

Ref: FOI/CAD/ID 3230

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Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to escalation procedures for ITU/ICU/HDU.

This is FOI request, please tell me what happens if you get patients for ITU / ICU / HDU but they are full with other patients, what do you do?

The basic principle if there is no capacity is available in ICU is the patient is transferred to theatre recovery where full IUC care can be given for a period of time pending a review and decision regarding ICU capacity.

Please find attached the relevant policies and procedures.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Standard Operational Policy for the Management and Delivery of Critical Care in the Emergency Recovery Unit

**Requested/
Required by:** Trust Clinical Governance Committee

Main author: Senior Sister Critical Care Outreach

Other contributors: Matron Maidstone ITU & Critical Care Outreach

Document lead: Senior Sister Jo Wade **Contact details:** ex 35391

Directorate: Critical Care

Specialty: Critical Care Outreach

Approved by: Clinical Governance Committee

Ratified by: Local Policy – not required

Review date: Jan 2017 or at time of significant change.

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The master copy is held on Q-Pulse Document Management System
This copy – REVX.X

Document history

<p>Requirement for document: (Why is this document necessary?)</p>	<ul style="list-style-type: none"> To ensure the highest standard of safety, quality and continuity of care for ALL patients requiring Critical Care in ICU, Emergency Recovery Unit, A&E and the General Wards by providing all staff with a clear and robust procedure for the care of critically ill patients when ICU is running at full capacity.
<p>Cross references: (List all best practice documents supporting this document)</p>	<ol style="list-style-type: none"> Association of Anaesthetists of Great Britain and Ireland. Immediate Post Anaesthesia Recovery 2013. Anaesthesia 2013; 68:pages 288-97 Core Standards for Intensive Care Units. 2013. Edition1. Royal College of Nursing. Standards for Contingency management and delivery of critical care in a post anaesthesia care unit (PACU) Marie Curie Palliative Care Institute.-Liverpool Care Pathway for the Dying Patient. Http://www.liv.ac.uk/mcpcil/Liverpool-Care-Pathway accessed 07/04/2014 Department of Health (2008a) The national education and competence framework for advanced critical care practitioners. London:DH Department of Health (2008b) The national education and competence framework for assistant critical care practitioners.London:DH Department of Health (2009) Competencies for recognising and responding to acutely ill patients in hospital. London:DH Intensive care Society(2009) Levels of Critical care for adult patients:standards and guidelines, London:ICS NMC Code of Conduct
<p>Associated documents : (List all documents associated with this document)</p>	<ol style="list-style-type: none"> Maidstone and Tunbridge Wells NHS Trust. <i>Escalation Policy and Procedure for Emergency Admissions.</i> RWF-OPPPES-C-AEM8 Maidstone and Tunbridge Wells NHS Trust. <i>Patient transfer Policy and Procedure.</i> RWF-OPPPCS-C-TM3 Critical care Bed Escalation Policy. Maidstone and Tunbridge Wells NHS Trust. <i>Infection Control Policy and Procedure.</i> RWF-OPPPCSS-C-PATH15 Critical Care Standard Operational Policy

Version Control: Details of approved versions		
Issue:	Description of changes:	Date:

Standard Operational Policy statement for

The Management and Delivery of Critical Care in the Theatre Recovery Unit

Due to the increasing demands for Critical Care beds and the corresponding demands for Ward Beds within the Trust, the Theatre Recovery Units may be required to accommodate Critically Ill Patients when a Critical Care bed space is unavailable. As a consequence, the capacity in the Theatre Recovery Unit is compromised resulting in the potential cancellation/delay of Operating lists and the suspension of the Critical Care Outreach service.

Therefore the utilisation of a Critical Care bed in this area should be avoided as far as practicable. However, a lack of a Critical Care Bed **MUST NOT** affect the decision to admit to the Critical Care Unit.

The decision to open a Critical Care bed space in Theatre Recovery must be in accordance with the Critical Care Bed Escalation Policy and must be escalated to the Clinical Site Management Team and Associate Director as soon as practicable with the aim to facilitate transfer to the Critical Care Unit within 4 hours of a request for a Critical Care Bed. If this is not possible a Datix form must be completed and the incident included in the site report.

