Hospital Status	Unit Status	Admission Status
Black	No bed available	Closed to ED and all other external referrals. New in-house patients cannot be accommodated without transferring either the new patient or a more stable patient. Alternative provisions may be made in the case of pandemic disease situations.
Red	Two or fewer empty bed spaces or dependency equals or exceeds nursing staffing level	Closed to external transfers. In-house emergencies can be managed (by flexible use of HDU beds, by short-term ventilation in Recovery or Theatre areas, or by other means) but transfers cannot be accommodated, whether from within or outside the Network.
Amber	Four or fewer empty bed spaces and/or nursing staffing dependency exceeds dependency by two or less.	Open to all admissions. The unit is able to accept referrals from within the Trust, elsewhere in the Network, or outside the Network on the basis of clinical need.
Green	Six or fewer empty bed spaces and nursing staffing exceeds dependency by more than two.	
Green +:	More than six empty bed spaces and nursing staffing exceeds dependency by more than two	

2.8 Coding of Critical Care Unit Patients

Level 3: Cannot be discharged from Critical Care Unit
Level 2: Really needs Critical Care Unit but in event of extreme pressures on Critical Care Unit could be managed on a ward with Critical Care Team Input
Level 1: Would benefit from staying in Critical Care Unit but may be transferred to the ward if the bed state requires it
Level 0: Fully ready to be discharged from Critical Care Unit
Level Minus 1: Patient fully ready to be discharged from Critical Care Unit and this patient (or other patients in Critical Care Unit) disadvantaged by remaining in Critical Care Unit.

2.9 Actions

2.9.1 Critical Care Unit Status – Black

Level 3	Level 2	Level 1	Level 0	Level -1
Patients cannot be moved. Further level 3 admissions will need to be transferred to another Critical Care Unit or managed in an escalation area such as recovery.	Do not move patients out of Critical Care Unit unless more severely ill patient needs admission.	Move Level 1 patients out of Critical Care Unit as top priority. Receiving ward may need additional staffing	Move Level 0 patients out of Critical Care Unit as top priority	Move Level -1 patients out of Critical Care Unit as top priority.
Critical Care Unit Consultant needs to make admission, discharge and contingency plans. Site manager and Senior Critical Care Unit nurse need to identify escalation area.	Critical Care Unit Consultant needs to make admission and discharge decisions. Site manager to plan where any potential discharge could go and how it could be managed	Critical Care Unit Consultant to confirm patient status. Site manager to arrange discharge from Critical Care Unit	Site manager to arrange discharge from Critical Care Unit	Site manager to arrange discharge from Critical Care Unit

2.9.2 Critical Care Unit Status – Red

Level 3	Level 2	Level 1	Level 0	Level -1
Patients cannot be moved.	Do not move patients out of Critical Care Unit unless more severely ill patient needs admission.	Move Level 1 patients out of Critical Care Unit following discussion with Critical Care Unit Consultant.	Move Level 0 patients out of Critical Care Unit as top priority.	Move Level -1 patients out of Critical Care Unit as top priority.
		Critical Care Unit Consultant and Senior Nurse to decide whether patient discharged to ward or not. Site manager to arrange discharge from Critical Care Unit.	Site manager to arrange discharge from Critical Care Unit	Site manager to arrange discharge from Critical Care Unit

2.9.3 Critical Care Unit Status – Amber

Level 3	Level 2	Level 1	Level 0	Level -1
Patients cannot be moved.	Do not move patients out of Critical Care Unit unless more severely ill patient needs admission.	Do not move Level 1 patients out of Critical Care Unit unless more severely ill patient needs admission	Move Level 0 patients out of Critical Care Unit as top priority.	Move Level -1 patients out of Critical Care Unit as top priority.
			Site manager to arrange discharge from Critical Care Unit	Site manager to arrange discharge from Critical Care Unit

2.9.4 Critical Care Unit Status – Green

Level 3	Level 2	Level 1	Level 0	Level -1
Patients cannot be moved.	Do not move patients out of Critical Care Unit unless more severely ill patient needs admission.	Do not move Level 1 patients out of Critical Care Unit unless more severely ill patient needs admission	Move Level 0 patients out of Critical Care Unit where possible. Give priority to those patients who need discharge to specific ward.	Move Level -1 patients out of Critical Care Unit as top priority.
			Site manager to arrange discharge from Critical Care Unit	Site manager to arrange discharge from Critical Care Unit
Critical Care Unit Consultant to start to consider soft admissions when taking referrals from ward teams				

2.9.5 Critical Care Unit Status – Green+

Level 3	Level 2	Level 1	Level 0	Level -1	
Patients cannot be moved.	Do not move patients out of Critical Care Unit unless more severely ill patient needs admission.	Move Level 1 Do not move patients out of Critical Care Unit unless more severely ill patient needs admission	Move Level 0 patients out of Critical Care Unit where possible. Give priority to those patients who need discharge to specific ward.	Move Level -1 patients out of Critical Care Unit as top priority.	
			Site manager to arrange discharge from Critical Care Unit	Site manager to arrange discharge from Critical Care Unit	
Critical Care Unit Consultant to consider soft referrals. Site manager may suggest soft referrals. These should be based on requiring low level organ support rather than simply expedient for waiting times etc. Critical Care Unit consultant is final arbiter of such admissions. Critical Care Unit medical and nursing employees could be asked to support other areas of the hospital.					

2.10 Considerations between Admission and Discharge

2.10.1 Cleaning and Restock of Rooms

When a patient is discharged from the unit their room and its immediate area must be cleaned and restocked. The stripping, cleaning and restocking of each room needs to be carried out correctly to reduce the risk of cross infection. Serco staff should be called to carry out a “deep clean” if the patient had an infection which poses a risk to the next patient occupying the room. The Critical care team are responsible for other cleaning and restocking. Rooms should always be left clean and set up ready for the next admission.

