

# **NORTH TRENT CRITICAL CARE NETWORK.**

## **POLICY FOR DISCHARGING PATIENTS FROM ITU.**

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This policy was prepared in conjunction with clinical colleagues  
from the NTCCN and agreed by  
North Trent Critical Care Network Steering Group 08.01.01

### **1.0 Discharge Criteria**

Discharge from the critical care area should be considered when:

The condition which led to admission has been treated and the patient improved.

The patient no longer requires advanced respiratory support, or the support of more than one other organ.

The patient is no longer benefiting from the treatment. [ See treatment limitation, withdrawal. ]

The patient / relatives no longer wish to be treated in the critical care area.

The patient requires transfer to another hospital for specialist care.

Occasionally a patient may need to be transferred to another ITU in order to admit a patient who is more acutely ill. [ See transfer policy. ]

Information becomes available about a patient's pre-existing health which means that further treatment will not benefit the patient. [ See treatment withdrawal, limitation. ]

There is some debate about whether a patient should ever be discharged earlier than is clinically ideal in order to accommodate a new patient who is more acutely unwell. It is impossible to be prescriptive about this, but any such decision must be taken by the consultant on duty for ITU and the discharge should be considered an adverse incident. Audit of such occurrences should be performed.

## **2.0 Approval for discharge.**

Patients should only be discharged with the knowledge and approval of the consultant on duty for ITU.

The nurses caring for the patient should be consulted.

The admitting team should be informed and their views obtained.

In cases of dispute it is wise to obtain another opinion, but **THE DECISION OF THE ITU CONSULTANT IS FINAL.**

The patient and where possible the relatives should be informed.

## **3.0 Prior to discharge.**

The admitting team must find a bed.

Any problems relating to appropriate bed availability should be referred to the appropriate bed manager. It is vital that critical care areas are given the highest priority.

A discharge summary should be written including where appropriate any limitations on future treatment.

Inform the outreach team [ if operational. ] Visits from this team may help prevent problems following discharge.

Regular visits by the admitting team prior to discharge help to facilitate timely discharge.

Whenever possible as much notice of discharge should be given to the receiving ward so that they can plan the best care possible. This may be done in conjunction with the outreach team.

#### **4.0 Discharge to HDU.**

This may be appropriate if the patient has been on ITU for a prolonged period. The ability to “ step-down ” may prevent bed blocking.

Patients may be considered for discharge to HDU if they still require high levels of nursing care, monitoring or active support of one or more organs.

#### **5.0 After Discharge.**

Patients should be visited regularly and advice given to the admitting team. The outreach team has a valuable role to perform here.

#### **6.0 Treatment Limitation / Withdrawal.**

Assessment of the continuing benefit of ITU care should be made on a regular basis.

The decision to limit further treatment should only be taken after discussion with the rest of the intensive care team and the referring team. The decision should also be discussed with the patient / relatives.

When a decision is taken to limit or withdraw treatment it is essential that the patient is made comfortable and that all basic care is given. Whether such a patient should remain on ITU or be discharged depends on the individual circumstances.

When there are disagreements about appropriateness of further intervention the views of other intensive care doctors and other doctors in the admitting specialty should be sought.

## **7.0 Organ donation.**

When a patient is declared brain-stem dead a senior ITU doctor should approach the relatives to discuss organ donation. Further management should be handled in conjunction with the Transplant Coordinator.

It is not currently policy to accept patients onto ITU simply to facilitate organ donation. [ Elective ventilation. ]