

Policy on Discharge from Adult Critical Care Services

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Table of Contents

	Page
1. Aim	4
2. Background	4
3. Definitions	4
4. Discharges from Critical Care	5
5. Categories of Discharge	5
6. Process of Discharge	6
7. Long Term Critical Care Patients	6
8. Tertiary and Specialist Service Access	7
9. Roles and Responsibilities	7
10. Handover of Care	8
11. Critical Care Outreach Service	9
12. Appendix 1	10
13. References	11

1.0 **Aim**

The aim of this policy is to support well-organised, safe and timely discharge of patients from adult Critical Care areas (level 3 and level 2 care) in acute hospitals. It is also intended to support improvements in access to Critical Care areas.

2.0 **Background**

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 mortality³.

Timing of patient discharge from Critical Care impacts on the outcome of the patient. Poor planning may result in disruption of care, delayed recovery and high readmission rates. It has been shown for example that discharge at night increases patient mortality^{4, 5}. It has therefore been recommended that transfer from Critical Care areas to the general ward between 22:00 and 07:00 should be avoided and documented as an adverse event if it occurs⁶.

To make the best use of critical care facilities patients need to be discharged to a lower level of care as soon as it is clinically indicated and becomes safe to do so. Having patients in Critical Care facilities when not required is not best use of an expensive resource, potentially blocks the bed for a new admission. There is often limited environmental space for rehabilitation/ongoing care, there is an increase stress for patients who continue to be treated in a critical care environment when it is not appropriate to condition.

All Critical Care units will have periods of excessive demand. This can be compounded by a delay in discharge. Ultimately delayed discharge results in delayed admission, which in turn increases patient mortality.

3.0 **Definitions**

Critical Care relates to intensive care and/or high dependency areas providing level 3 and level 2 care.

Discharge refers to the transfer of a patient out of level 2 or 3 care to a ward bed when this is no longer clinically indicated.

4.0 Discharges from Critical Care

Critical Care is a precious and limited resource and so discharge should occur as quickly as is compatible with patient safety so that the Critical Care space is available for the care of another patient. Critical Care forms an integral part of the hospital system. In recognition of balancing these often conflicting needs, discharges are categorised according to critical care bed availability at the time, i.e. routine, urgent and emergency. The balance between needs of Critical Care and the rest of the hospital can be recognised in categorising discharges as routine, urgent and emergency.

Discharge from Critical Care should only be considered for patients where level 2 or level 3 care is no longer required. All categories below relate only to those patients deemed fit for discharge from critical care. Discharge should proceed in a safe and timely manner. Once a clinical decision has been made to discharge, time zero is considered to be the time a request is made for a bed to either the ward / bed manager / via whiteboard system. The maximum time for discharge (routine) is four hours and outside this, is defined as a 'delayed discharge' as recommended (7).

5.0 Categories of Discharge

- **Category 1 Routine.**

Critical Care has at least one available bed.
Patients will be discharged within **4** hours.

- **Category 2 Urgent**

Critical Care areas have no available space i.e. reached capacity.
Patients will be discharged within **2** hours.

- **Category 3 Emergency.**

Critical Care has no available space and a critically ill patient requires immediate admission.

Patient will be discharged **as quickly as possible.**

***This situation is not desirable and may result in a compromise to patient safety.**

6.0 **Process of Discharge**

Critical Care staff should designate a predicted discharge date (PDD) as soon as possible, accepting this may change dependent on the patient's condition. Critical Care staff should then inform Bed Managers of the need for a patient discharge as soon as possible by critical care staff.

Bed Managers will facilitate discharge to the appropriate ward/unit in partnership with the ward staff. This may be facilitated by an outreach service if available.

Bed Managers should liaise with Critical Care areas at agreed time periods to assess the potential for discharge

Bed requirements within Critical Care may fluctuate. Bed managers must be informed of such changes as soon as possible.