2.10.2 Same Sex Accommodation

In order to facilitate same sex care, discharge and admission may result in a movement of more than one patient to more than one room or bay. The cleaning and restock must be carried out as above in section for each patient moved. This must be factored in when considering the movement.

2.10.3 Adult Discharge from the Department of Critical Care Unit

The Consultant on call for critical care determines when it is appropriate for a patient to be discharged from Critical Care Unit. In general, patients are ready for discharge when specific requirements for critical care are no longer needed. This may be because the patient’s condition has improved or because the condition appears irreversible and further support has been discontinued.

There may be occasions when discharge may be dependent on other factors than the patient being read for discharge from the Units. Patients may be discharged when there is a pressing need for other critical patients to use the Critical Care Unit

There may be occasions when a patient is fit for discharge from the unit cannot be discharged if there is no bed available for them to be admitted to a GWH general ward.

2.10.4 Out of Hours Discharge

It is considered bad practice to discharge a patient from the Unit outside the normal working day of the area they are being discharged to as this prevents suitable handover to the ward teams and is disruptive for the patient, therefore all reasonable efforts should be made to discharge a patient from the Critical Care Unit to a receiving ward between 0800-1800. All out of hours discharges must be reported via the incident reporting system.

2.10.5 Communication Regarding Discharge from the Unit to a GWH Ward

Patients and their family/carer/friends are to be informed and updated with decisions made about their care and to be informed that as they are no longer considered critically ill it is appropriate to discharge then to a general ward within the GWH.

2.11 Deviations from Best Practice Discharge

The timing of discharge is often precipitate and unplanned. It is important that the patients are discharged from Critical Care Unit and into the correct specialty ward for their needs. Discharge for complex cases is significantly improved and streamlined if the receiving team have opportunity to be involved in patient care before the patient leaves the Critical Care Unit, however this is not always possible. Often due to the nature of an acute hospital, discharge planning may not be possible to follow through with and decisions are often reconsidered to fall in line with the GWH overall bed capacity.

When a patient is fit for ward discharge, their swift transfer out should be a priority in order to ensure appropriate patients can be accepted to the unit. The Unit should attempt to admit all patients accepted to the Critical Care Unit in less than one hour.

2.12 Failure to Admit

Just as timing of discharge from Critical Care Unit is complex, the decision to admit patients is. Depending on the bed state of the Critical Care Unit the decision whether or not to admit patients may be different. Sometimes the admission may be to solve a specific problem, for example a complex pain management problem. Sometimes it is felt patients might benefit from Critical Care Unit admission even if none of the specific Critical Care Unit interventions are planned. Early admission may prevent deterioration.

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
Unavoidable Delayed discharges	Intensive Care National Audit & Research Centre (ICNARC) data	ICNARC team	Continuous	Quarterly reports to Surgery Women and Children Divisional Board	An improvement plan will be requested and a re-audit back to the committee.
100% of patients admitted within four hours of decision to admit	Paper notes audit – of 10 consecutive patients	Medical CCU team	Quarterly	Exception reporting to Surgery Women and Children Divisional Board	An improvement plan will be requested and a re-audit back to the committee.

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Ward Managers, Matrons and Managers for Non Clinical Services

All Ward Managers, Matrons and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.3 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.4 Intensive Care National Audit & Research Centre

Provide report on a quarterly basis to the Surgery Women and Children Divisional Board.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	GPICS 2: Guidelines for the Provision of Intensive Care Services Ed 2, June 2019	https://www.ficm.ac.uk/sites/default/files/gpics-v2.pdf
2	Dept of Health document EL-96-20, "Guidelines on admission to and discharge from Intensive Care and High Dependency Units", March 1996	*https://www.gov.uk*
3	(National Framework Document "Comprehensive Critical Care: A review of Adult Critical Care Services")	*webarchive.**national**archives.gov.uk*
4	http://picsociety.uk/wp-content/uploads/2016/05/PICS_standards_2015.pdf	lhttp://picsociety.uk
5	Treatment Escalation Plan (TEP) and Resuscitation Decision Policy	T:\Trust-wide Documents
6	Deprivation of Liberty Safeguards (DoLS and Mental Capacity Act) Policy	T:\Trust-wide Documents
7	Mental Capacity Act 2005 Policy and Procedures	T:\Trust-wide Documents
8	Mental Health Act Policy and Procedures	T:\Trust-wide Documents
9	Resuscitation Policy	T:\Trust-wide Documents
10	Acute Pain Assessment and Management in Adults Including the Abbey Pain Scale for Use with Patients who are Cognitively Impaired Guideline	T:\Trust-wide Documents
11	Delivering Same Sex Accommodation Policy.	T:\Trust-wide Documents

Ref. No.	Document Title	Document Location
12	Consent for Medical Treatment for All Patients at the Great Western Hospital Policy	T:\Trust-wide Documents

5.2 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Consultant Cardiologist	27.04.21
Deputy Divisional Director of Nursing	27.04.21
Matron ICU	28.04.21

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Critical Care Unit (CCU) (all patients) Admission and Discharge Policy		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? This document sets out the Great Western Hospitals NHS Foundation Trust (the Trust) policy regarding the admission and discharge of both adult and child patients from the Department of Critical Care (Level 3 – Intensive Care patients; Level 2 – High Dependency patients)at the Great Western Hospital (GWH).		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Mark Yeates
Date completed	10.05.21
Job Title	Consultant Anaesthetics

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.