

NORTH TRENT CRITICAL CARE NETWORK

ADMISSION POLICY FOR INTENSIVE CARE

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This policy was prepared in conjunction with consultant colleagues throughout the NTCCN

1.0 GENERAL

Intensive Care may be defined as a service for patients who can benefit from more detailed observation, monitoring and treatment than is available on a general ward (or high dependency unit).

It is appropriate for patients requiring or likely to require advanced respiratory support (IPPV), or support of two or more other organ systems.

Patients with existing chronic impairment of organs may well require intensive care at a lower degree of acute organ failure.

It is not appropriate for an admission policy to be too proscriptive about which patients should be admitted or not to intensive care but inappropriate admissions or failure to admit appropriate patients can be minimised by ensuring that referral to ITU is normally by:

Consultant to Consultant referral. It is acceptable for this decision to be delegated to senior trainees.

It is not acceptable for trainee staff to refuse admission without discussion with more senior staff.

It is not acceptable to refuse admission because there are no available beds.

Any referral to ITU will be seen prior to admission.

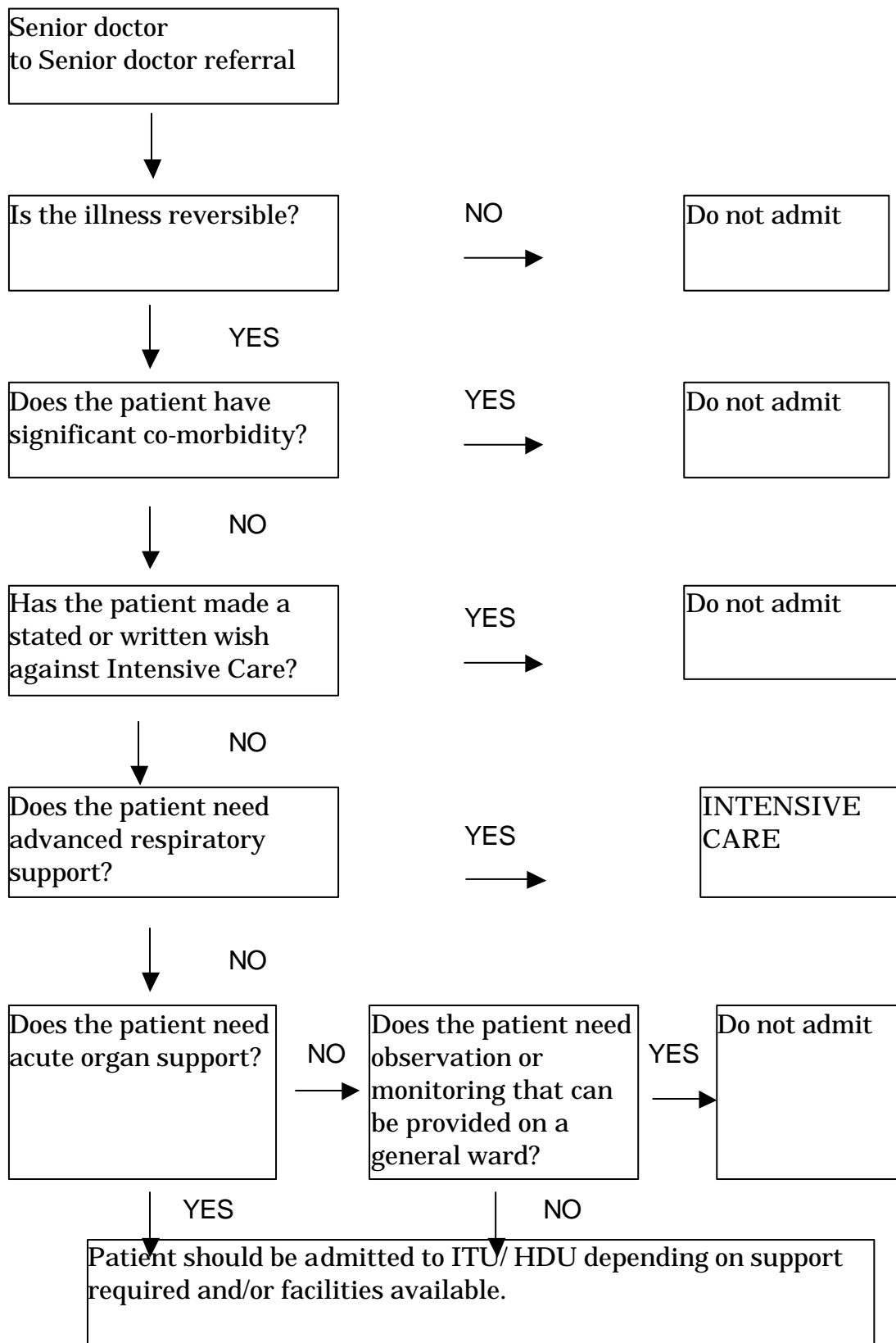
Admission should not be refused on the basis of age.

The nurse in charge of Intensive Care must always be consulted prior to admission to ensure there are adequate staff and equipment.

