1. Introduction and Who Guideline applies to

This guideline covers all patients admitted to or discharged **from Glenfield Adult Intensive Care Unit.**

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

Admissions

- **All admissions** to Glenfield Hospital AICU need to be approved by the duty consultant. There are **no** exceptions to this.

- Please also discuss with the consultant on duty any patients in whom escalation to AICU could be considered inappropriate following referral for an Intensive Care opinion. The outcome of this discussion **must** be clearly documented within the notes.

- Following the decision to admit a patient from the ward the transfer **must** happen within **2** hours with appropriate monitoring. Please contact the Deteriorating Adult Resonse Team (DART) on bleep: 2808 for assistance if they are not already present at the bedside.

- Following the decision to admit please contact the nurse in charge on AICU to ensure the ICU is prepared in advance of patient arrival. This will also allow relevant equipment such as ventilators, transducers for arterial or central access lines to be prepared.

- The decision for escalation to AICU remains the responsibility of the duty Consultant for AICU.

Discharge

- All patients **must** be reviewed by a consultant prior to to discharge.

- The ward drug card **must** be reviewed prior to discharge.

- The ward drug card **must** be checked by a consultant prior to discharge.

- The discharge sticker can **only** be used for post cardiac surgery patients.

- **All** non-cardiac patients **must** have a written discharge summary.

- **All deaths** must be entered into the Morbidity and Mortality template for subsequent discussion at local meeting.
- **All ECMO** patients require a ECMO discharge summary. This must be checked by the ECMO consultant prior to discharge. If the ECMO consultant is not available this must be checked by the consultant for AICU.

- Patient discharge, **should** not occur after 19:00 and **must** not occur after 21:59.

- Verbal handover **must** occur prior to discharge. A confirmation of handover **must** be documented in the notes. Handover must include:
    1. A summary of critical care stay including diagnosis, treatment and changes to chronic therapies
    2. A monitoring and investigation plan
    3. A plan for ongoing treatment
    4. Physical and rehabilitation needs
    5. Psychological and emotional needs
    6. Specific communication needs
    7. Follow-up requirements

- Discharge **should** occur within **4 hours** of decision to discharge. Please inform duty consultant if this is not the case.

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

Glenfield

Admission

Discharge

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Dr Richard Porter Consultant in AICU and ECMO	**Lead Committee or Executive Lead** ICU Core Group