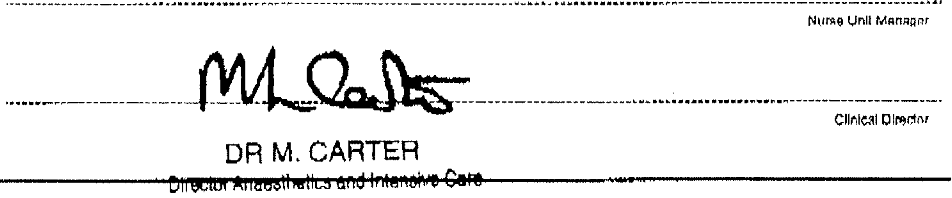
Queensland Government
Queensland Health

BUNDABERG HEALTH SERVICE DISTRICT
Intensive Care Unit Protocol

PROTOCOL No. – G1

TITLE:	**Intensive Care Unit Admission and Discharge Policy**
DATE:	01 July 2003
TARGET AUDIENCE:	All staff
DEVELOPED BY:	Dr. Martin Carter
OBJECTIVE:	To ensure that patients who require intensive health care are provided with a service that is equal to their needs
AUTHORISATION:	



Nurse Unit Manager

Clinical Director

DR M. CARTER
Director Anaesthetics and Intensive Care

Guidelines

Only patients who meet the admission criteria for intensive care shall be admitted to the Intensive Care Unit.

Patients within the Intensive Care Unit shall be discharged or transferred to another Unit on meeting the discharge criteria.

The patient's Local Medical Officer shall be notified of the patient's admission to the Intensive Care Unit within twenty-four (24) hours, upon obtaining the patient's consent.

A Discharge Summary (Form MR53) shall be completed for the patient on discharge from the Health Services' in-patient services.

Description of Services Offered:

The Intensive Care/Coronary Care Units are level one facilities that provide five acute beds for patients who require intensive health care or coronary care. This number may vary depending on nursing staff availability. Medical services are coordinated by the Director of Intensive Care. Medical cover for the Intensive Care Unit is by an Intensive Care Consultant (24 hrs/day), a resident JHO during working hours and the Medical PHO for after hours and the weekend. The On-call Medical teams cover CCU.

Nursing services are coordinated by the Nurse Unit Manager and Nurse Manager. The Nurse Unit Manager is responsible for coordinating clinical nursing services within the Unit. The Nurse Manager is primarily responsible for nursing staff resources and material resources.

The Unit accommodates patients who require ventilation and/or invasive monitoring. The Unit has a central monitoring facility with network monitors at each bedside.

There are facilities for conducting blood gas analysis and coagulation studies within the Unit. Radiology and Pathology Services are available 24 hours a day as required.

Admission Criteria:

Coronary Care Unit

Admission to Coronary Care Unit is intended for patients with an acute cardiac condition (e.g. acute coronary syndromes, arrhythmias, D.C. reversion, cardiac pacing).

The Intensive Care Unit is not intended for the management of dying patients. It is essential that potential patients are referred for consultation or referral early in order to maximise the results and shorten Intensive Care stay. It is essential that the referring doctor is fully conversant with the patient's premorbid condition so that possible outcome of an Intensive Care Unit intervention can be assessed and the usefulness of Intensive Care management can be assayed.

Age, of itself alone does not preclude an Intensive Care admission but significant limitation in daily living or quality of life with chronic pain; sensory deprivation, dementia etc may well reduce the value of an intensive Care Unit experience

Patients admitted to the Intensive Care/Coronary Care Units shall require at least one of the following admission criteria:

Respiratory

1. Mechanical ventilation.
2. Continuous Positive Airway Pressure while spontaneously breathing.
3. Maintenance of an unstable airway.
4. Monitoring for acute respiratory distress.

Cardiac

1. Continuous Cardiac Monitoring.
2. Central Venous Pressure Monitoring.
3. Arterial Pressure Monitoring.
4. Administration of intravenous nitrates, beta-blockers, vasodilators and continuous fibrinolytic agents.
5. Temporary Cardiac Pacing.
6. Pulmonary Artery Wedge Pressure Monitoring.