Where Critical Care capacity is reached or exceeded (Category 2 and 3) the discharge of Critical Care patients should take priority over elective admissions and placements from accident and emergency. Senior management should guarantee this process.

At any time a discharge category can change as pressures within critical care fluctuate.

7.0 **Long Term Critical Care Patients**

The discharge of any patient from Critical Care involves planning however it is especially important to plan the discharge of long term or complex patients. Defining this group is difficult but should include all patients who have required Critical Care for more than 4 weeks. Patients, their relatives and ward staff all need time to prepare for the discharge. Specific needs must be identified as soon as practical. Specialist services will need time to co-ordinate all aspects required for continuing care. This may take several days but the process should start before the PDD i.e. discharge planning should not be a reason for patients staying beyond their need for Critical Care. To support this process it is useful for ward staff to visit the critical care unit to familiarize themselves with patient, relatives and treatments.

8.0 Tertiary and Specialist Service Access

Tertiary referral centres manage access to specialist service. Managing these services may necessitate discharge to another Critical Care unit if specialist services are not required. (e.g. repatriation following PCI and trauma protocol)

The possibility of discharge to another Critical Care facility needs not only agreement between the intensivists but also agreement of the referring team in the tertiary centre and in the non-specialist unit. The patient's needs are paramount to any change of facility.

Once agreement has been reached that patient requires transferred. A bed should be identified as soon as possible. The national bed bureau will help to identify available beds in the region and the bed manager may be involved in securing a bed. All relevant parties, including the relatives, should be informed that the discharge is taking place. Notes and X-rays should go with the patient in line with guidelines for inter-hospital transfer. NICCaTS is the preferred method of transfer.

Trusts should note that a patient deemed fit for transfer/discharge, albeit to another hospital does not always require a critical care bed. They can be transferred if clinically indicated to a base ward.
(Network Transfer Policy 007 – Guidelines for the Transfer of Critical Care Patients (Level 2/3) non NICCaTS).

9.0 Roles and Responsibilities

9.1 Medical Staff

The final decision that a patient is fit for discharge/step down from critical care remains with the Critical Care consultant. It is essential that the parent team (or their representative out of hours) is aware of all discharges. The nurse in charge may initiate discharge in certain circumstances, for example when clearly documented parameters have been met.

9.2 Nursing staff

It is the nursing staff's responsibility to ensure a safe and timely discharge of a patient from Critical Care areas once a bed has been identified. They must also ensure all documentation is complete to accompany the patient. (CCaNNI Handover Guidelines – Minimum dataset)

9.3 **Bed Manager**

It is the responsibility of the bed manager to ensure identification of an appropriate bed in conjunction with key stakeholders. Patients should be cared for in the most appropriate setting and maximise availability of Critical Care capacity.

10.0 **Handover of Care⁶**

The discharging team and the receiving team both have a responsibility to ensure the appropriate care of the patient being discharged.

They should ensure:

- There is continuity of care facilitated by 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.
- 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.

10.1 **The 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 ;
- specific communication or language needs.

A summary of a systematic approach to enhance handover and the minimum data set to be included is contained in 'A guideline for the multidisciplinary handover of patients discharged from critical care to ward settings' CCaNNI (012).

It is essential to give a detailed review of medication. Treatment to be reviewed or stopped must be clearly identified, as must the timing. Long term medications must be also considered. If these have been changed or not yet restarted this must be documented.

