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Appendices
1 – Bed Booking Form
2 – Discharge Summary (Draft)

References
- Guidelines on and admission to and discharge from Intensive Care and High Dependency Units – Department of Health 1996
- Quality Requirements for Adult Critical Care in Wales
- Comprehensive Critical Care
- Audit Commission Critical to Success
- NICE Guidelines CG50 Care of Acutely Ill
- National Good Practice Guidance on Pre-operative Assessment for Inpatient Surgery – NHS Modernisation Agency
- Patients requiring scheduled surgery (NCEPOD 3)
- Pre-operative process for elective (CEPOD 4) booked inpatient

Acknowledgements
- Mid Trent Critical Care Network
- North West London Critical Care Network
- SEWCCN Admission and Discharge Policy Working Group
1. INTRODUCTION

This document sets out the admission, discharge and operating policies for the Critical Care services in the South East Wales Care Network. This includes adult critical care (Level 3 and Level 2) beds, outreach services and flexible, extended provision of critical care where these exist. These guidelines outline best practice and it is recommended that the individual critical care units assess their current practices.

This policy relates to Critical Care services in:

**Cardiff and Vale NHS Trust**
- University Hospital of Wales
- Llandough Hospital

**Cwm Taf NHS Trust**
- Prince Charles Hospital
- Royal Glamorgan Hospital

**Gwent Healthcare NHS Trust**
- Nevill Hall Hospital
- Royal Gwent Hospital

The current critical care service provision in each hospital is as follows:

<table>
<thead>
<tr>
<th>Site</th>
<th>Level 3</th>
<th>Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital of Wales, Cardiff</td>
<td>14</td>
<td>10 Flexible – 1 unit. Capacity to increase by 5 Level 3 beds</td>
</tr>
<tr>
<td>Llandough Hospital, Cardiff</td>
<td>5</td>
<td>4 Capacity to increase 1 additional Level 3 bed</td>
</tr>
<tr>
<td>Royal Glamorgan Hospital, Llantrisant</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Prince Charles Hospital, Merthyr Tydfil</td>
<td>5</td>
<td>2 Flexible – 1 unit</td>
</tr>
<tr>
<td>Royal Gwent Hospital, Newport</td>
<td>6</td>
<td>8 2 separate units</td>
</tr>
<tr>
<td>Nevill Hall Hospital, Abergavenny</td>
<td>6</td>
<td>2 Flexible – 1 unit</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>30</strong></td>
</tr>
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</table>
2. **LEVELS OF CARE**

The table below describes the Levels of Care used in the Quality Requirements for Adult Critical care and are referred to throughout this document.

With the development of more flexible and integrated critical care services the distinction between level 2 and level 3 care units is becoming blurred and the term critical care unit is used throughout this document.

For clarification Level 2 care was previously referred to as High Dependency Care and Level 3 care was previously referred to as Intensive Care.

<table>
<thead>
<tr>
<th>Level 0</th>
<th>Suitable for patients whose needs can be met through normal ward care in an acute hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Suitable for patients at risk of their condition deteriorating, those recently relocated from higher levels of care, and those whose needs can be met on an acute ward with additional advice and support from the critical care team.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Suitable for hospitalised patients requiring more detailed observation or intervention, including support for a single failing organ system, postoperative care and those stepping down from higher levels of care.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Suitable for hospitalised patients requiring advanced respiratory support in addition to the above, but the duration of multi-organ support or ability to manage multiple patients might be limited by staffing or equipment constraints.</td>
</tr>
<tr>
<td>Level 3T</td>
<td>Organ support and monitoring for most body systems should be available at Level 3T and these facilities would normally be available to multiple patients simultaneously. This level is suitable for critically ill patients requiring prolonged support for multi-organ failure. Such units would have a significant teaching and training role.</td>
</tr>
</tbody>
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3. COMMON PRINCIPLES

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.

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.

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.

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.

The final decision to admit or refuse admission of patients to the critical care unit is the responsibility of duty critical care consultant. Any disputes should initially be discussed between the duty critical care consultant and referring consultant. If further resolution is required this should involve the respective lead clinicians or clinical directors.

All patients admitted to critical care will have their care directed by critical care staff. Whilst the referring team will be encouraged to regularly visit critical care and discuss the case with critical care staff the final decisions regarding changes to therapy will rest with the duty critical care consultant.

