1. Introduction and Who Guideline applies to

The objective of this guideline is to ensure appropriate and timely admission of patients (planned and unplanned) to critical care and to facilitate the proper utilization of limited resources.

If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient on the ward and the consultant staff in critical care.

The decision to admit a patient to a critical care unit should be based on the concept of potential benefit. Patients who are “too well” to benefit or those with no hope of recovery to an acceptable quality of life (“too ill to benefit”) should not be admitted. This is a clinical decision based on individual circumstances.

The refusal of an admission to a critical care area on clinical grounds should only be made by a critical care consultant. Patient autonomy should always be respected e.g. advanced directives.

Good communication between the referring medical and nursing team to the critical care medical and nursing teams is essential for optimal referral, transfer and care. Timely communication with the critical care nurse in charge prior to transfer to critical care is crucial to ensure optimal treatment on arrival.

2. Guideline Standards and Procedures

i. Emergency Admissions

- Admission to critical care should be agreed between the referring consultant and the duty critical care consultant. It is the critical care consultant's responsibility to ensure that an admission can be accommodated safely, taking into context other workload within the critical care, within the hospital and beyond the hospital. The critical care consultant is best placed to make such admission decisions, and therefore all admissions to critical care/decisions to proceed with elective surgery must go through the on call critical care consultant with no exceptions.

- For patients being transferred from within the hospital it would normally be appropriate for the critical care consultant or a member of the critical care team to see the patient prior to making an admission decision except when patient's condition is critical.

- If there is an agreed need for intensive care and a critical care bed is unavailable in the hospital, it should be the shared responsibility of the referring clinician and the critical care consultant to make efforts to arrange appropriate alternative care

ii. Elective Admissions

- Patients undergoing elective high-risk major surgery and requiring post-op HDU care should be booked into the critical care unit giving as much notice as possible.

- Decisions regarding elective admissions are best performed by direct communication between the critical care consultant or nurse in charge/floor control/relevant surgeon or anaesthetist with appropriate input from non-clinical management team when necessary. It is not acceptable for non-clinical management team to make decisions regarding admissions and allocation of beds. As above, this is the responsibility of the critical care consultant.

- Emergency admissions take priority over elective admissions.

- Once the surgery has begun the critical care bed is considered occupied

iii Refusals

If a patient is refused admission for clinical reasons or lack of critical care capacity this must be recorded by critical care staff.

3. Education and Training

This will be included as part of induction for medical staff to the intensive care unit.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
ICNARC data	Review of data for delayed discharges or discharges outside of agree hours	A Srivastava	Ongoing	ICNARC Report

5. Supporting References (maximum of 3)

None

6. Key Words

Intensive Care

Leicester General Hospital

LGH

Admissions

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Dr James Sadler	**Executive Lead** ICU Core Group
Details of Changes made during review: **N/A**	