Title:  
Policy for Admission to Adult Critical Care Services  

Operational Date:  
December 2009  

Review Date:  
December 2012  

Type of Document:  
Corporate [x]  
Clinical [ ]  

EQIA Screening Date:  
December 2009  

Replaces (if appropriate):  
N/A  

Lead Author:  
Linda Mulholland on behalf of CCaNNI  

Executive Director:  

CCaNNI Board Approval:  
December 2009  

Trust Approval:  

Policy for Admission to Adult Critical Care Services

1. The purpose/objective of the standard/guideline:

   The objective of this policy is to ensure appropriate and timely admission of patients to critical care and to facilitate the proper utilisation of limited resources.

2. Intended target population:

   All acute hospitals with level 2 and level 3 critical care facilities in Northern Ireland.

3. Time scale for implementation

   Admissions are a daily occurrence within the network, in the interest of safety these guidelines should be implemented as soon as possible.

4. Resource Implications

   No cost implications as resources required for admissions are already present within the system.

5. Financial disclosures/conflicts of interest

   None.

This guideline was produced by a multidisciplinary sub group of the Policy Standards & Guidelines Committee on behalf of the Critical Care Network Northern Ireland.
Policy for Admission to Adult Critical Care Services

Objectives

The objective of this policy is to ensure appropriate and timely admission of patients to critical care and to facilitate the proper utilization of limited resources. Admissions to critical care areas are often unplanned. Immediate access to resuscitation and critical care facilities is fundamental in the management of many conditions. Delayed admission to intensive care is associated with a significant increase in mortality\(^1,2\). Lack of access to critical care has been identified as a major contributor to post surgical mortality\(^3\).

Any patient in hospital may become acutely ill. However the recognition of acute illness may be delayed or its subsequent management may be inappropriate. This may result in late referral and/or avoidable admissions to critical care, and may lead to prolonged critical care stay and increased morbidity and mortality. Recent guidelines\(^4\) have recommended that physiological track and trigger systems should be used to monitor all adult patients in acute settings.

Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation and prompt response to the acutely ill patient appropriate to the level of care they are providing. Algorithms or critical care pathways should ensure high-quality clinical assessment of at risk patients and judgement by appropriately skilled and experienced medical staff. 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.\(^4\)

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 should not be admitted. This is a clinical decision that can only be made for each individual patient at the time of referral. The refusal of an admission to a critical care unit on clinical grounds should only be made by a critical care consultant.

Increasing age is associated with diminishing physiological reserve and increasing frequency of coexisting disease. However age alone should not be a barrier to admission.

Patient autonomy should be respected. Patients should not be admitted if they have a stated or written desire (for example, in an advanced directive) not to receive the treatments usually required as part of intensive care management.\(^5\)
Definitions of levels of care

Level 0
Patients whose needs can be met through normal ward care in an acute hospital.

Level 1
Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team.

Level 2
Patients requiring more detailed observation or intervention including support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.

Level 3
Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems - this level includes all complex patients requiring support for multi-organ failure.

Critical Care refers to level 2 (high dependency) and level 3 (intensive) care.

Categories of Admission

Category 1 - Unstable
Requires intensive treatment and monitoring that cannot be provided outside of the critical care unit. E.g. respiratory support, continuous vasoactive drug infusions, etc. Admission should take place as soon as possible.

Category 2 – High risk of sudden deterioration.
Requires invasive monitoring and may potentially need immediate intervention. E.g. a patient with chronic co-morbid conditions who develops acute severe medical or surgical illness

Category 3 – Reduced likelihood for recovery due to underlying illness.
May receive intensive treatment to relieve acute illness but limits on therapeutic limits may be set, such as no intubation or cardiopulmonary resuscitation.

Category 4 – Little or no anticipated benefit from critical care or patients with terminal and irreversible illness facing imminent death.

* Modified - Society of Critical Care Medicine Guidelines for ICU Admission, Discharge and Triage
Required care and monitoring can be administered in a ward setting. Admission of this type of patient is generally not considered appropriate.

**Process of Admission**

**Emergency Admissions**
Admission to critical care should normally be agreed between the referring Consultant and the duty critical care Consultant.

- For patients being transferred within the hospital it would normally be appropriate for the critical care Consultant or a member of the critical care team to see the patient prior to making an admission decision except when patient’s condition is critical.

- It may be appropriate to admit for assessment and to monitor the patient’s initial response to therapy.

- The Critical Care Consultant should check the available level of service the critical care unit can offer both in terms of the number of beds and the number of nurses available in the current and subsequent shift.

- If there is an agreed need for intensive care and a critical care bed is unavailable in the hospital, it should be the shared responsibility of the referring clinician and the critical care Consultant to make efforts to arrange appropriate alternative care. The Directorate manager should be informed of the difficulty and resource implications, and will then inform the Clinical Director. An available critical care bed may be identified by accessing the live bed bureau.

- Where a Consultant in another hospital requests admission of a patient to critical care and a bed is made available, the referring Consultant is responsible for arranging continuing care by a surgical/medical consultant located on the same site as the critical care bed. The referring consultant is also responsible for arranging safe transfer arrangements before the patient is accepted (in consultation with the receiving consultant). If no bed is available this should be documented as a refusal.

- It is essential that all information relating to the patients condition and rationale for transfer, is clearly recorded, using an agreed standardised format for written communication. [11]

- When a severely ill patient has to be transferred to a critical care unit in another hospital within the Northern Ireland Critical Care Network it is essential that an experienced doctor should accompany the patient with the appropriate skills in resuscitation. NICCaTS is the preferred means of transfer for all Level 3 patients unless the transfer is time critical. (See Transfer Guidelines CCaNNI007)[12]
**Elective Admissions**
- Patients undergoing elective high-risk major surgery should be booked into the critical care unit giving as much notice as possible. Patient details should be recorded.
- It is the responsibility of the Surgeon/Anaesthetist to check the availability of bed before starting surgery.
- Emergency admissions take priority over elective admissions.
- Once the surgery has begun the critical care bed is considered occupied.

**Organ Donation**

Such patients can be admitted to the Intensive Care Unit provided that:

a) They are not displacing those potentially capable of recovery.
b) They are not currently being supported in another ICU/HDU.
c) The patient’s relatives have been informed and have agreed to the transfer and subsequent organ retrieval.

**Refusals**

If a patient is refused admission for clinical reasons or lack of critical care capacity this must be recorded.

**Critical Care Outreach Services (CCOS)**

The role of CCOS is

- **To avert admissions** – identifying deteriorating patients and either prevent admission or facilitate timely admission to ensure best outcome
- **To enable discharges** - supporting continued recovery of discharged patients on ward
- **To share critical care skills** with ward staff

Where Critical Care Outreach Services are present their role is not solely to facilitate critical care admission. Their principal line of communication is with the primary team. However if the CCOS has immediate concerns about a patient they may contact the critical care team directly, the primary team will then be contacted.
References


2. Young, Goodner et al. Inpatient transfers to the intensive care unit. Delays are associated with increased mortality and morbidity. J Gen Intern Med Feb 2003;18: 77-83


10. Admission Policies from participating Trusts

11. Protocol for the inter hospital transfer of patients and their records CREST Aug 2006

12. Guidelines for the Transfer of Critical Care Patients (Level 2 / 3) non NICCaTS (CCaNNI 007) CCaNNI May 2009