

Network Admissions Policy for Adult Critical Care Services	
Policy author	NWLCC Network Clinical Lead
Version	September 2018
Date ratified	Changes from 2017 - none Changes from 2016 - none
Ratifying Body	Network Joint Clinical Forum Board
Review date	September 2019

1 Definitions

1.1 Levels of care

(National Framework Document “Comprehensive Critical Care: A review of Adult Critical Care Services”)

Level 0: Normal acute ward care.

Level 1: Acute ward care with additional advice and support from critical care team.

Level 2: More detailed observation or for support of a single failing organ system only, *other than* advanced respiratory support

Level 3: Support of at least two organ systems, *or* advanced respiratory support

2 Common principles

2.1 Philosophy of adult ITU admission

(Reworked from Dept of Health document EL-96-20, “Guidelines on admission to and discharge from Intensive Care and High Dependency Units”, March 1996)

- i. 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
- ii. 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.
- iii. 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 or ethnicity.
- iv. A patient’s stated or written preference for or against intensive care must be taken into account. The role of relatives in the case of an incapacitated patient is to represent their understanding of what the patient would wish.

3.1 Referral

- i. Any consultant or appropriately experienced member of their team may refer patients to critical care services.
- ii. In addition, nursing or allied health professional staff, or members of the outreach team where one exists, may need to alert critical care medical staff directly in circumstances of unusual urgency. In these cases the referring team must always be alerted in parallel and are expected to attend.
- iii. The referring team shall maintain responsibility for the patient up to admission to intensive care, and shall remain responsible for ongoing management if admission is refused or deferred.
- iv. No Unit in the Network shall accept a patient for transfer from any department (wards/theatres/A&E) of another hospital unless he or she has been referred to the critical care team of the referring hospital and assessed as suitable.

3.2 Response to referral

The critical care team shall review the patient according to clinical urgency. Critical care review does not imply that care of the patient has been taken over, or absolve the referring team of responsibility. Review may result in one of several outcomes:

i. Decision to admit*Criteria*

- Patient has a reversible acute condition and is appropriate for advanced intervention as discussed in section 2.1.
- Patient needs level 2 or level 3 care, 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.
- 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.

Action

- Transfer to appropriate critical care area as soon as available. This may mean transfer within the hospital, within the Transfer Group, or outside the Transfer Group. See section 4 – admission procedure.

ii. Decision for active level 1 (ward) management and review

Criteria

- Patient has a reversible acute condition and is appropriate for advanced intervention as discussed in section 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 critical care team (level 1).
- Patient would benefit from further investigation and management of underlying acute condition in an acute ward setting.

Action

- 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. Critical care team input shall be advisory and may include bedside training or interventional support at their discretion.
- Critical care team shall maintain active review at agreed intervals, either direct review by Unit clinicians or via outreach team. Patient shall be urgently reviewed with a view to admission if condition deteriorates.

iii. Substantive decision not to admit

Criteria

- 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.

Action

- 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 according to local policy 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 staff may order or force an admission which has been refused by the critical care team after discussion at consultant level. In cases of extreme dissent the Unit lead clinician, respective clinical directors and risk management team should be consulted.
- Critical care staff shall render assistance and advice on palliative or other supportive care of refused patients. However, final responsibility for ongoing management shall rest with the referring team.
- The patient's resuscitation status should be reviewed under the Trust's "Do Not Resuscitate" policy as a logical and integrated part of critical care discussion.

4 Admission procedure

4.1 ITU Bed State

- The nurse-in-charge and the intensive care consultant shall agree upon one of three operating states for level 3 (ITU) areas:
- **“Green”:** **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.
- **“Amber”:** **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. *A Unit with one remaining full ITU bed may declare itself to be in either the Green or the Amber state: this will depend on local policy, availability of other in-house resources, and individual judgement.*
- **“Red”:** **Closed to A&E and all other external referrals.** New in-house patients cannot be accommodated without transferring either the new patient or a more stable patient (see below).

4.2

Course of action when Unit closed to referrals (State Red)

- If a new in-house referral is judged to be suitable for ITU 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 medicolegal implications. Each Trust has a duty of care to all its patients inside and outside ITU, and must triage resources accordingly. However, transferring an existing stable ITU patient means removing them from a place of safety against that patient's own best interests.
- Therefore, in line with prevailing opinion and practice throughout the vast majority of hospitals in the Network, it is anticipated that a patient already on ITU should be transferred out *only under exceptional circumstances*.
- Conversely, the Network clinicians as a body accept that 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 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 ITU 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.

4.3

Successful admission (State Green or Amber): 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 patient is transferred directly from A&E 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 ITU.
- Relatives shall be informed of admission by ITU staff.
- The patient's GP shall be informed of admission by telephone, letter or email.

5 ITU admissions from outside the hospital

5.1 **Ward to ITU (i): Patients needing current or anticipated ITU care and local specialist care (e.g. oncology, vascular surgery), referred from another hospital to a medical or surgical team outside ITU**

Referral to critical care will be made by the local (receiving) consultant or their team. Referral centres may operate a priority system between referring hospitals to manage demand. *It is the responsibility of the receiving specialty team to contact the ITU medical staff and to verify bed availability before accepting the patient into the hospital.*

Tertiary referral centres with existing links outside the Network may choose to prioritise their admissions so as to provide a service both within the Network and to other hospitals relying on them for support.

5.2 **Ward to ITU (ii): Patients needing current or anticipated ITU care and local specialist care (as above), referred from another hospital direct to the receiving ITU 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.

5.3 **ITU to ITU: Patients primarily requiring ITU care and critical care expertise, referred directly from Unit to Unit. Includes clinical transfers to specialist Units, 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 ITU, and will be notified as such.

5.4 **ITU to ward: Repatriation of ITU patients**

A repatriation policy is under separate discussion.

5.5 **Private sector to NHS: Emergency requests for critical care assistance**

The Network and its constituent Trusts have 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.