It is not an appropriate use of critical care resources to admit to or delay discharge from the critical care unit patients who cannot be managed on an appropriate general ward due to organisational factors (e.g. ward staff shortages). Such organisational factors should be brought to the attention of the referring consultant and if required the clinical director and management team of the referring location.
4. ADMISSION CRITERIA

The Department of Health document (EL-96-20) published in March 1996 provides a list of conditions and physiological parameters that may trigger admission to critical care.

Whilst these may be useful they should not take precedence over the philosophy outlined in the previous section (common principles).

Furthermore there have been significant advances in surgical and anaesthetic practice since 1996 and many postoperative patients can now be safely managed in a Level 1 setting rather than critical care.

Postoperative pain services provide support for patients requiring appropriate ward care and it is inappropriate to admit a patient to a critical care area for the main purpose of postoperative analgesia management (epidural management).

5. REFERRAL PROCEDURE

5.1 PLANNED REFERRALS (POST OPERATIVE CRITICAL CARE ADMISSION)

1. The referral to Critical Care for postoperative care should be based on the assessment of the patient’s care requirements and not based on the procedure to be carried out. The lack of evidence-based admission criteria mandates an early consultant to consultant referral of such patients.

2. Pre-operative assessment is an important part of the surgical patient’s pathway. It must be integrated within the wider system, including waiting list management, elective and emergency admissions, booking of dates, operating theatre list compilation, bed management and discharge planning.

“Pre-operative assessments should identify requirements to aid scheduling of the surgical procedure, including specialist equipment, approximate length of surgery and any special requirements for the post-operative stay, eg critical care beds”

3. For planned (elective) admissions, the referring consultant’s team should liaise directly with the medical and nursing staff on the Critical Care Unit as early as possible completing the attached Bed Booking form or similar (see appendix 1). These admissions must be booked in the admissions diary and countersigned by a senior member of the medical or nursing staff. Bookings will be accepted for specific patients only.
Substitution of patients must be negotiated with the critical care team.

4. In line with NICE CG50 - if admission to a critical care area is clinically indicated, then the decision to admit for elective admissions should normally involve both the consultant caring for the patient on the ward and the consultant in critical care.

5. Recording and reporting of cancelled operations due to lack of critical care bed should be reported by the Critical Care Unit and reported to the Trust’s information department as part of the regular Emergency pressures reporting.

6. Critical Care Units should complete the “outcome” section of the Bed booking form to monitor booked planned admissions against actual booked admissions.

7. In some instances, when a critical care bed has been identified as required, but a bed is not available, the surgeon decides to proceed with the planned operation. These instances should also be monitored.

8. Cancelled cardiac operations due to lack of Cardiac Intensive Care bed should be identified and reported separately to the critical care beds. Beds within the Specialist Cardiac Intensive Care Units are ring fenced and separated from the Critical Care units and therefore data needs to be reported separately in order for both the Critical Care Networks and Cardiac Networks to develop appropriate solutions and monitor performance accordingly.

9. Where there are also separate Intensive Care units for Burns/Plastics, neurosurgery, etc. These should also be identified and reported separately.

5.2 UNPLANNED REFERRALS

Referral of patients to critical care services should be undertaken at consultant level (NICE Guidance CG50). All potential patients should be discussed with the duty critical care consultant by the admitting consultant. Direct referrals from the Emergency Department should come from either the admitting consultant or the emergency medicine consultant.

In circumstances of unusual urgency, junior medical staff, 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 these cases the referring consultant must always be
alerted in parallel and the most senior member of the referring team is expected to attend.

All patients referred for critical care should be reviewed by the Critical Care Consultant prior to admission. This may not be appropriate in certain circumstances in which case these patients should be reviewed by the Critical Care consultant within 12 hours.

It is the responsibility of the Critical Care service to assess patient’s suitability for critical care need wherever possible

No patient should be admitted without the explicit agreement of the Critical Care Consultant.

Critical Care referrals from the Outreach team should still be reviewed by the Critical Care consultant and decision to admit remains with the critical care Consultant.

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.

Trainee medical staff are not empowered to refuse patient admission without discussion with the duty critical care consultant.

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.

6. 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 absolves the referring team of responsibility.

The referring team shall maintain responsibility for the patient up to admission to critical care and shall remain responsible for ongoing management if admission is refused or deferred.