Fluid and Electrolytes

1. Administration of fluid and electrolytes for a life threatening condition.
2. Acute haemodialysis.

Neurological

1. Monitoring/support of severe alterations in consciousness or neurological functions.
2. Surgical / Trauma.

Admission Procedure from within the Hospital

Medical staff requiring to admit a patient into the Intensive Care/Coronary Care Unit shall:

- Consult with either the Intensive Care Consultant, the JHO working in the Unit during working hours or the Medical PHO on call after hours regarding the intended admission and discuss the suitability of the Intensive Care Unit for the patient. If the patient is intended for Coronary Care then the consultant Physician on call should be notified prior to admission.
- Ensure that the patient is reviewed by one of the Intensive Care team before admission.
- Notify the Nursing staff within the admitting area (e.g.. Department of Emergency Medicine) of the intended admission and the area to which they prefer the patient to be admitted.

Note: No patient is to be admitted to the Intensive Care Unit without prior consultation with the Intensive Care Team.

A member of the Nursing Staff within the admitting area (e.g. Department of Emergency Medicine) then contacts the most senior nursing staff member (i.e. Nurse Unit Manager or team leader after hours) and notifies them of:

1. The intended admission.
2. Patient's full name, age, UR number and diagnosis
3. The patient's estimated time of arrival.

They also notify the Bed Co-ordinator during day or After Hours Nurse Manager on duty (ext 2267) of the intended admission, and discuss the availability of beds and nursing staff.

The patient is normally transferred to the Intensive Care Unit with at least a nurse escort and possibly a medical escort if clinically appropriate. The nurse or Doctor who has been caring for the patient gives a detailed hand-over on arrival of the patient to the Unit.

Admission of patients referred from outside the hospital

- Any patient being referred from another hospital or the private sector should be first discussed with the Intensive Care team (ICU admission) or the Consultant Physician on call (CCU admission) prior to transfer of the patient.
- The patient is to be admitted to the Hospital via the Department of Emergency Medicine and assessed by the appropriate team prior to admission to the Unit.
- The remainder of the admission is as for an inpatient admission.

Transfer procedure of Patients to other Facilities

If a patient requires transfer to another hospital for treatment, the Director of Medical Services is notified and approval may be sort for aerial transfer, if appropriate. The Medical Officer then notifies the appropriate Specialist at the admitting hospital to determine availability of beds. If aerial transfer is appropriate, transportation is negotiated with the Flight Co-ordinator at the Royal Brisbane Hospital. The flight coordinator then contacts the Health Service with the flight details.

Criteria for Transferring Patients to another Ward/Area

Patients shall be transferred to another ward once they no longer meet the admission criteria. They remain the responsibility of the Intensive Care Unit Medical and Nursing staff until they physically leave the unit. They, therefore, are treated as Intensive/Coronary Care patients and are monitored as such until that time.

Transfer procedure of Patients to other Ward/Areas

Medical staff wanting to transfer a patient into another Ward/Unit once the patient no longer meets the admission criteria shall:

1. Notify the Specialist or PHO for the speciality of the intended transfer and discuss the suitability of the ward/area for the patient.
2. Write a full summary of the patient's admission, including diagnosis; management; procedures; complications and a future management plan.
3. Notify the Nurse Unit Manager or most senior nursing staff member on duty of the intended transfer. They will then discuss the availability of beds and nursing staff with the Casemix Co-ordinator (or Nurse Manager, after hours).
4. Notify the Nursing staff within the transferring area (i.e. Intensive Care) of the intended transfer and the area to which the patient is going, as discussed with the Nurse Manager.

A member of the nursing staff within the admitting area shall then contact the most senior nursing staff member (i.e. Bed Co-ordinator on ext 2267) and notify them of:

1. The intended transfer
2. Patient's full name, age and diagnosis
3. The patient's estimated time of arrival
4. The patient's condition and care required

The Intensive Care Unit nursing staff then notifies the Casemix Coordinator (or Nurse Manager, after hours) immediately after the patient has left the area.

The patient is normally transferred to the ward/area by a wardsperson and possibly a nurse if clinically appropriate.

Procedure for Discharge of Patients directly out of the Unit to Home

Discharge of patients is authorised by either the Specialist or Principal House Officer. If the patient stays longer than 24 hours, any discharge scripts are sent to pharmacy the day before discharge. On the day of discharge the Specialist or Principal House Officer completes:

1. The Discharge Summary Form (MR53)
2. Any follow-up letters required.

The nursing staff completes the Nursing Discharge checklist (MR 93) and places it in the progress notes. The Nurse Manager is notified of their departure immediately after the patient leaves the Unit. The Medical Record and accompanying films are then collected by the Ward Clerk.

BIBLIOGRAPHY

Australian and New Zealand College of Anaesthetists. 1994. *Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care*