Once referred **and** accepted by the Critical Care Team, the care for these patients is the **Primary Responsibility** of the Consultant Intensivist and the Critical Care Team.

The standard of Medical and Nursing Care delivered to the patient will be of a safe and equitable standard to that care that would be received on the Critical Care Unit.

Introduction and scope

The Guidelines and Procedure outlined in this Operational Policy are intended to provide direction, guidance and the underlying principles to allow all staff to provide and facilitate a safe standard of care for any patient requiring Critical Care in the Theatre Recovery Units within the Trust.

It will provide a clear Escalation Pathway to enable all relevant staff involved in the patient's care to facilitate a timely admission into the Critical Care Unit thereby reducing disruption to patient flow through the Theatre Recovery Unit and potential delays/cancellation of operating lists and suspension of the Critical Care Outreach Service

The principle responsibility of all staff is to provide and maintain optimal patient care, dignity and safety at all times, reporting and documenting all care, actions and outcomes throughout the patient's time in the Theatre Recovery Unit.

The key to achieving this goal is through clear effective communication and supportive interdisciplinary working.

Patients who may need to be transferred to the Emergency Recovery Unit include:

Planned surgery requiring Extended Post-Operative Recovery in Critical Care Unit e.g. overnight ventilation.

Emergency surgery / deterioration/prolonged surgery requiring post-operative Critical Care.

Ventilated patients from A&E

Potential organ donation patients

Deteriorating patients from wards requiring Organ Support

Post cardiac arrest patients.

Post peri arrest patients.

If a patient in A&E is expected to die imminently, they MUST NOT be transferred to Theatre Recovery under any circumstances. If a patient is transferred to the Theatre Recovery Unit, for whom treatment is then withdrawn, the Site Practitioner must be informed and a ward bed must be prioritised immediately. If there is no bed available and the patient remains in the Theatre Recovery Unit an End of Life Care pathway must be implemented. The patient is to be nursed in an area of the Theatre Recovery Unit by a named

Nurse. Relatives should be allowed to be present should they wish and the Hospital Chaplaincy contacted according to the patient's and/or family's wishes. A Datix Incident form MUST be completed and Incident included in the Trust Site report.

1.0 Definitions

AD- Associate Director

CCMDS – Critical Care Minimum Data Set

ICU – Intensive Care Unit

NIC- Nurse in Charge

CCOT- Critical Care Outreach Team

ODP – Operating Department Practitioner

2.0 Training / competency requirements

A Qualified Recovery/Critical Care Nurse/ODP must care for the Patient.

Additional Critical Care skills required by the Theatre Recovery Nursing Team need to be identified from the existing NICE 50 framework utilised within the Trust and learning opportunities, assessment and maintenance of these skills will be facilitated by Theatre and ICU practice educators and the Critical Care Outreach Team.

3.0 Procedure

3.1 A Patient requiring a Critical Care Bed will only be transferred to the Theatre Recovery Unit if there is **NO Physical** Critical care bed space available to accommodate them.

3.2. If there is a fully staffed Critical Care Bed available the patient will be admitted to the Critical Care Unit with minimal delay.

3.3 If there is an unstaffed Critical Care bed space available and a patient is to be transferred from the Ward by the Critical Care Outreach Team to the Critical Care Unit, the Critical Care Outreach Team will normally care for the patient for a **maximum of 4 hours**.

3.4 ICU Consultant and ICU Nurse in Charge to review all Patients for potential discharge to Ward Bed, review patient dependency and escalate staffing, trigger bed escalation policy and inform Critical Care Matron and Site Practitioner Team immediately of their plan and request any support as required.

3.5 Critical Care Outreach Team **must** inform the Senior Clinical Site Manager and the Critical Care Outreach Matron if the Critical Care Outreach Service has been suspended. The Site Practitioner Team will inform the on call Associate Director/ General Manager and prioritise a ward bed for an ICU discharge if required.

