1. Introduction and Who Guideline applies to

The objective of this guideline is to ensure appropriate and timely admission of adult patients to critical care and to facilitate the proper utilisation of limited resources. Admissions are a daily occurrence within the hospital and in the interests of patient safety this guideline should be implemented as soon as possible.

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 anacceptable 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 normally be agreed between the referring consultant and the duty critical care consultant.

- For patients being transferred 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. It may be appropriate to admit for assessment and to monitor the patient's initial response to therapy.

- The critical care consultant should check the available level of service the critical care unit can offer both in terms of the number of beds and the number of nurses available in the current and subsequent shift. 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. The duty manager should be informed of the difficulty and resource implications. An available critical care bed may be identified by accessing the live bed bureau.

- Where a consultant in another hospital requests admission of a patient to critical care and a bed is made available, the referring consultant is responsible for arranging continuing care by a surgical/medical consultant located on the same site as the critical care bed. The referring consultant is also responsible for arranging safe transfer arrangements before the patient is accepted (in consultation with the receiving consultant). If no bed is available this should be documented as a refusal. It is essential that all information relating to the patients condition and rationale for transfer, is clearly recorded, using an agreed standardised format for written communication.

- When a severely ill patient has to be transferred to a critical care unit in another hospital it is essential that an experienced doctor should accompany the patient with the appropriate skills in resuscitation.

ii Elective Admissions

- Patients undergoing elective high-risk major surgery should be booked into the critical care unit giving as much notice as possible. Patient details should be recorded (in appropriate record).

- It is the responsibility of the surgeon/anaesthetist to check the availability of a bed before starting surgery.

- Emergency admissions take priority over elective admissions.

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

iii Organ Donation admissions

Such patients can be admitted to the Intensive Care Unit provided that:

- They are not displacing those potentially capable of recovery.

- They are not currently being supported in another ICU/HDU.

- The patient's relatives have been informed and have agreed to the transfer and subsequent organ retrieval.

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)

Young, Goodner et al. Inpatient transfers to the intensive care unit. Delays are associated with increased mortality and morbidity. J Gen Intern Med Feb 2003;18: 77-83

Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. National Institute for Health and Clinical Excellence, July 2007

1999

6. Key Words

Intensive Care Unit

Leicester Royal Infirmary

LRI

Admission

ITU

ICU

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