It is essential that the date, time, and grade of critical care staff reviewing the patient together with the decision must be clearly documented in the patient’s notes.

Review may result in one of several outcomes:
6.1 Decision to admit

Criteria
- Patient has a reversible acute condition and is appropriate for advanced intervention as discussed in the common principles section.
- 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 or to another critical care facility either within or out with the SEWCCN.
- Acceptance of referral implies take over of patient care and accepted clinical responsibility

6.2 Decision for enhanced ward management and review

Criteria
- Patient has a reversible acute condition and is appropriate for advanced intervention as discussed in common principles section.
- 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.

6.3 **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 and critical care team. This decision needs to be communicated to the 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.

- **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.
7. ADMISSION PROCEDURE

CRITICAL CARE Bed State

- The nurse-in-charge and the intensive care consultant shall agree upon one of three operating states for critical care:

- **“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 unoccupied Critical Care 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 clinical 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).

**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 Critical Care.

- Relatives shall be informed of admission by Critical Care staff.

The patient’s GP shall be informed of admission by telephone, letter or email.

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

The intensivist will undertake a balanced clinical risk assessment of the short-term strategies available to deal with further referrals for
care, pending a definitive critical care bed: these may include flexing above capacity either within the unit, or by use of theatres/recovery, and premature discharge of level 2 patients (with Outreach support). These decisions will be influenced by medical and nursing staff issues, and the availability of physical resources.

The manager of the site should also be made aware of the critical care bed state, and they should then consider whether the hospital should close to emergency intake of further patients.

- If a new in-house referral is judged to be suitable for Critical Care 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 medico legal implications. Each Trust has a duty of care to all its patients inside and outside Critical Care, and must triage resources accordingly. However, transferring an existing stable Critical Care patient means removing them from a place of safety against that patient’s own best interests.

- If however an existing patient can be transferred to another unit to receive a higher level of care then this may be appropriate.

- 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 Critical Care 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 Critical Care 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.

• Even if the critical care unit is full and cannot accept a new admission, the critical care service has shared responsibility (with the referring team) to facilitate appropriate patient care (as above). It is not acceptable use capacity constraints as a reason to abdicate responsibility for a critically ill patient outside the critical care unit.

It is not acceptable practice to transfer a critical care patient solely to generate bed capacity for elective activity.

Referrals from Operating Theatres when there are no available critical care beds

Where a patient requires critical care as a result of an emergency/unforeseen circumstance and no bed is available, that patient will be the clinical responsibility of the critical care service. They may be ventilated in recovery if possible in that hospital or require transfer to another hospital.

Recovery staff should first contact critical care services if medical input is required. If an immediate response is required but critical care is unable to respond immediately, the on-call Anaesthetic team should be called.

The accepted practice is that prior to planned surgical procedures being undertaken in an individual requiring intensive care, it is the anaesthetist’s responsibility to ensure that intensive care facilities are available.

Anaesthetists should not undertake elective anaesthesia which is predicted to require critical care in the knowledge that there is no available critical care resource.

If this is contemplated then the patient should be informed of the increased avoidable risk. If the operation proceeds in the knowledge that the Trust’s critical care resource is operating at capacity, that anaesthetist will provide ongoing medical care for the patient until a critical care resource becomes available. Critical Care skills for the provision of short-term level 3 care is a core skill for all anaesthetic consultants.
8. ADMISSION TO CRITICAL CARE FROM OUTSIDE HOSPITALS

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.

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

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 Critical Care 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.

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

**CRITICAL CARE to CRITICAL CARE: Patients primarily requiring Critical 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, and will be notified as such.

**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. (work underway in this area)

9. **OPERATIONAL POLICY**

1. All Critical Care Units will keep a record of all referrals, whether admitted, refused or postponed. A record will also be kept of premature discharges and re-admissions to critical care during the course of a single hospital admission.

2. Protocols for the various aspects of medical and nursing care will be available in critical care ward areas. All staff including visiting staff should be aware of these protocols.

3. All decisions to admit patients to a critical care area must involve the duty critical care consultant.

4. All new admissions to critical care will be reviewed by a critical care consultant within 12 hours of admission. However it should be recognised that many patients will benefit from earlier review. The date and time of first consultant review must be clearly documented in the patients notes.