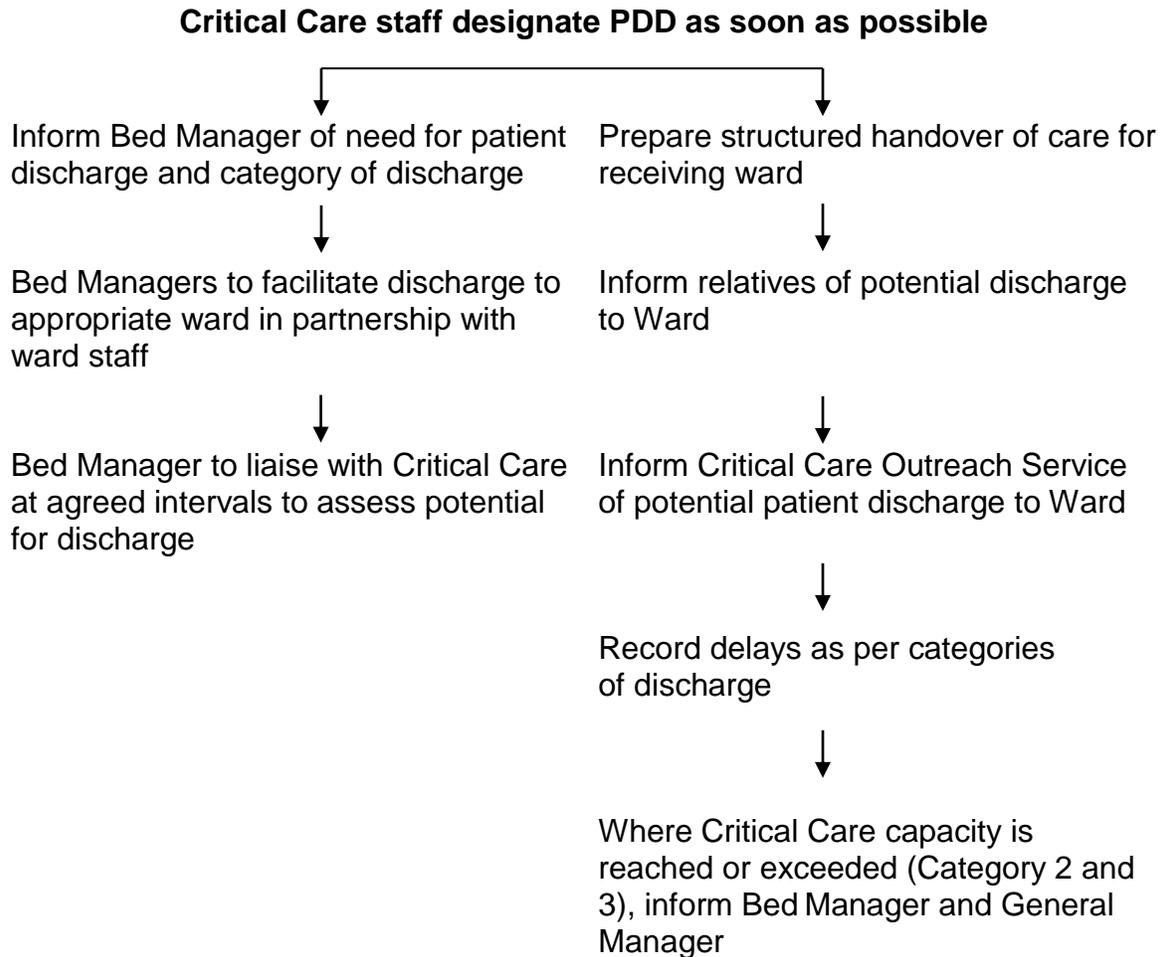
Outstanding procedures and diagnostic tests must be highlighted.

11.0 **Critical Care Outreach Service⁷**

The Critical Care Outreach Service (CCOS) is provided by a multidisciplinary team from anaesthetics, nursing and physiotherapy in Altnagelvin. Its primary purpose is to assist staff in the care of acutely ill adult in-patient on wards. This is through education, clinical support and audit.

- The CCOS will support discharge from Critical Care by providing education, clinical support and audit to ward areas;
- Enhancing the knowledge and skill of nursing and medical staff in the care of the acutely ill adult patient.

Discharge From Adult Critical Care Services



All delayed discharges to be recorded with reason for delay

All discharges between 22:00 and 07:00 to be documented on Datix

All situations when an emergency admission to critical care cannot be immediately admitted must be recorded on Datix.

11.0 References

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