3.6 The Clinical Site Management Team will inform the Critical Care Outreach Team of plan and timeframe in which the Critical Care Outreach Service will be resumed and inform the Wards and Medical Teams that the Critical Care Outreach Service has been suspended.

3.7 In some circumstances it may be necessary for a CCOT nurse to provide care for a Critical Care Patient for longer than 4 Hours. This could occur if ICU is unable to escalate staffing on the current shift. However it is expected that every effort will be made by the ICU NIC to optimise staffing levels in order for the CCOT service to be resumed at the earliest opportunity and that the Clinical Site Manager will prioritise a ward bed if there are ward fit patients awaiting discharge from the Critical Care Unit.

3.8 It is the responsibility of the AD or On Call Manager to make the decision to suspend the Critical Care Outreach Service following discussion with the Critical Care Outreach Sister on duty at the time. This decision must be seen as a last resort, as suspending the CCOT Service will lead to delays in the review of deteriorating patients on the wards and therefore unable to potentially avert admission to ICU. If the CCOT service is suspended a member of the Clinical Site Management Team will hold the CCOT Bleep during this time and inform the wards and Consultants that the Critical Care Outreach Service has been suspended.

3.9 In addition to the Critical Care Bed Escalation Policy, the ICU NIC must consider all options in order to release the CCOT Nurse at the earliest opportunity. These options could include the following:

- Taking a low dependency patient themselves whilst awaiting a ward bed.

- Utilising the Unit CSW to care for ward fit patients under the direct supervision of the NIC.
- Utilisation of non ICU trained bank/agency staff to care for the ward fit/low dependency patients under the direct supervision of the NIC.
- Discuss with other Trust ICU re: sending staff over to cover staff shortage.
- Forward planning and booking of Bank/Agency Staff.
- Consider increasing Nurse:Patient ratio if more than 2 patients awaiting Ward beds
- Consider direct bed swaps for patients requiring ICU Beds and those whom require ward beds. Site Team to help expedite bed turn around as requested

4.0 Critical Care Patients awaiting Critical Care bed post- surgery

4.1 Patients not invasively ventilated and/or receiving inotropic support will be transferred to the Theatre Recovery Unit under the care of Anaesthetic and Recovery Staff supported by the critical care team until a critical care bed is available.

4.2 The Theatre Recovery Co-ordinator must inform the Theatre Clinical Co-ordinator, Clinical Site Management Team, ICU Consultant and ICU NIC of the patient's transfer to the Theatre Recovery Unit as soon as practicable with the aim of transferring the patient to the Critical Care Unit within a **4 hour time** frame. If it is unlikely a bed will become available, early consideration should be given, by the ICU Consultant, to transfer of a patient to another local Intensive Care Unit as per the Critical Care Bed Escalation Policy.

4.3 If the patient is ventilated using an anaesthetic machine to deliver volatile agents such as Sevoflurane gas due to clinical need e.g. Asthma, an Anaesthetist must be present in the Theatre Recovery Unit at all times. It is the Anaesthetist and ODP's primary responsibility to ensure that the use of volatile agents are being used according to the Safety Guidelines for Volatile Gases

4.4 If the post-surgical patient is ventilated and/or requiring inotropic support, a Critical Care Nurse from the Critical Care Unit will provide nursing care for the Critical Care patient and will have immediate access to Critical Care support and Senior ICU Nursing assistance. If necessary and following discussion with the ICU Consultant, ICU NIC and the Critical Care Outreach

Sister on Duty, the Critical Care Outreach Team may be required to temporarily backfill the Critical Care Unit for a maximum of 4 hours to allow a Critical Care Nurse to attend the patient in recovery. The Clinical Site Management Team and the AD/Manager on call must be informed of this decision.

4.5 Anaesthetic and Nursing staff directly responsible for the care of the patient must receive a formal handover from the Anaesthetist and Parent Teams who have been responsible for their care up until this point. A formal management plan must be clearly documented in the patient's medical notes. It must be clearly documented in the patient notes that the referring Consultant is aware of the patient's transfer into the care of the Critical Care team.