Patients should be admitted under the care of a non Intensive Care Consultant. This Consultant must be made aware of the patients admission at the earliest opportunity.

Early referral of patients to ITU may prevent the need for admission if timely optimisation is carried out.

1.1 Flow Chart for ITU Admission



2.0 Reversibility of illness

This may be difficult to assess and if there is doubt the patient should be admitted and their response to therapy gauged after an appropriate time period.

Where possible the patient and /or relatives should be involved in decision making.

Inappropriate Intensive Care may prolong the process of dying and cause suffering.

No member of staff should be permitted to order that a patient is admitted to Intensive Care. WHERE THERE IS DISPUTE THERE SHOULD BE DISCUSSION BETWEEN CONSULTANT ICU STAFF AND CONSULTANTS FROM THE REFERRING SPECIALTY.

3.0 Co-morbidity

The presence of significant co-morbidity, with its attendant limited physiological reserve makes recovery from acute illness unlikely.

Patients in certain groups are highly unlikely to benefit from intensive care. (ALTHOUGH EVERY CASE SHOULD BE JUDGED ON ITS INDIVIDUAL MERITS)
These include:

Patients requiring domiciliary oxygen.

Patients who are bed ridden with a chronic deteriorating condition.

Patients in a persistent vegetative state.

Patients with severe subarachnoid haemorrhage or CVA.

Patients with proven disseminated malignancy.

Patients with terminal neurodegenerative states.

4.0 Advanced respiratory support

The decision as to whether a patient requires such support can only be made by a senior doctor from Intensive Care.

The decision to place a patient requiring non-invasive ventilation on HDU ITU/ or specialised ward depends on the capability of individual hospitals.

5.0 Other acute organ support

The number and severity of organ failures and what level of care these require will vary from hospital to hospital and will depend on staffing levels and dependency of other patients. The ultimate decision rests with a senior intensive care doctor and should be made in conjunction with nursing staff.

6.0 Elective Admissions to ICU

These should be booked as far ahead as possible by the admitting team.

Bookings should be for named patients only.

Surgeons and anaesthetists who have booked elective cases must check on bed availability before starting a case. If a case is started in the knowledge that there are no ITU beds then the surgeon/anaesthetist must accept responsibility for any adverse patient outcome.

At times of extreme pressure on the Networks ITU beds, individual hospitals may need to cancel elective surgery in order to help manage the Networks emergency workload.

Elective admissions that are cancelled due to lack of beds should be re-booked as soon as possible. (Noting previous cancellation). If a second cancellation appears likely the Executive Director of the hospital with responsibility for Intensive Care must be informed and all possible actions taken to prevent further cancellation.

Each hospital should agree a process to avoid repeated cancellations.

7.0 Transfers from other hospitals

These must be by direct consultant to consultant referral.

Patients must be admitted under a non ICU consultant. This is the responsibility of the referring hospital.

If patients arrive without a named consultant, they will be admitted under the appropriate on call consultant at the receiving hospital.

Prior to accepting a patient from outside of the Network (not including agreed unique transfer groups) each Trust must implement the process they have in place to advise the Trust Chief Executive (or nominated deputy) of the referring hospital of this transfer. It is the responsibility of the Trust Chief Executive (or nominated deputy) of the referring hospital to inform their opposite number at the receiving hospital of the transfer. It is the responsibility of the Chief Executive (or nominated deputy) of the referring Trust to inform its host Health Authority Chief Executive of the transfer by the next working day. **This process does not apply to transfers for clinical reasons.**

All non clinical out of Network transfers will be regarded as an adverse event.

Patients from other hospitals should not be refused admission in order to protect beds for internal emergency or elective admissions.

There will be occasions when hospitals are asked to take back patients who have required cardiac or neurosurgical procedures and when the patient no longer requires specialist ICU facilities. Every effort should be made to take these patients as soon as possible. Occasionally there may be disagreement over these cases. If these are not readily resolved there should be a discussion between the lead clinician for the specialised ICU, the lead clinician for the ICU the patient is being referred back to and the clinical co-ordinator of NTCCN.

See also NTCCN Transfer policy.

8.0 Admission of emergency patients when the unit is full

All hospitals within the Network should formulate a contingency plan to deal with additional emergencies in the short term particularly during periods of peak pressure.

These plans include admitting a patient to a designated area outside of the Intensive Care Unit to stabilise their condition until they or another patient can be transferred out. The locations that this may occur in will vary from hospital to hospital.

VENTILATION OUTSIDE THE INTENSIVE CARE UNIT SHOULD ONLY OCCUR IN EXCEPTIONAL CIRCUMSTANCES.

9.0 Admissions from the independent sector

Transfers from the private sector to the NHS will be regarded as clinical emergencies and wherever possible an appropriate bed within the Network will be found. It is important to try to prevent disruption to the NHS's elective operating and to minimise the risk of out of Network transfers.

The independent sector has a duty to determine the availability of local NHS critical care beds before proceeding with potentially difficult cases.

Occasionally during periods of extreme pressure it may be appropriate to transfer patients from the NHS to critical care beds in the independent sector.