5. All critical care patients will be reviewed at least twice per day by a critical care consultant.

6. All critical care patients will undergo a full daily review by the critical care staff. This should include a full clinical examination and a review of the chart, notes and investigations. The review and all significant interventions, verbal reports of results and other clinical events should be documented in the patient’s records.
7. Visiting staff reviewing patients should also record their findings and recommendations in the notes. Final decisions on day-to-day management rests with the Critical Care Consultants.

8. Management of critical care patients in critical care ward areas will be the responsibility of the critical care medical staff, headed by the duty consultant. For clarity of accountability, in areas of debate, the final decision will rest with the Critical Care Consultant.

9. Referring teams will be encouraged to review patients on a daily basis or more frequently if desired. Recommendations of referring teams will be actively solicited.

10. To ensure consistency and clarity only critical care staff will make entries on the drug and fluid administration charts.

11. Critical Care Teams will seek the opinion of any specialist in the best interest of the patient.

12. The critical care medical staff will communicate significant changes in a patient’s condition to the referring team.

13. Relatives of a critical care patient should be kept fully informed of his/her condition and any formal interviews should be recorded, together with their views as well as the explanations offered by staff. Discussion with relatives by referring teams should only occur once they have familiarised themselves with the content of previous discussions and should be well documented.

All discussion must take place in the presence of a member of the critical care nursing staff.

14. Patients in whom critical care therapy is only prolonging the process of death should receive compassionate care as any other course of action constitutes inhumane treatment. Compassionate care should be instituted only after the views of the referring team and the relatives have been obtained. If, however, there is a major disagreement, the advice of another Critical Care Consultant can be sought and their advice should be accepted. In all cases, the final decision rests with the medical staff as it is a medical decision.

15. **Patient Consent to Examination and Treatment**

The Welsh Assembly Government has issued guidance in respect of seeking consent to examination and treatment under WHC (2008) 010 and which recognises
the requirements of the Mental Capacity Act 2005 and Human Tissue Act 2004.

Each Critical Care Unit must ensure they adhere to their NHS Trust Consent Policy and that appropriate consent to treatment forms are completed.

10. DISCHARGE CRITERIA

Discharge from level 3 care should be considered when:
- The patient is stable and no longer requires mechanical ventilation or support of more than one organ.
- The patient is no longer benefiting from the available treatment.
- Information comes to light of the patient’s pre-existing functional health status.
- The patient enters a persistent/permanent vegetative state.

Discharge from level 2 care should be considered when:
- The patient is no longer receiving treatment or observation that cannot be given safely on a general ward.
- Information comes to light of the patient’s pre-existing functional health status. The decision has been made not to institute active intervention in the event of the patient’s deterioration.
- The patient is no longer benefiting from the available treatment.

Many patients recovering from critical care have a tracheostomy. The care of a tracheostomy (in a patient requiring only infrequent suction) is within the scope of appropriate ward care and this is not a reason for continued critical care stay.

11. DISCHARGE PROTOCOL

1. After the decision to transfer a patient from a critical care area to the general ward has been made, he or she should be transferred as early as possible during the day. Transfer from critical care areas to the general ward between 22.00 and 07.00 should be avoided whenever possible, and should be documented as an adverse incident if it occurs.

   Delayed transfer of care over 4 hours should also be documented as an adverse incident.

2. The critical care area transferring team and the receiving ward team should take shared responsibility for the care of the patient being transferred. They should jointly ensure:
• there is continuity of care through a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan.
• that the receiving ward, with support from critical care if required, can deliver the agreed plan. The formal structured handover of care should include:
  • a summary of critical care stay, including diagnosis and treatment
  • a monitoring and investigation plan
  • a plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment
  • physical and rehabilitation needs
  • psychological and emotional needs
  • specific communication or language needs.

See Appendix 2 for an example of a Discharge summary. The format can be tailored to individual needs, but the content should be the standard.

3. After discharge from the critical care area the patients need to be followed up on a daily basis until it deemed necessary by the Critical Care Follow-up/Outreach service to address any ongoing physical, nutritional, psychological and emotional needs.

4. When patients are transferred to the general ward from a critical care area, they should be offered information about their condition and encouraged to actively participate in decisions that relate to their recovery. The information should be tailored to individual circumstances. If they agree, their family and carers should be involved.

5. Staff working with acutely ill patients on general wards should be provided with education and training to recognise and understand the physical, psychological and emotional needs of patients who have been transferred from critical care areas. This training should be the remit of the Critical Care follow-up/Outreach team.