4.6 At least 2 qualified staff **should be present at all times** (1 nurse/ODP and 1 anaesthetist or 2 nurses depending on level of patient) when a Critically Ill patient is being cared for in the Theatre Recovery Unit one of whom will be available as a runner.

4.7 The ICU Nurse in Charge will be expected to count the patient into the ICU bed numbers and escalate staffing levels as required They will make frequent contact with the staff caring for the patient and also with the Theatre Recovery Co-ordinator to ensure all levels of Critical Care delivery are optimised at all times.

4.8 The patient must be reviewed and clerked in by a Critical Care Doctor ideally within 30 minutes of the patient being accepted by ICU and a treatment plan clearly documented in the patient notes. The patient must be reviewed by a Consultant Intensivist within 12 hours of admission.

5.0 Critical Care Patient transferred from Wards/Departments

5.1 Patient will be transferred to the Theatre Recovery Unit. Anaesthetic, Critical Care Outreach or ICU Staff are responsible for patient care. Critical Care Outreach Nurse will also inform and confirm to the Senior Clinical Site Manager and to the Critical Care Outreach Matron that the Critical Care Outreach service needs to be suspended. This will be included in the Trust Site report and a Datix incident form to be completed by the CCOT Nurse.

5.2 The Theatre Recovery Coordinator must inform the Theatre Clinical Co-ordinator of the transfer, and the Critical Care Outreach Nurse will inform Site Practitioner Team, ICU Consultant and ICU NIC of the patient's transfer to the Emergency Recovery Unit as soon as practicable with the aim of transferring the patient to the Critical Care Unit within a **4 hour** time frame. If it is unlikely that a bed will become available, the ITU Consultant should give early consideration to transferring a patient to another local Intensive Care Unit as per the Critical Care Bed Escalation Policy.

5.3 A Critical Care Outreach Nurse or ICU nurse must provide 1-1 nursing care for the Critical Care patient and will have immediate access to critical care support and senior ICU nursing assistance.

5.4 A second qualified nurse/ODP must be present at all times when a Critically Ill patient is being cared for in the Theatre Recovery Room by a Critical Care Outreach/ICU Nurse to help support and act as a runner.

5.5 The ICU Nurse in Charge will count the patient into the ICU bed numbers, review patient dependency and available staff in addition to escalating staffing levels as required, the aim of which is to **take responsibility for the patient's care to allow the CCOT service to resume as rapidly as possible**. They will make frequent contact with the CCOT Staff caring for the patient and also with the Theatre Recovery Coordinator to ensure all levels of critical care delivery are optimised at all times, to provide clinical support and to relieve for breaks as required.

5.6 The Critical Care Team and CCOT Nurse/ ICU Nurse directly responsible for the care of the patient must receive a formal handover from the parent teams who have been responsible for their care up until this point. A formal management plan must be clearly documented in the patient's medical notes. It must be clearly documented in the patient notes that the referring Consultant is aware of the patient's transfer into the care of the Critical Care team.

5.7 In discussion with the CCOT Nurse, the ICU NIC must consider the most appropriate nurse to care for the Patient in the Emergency recovery Unit. Not all CCOT Nurses are ICU trained and it may be more appropriate to allocate an experienced ICU Nurse to the Emergency Recovery Unit and the CCOT Nurse to go to ICU to care for an HDU Patient or stable ventilated patient depending on experience but this must always be following discussion with the individual CCOT Nurse.

5.8 The Patient must be reviewed and clerked in by a Critical Care Doctor ideally within 30 minutes of the patient being accepted by ICU and a treatment plan clearly documented in the patient notes. The patient must be reviewed by a Consultant Intensivist within 12 hours of admission.

6.0 All critical care patients in emergency recovery

6.1 The overall co-ordination of the care of any critical care patient in recovery is the responsibility of the NIC on ITU following detailed discussion with the Clinical Site Manager. This should involve looking at the dependency of the patient in recovery – ie. could they be looked after by a surgical nurse, the workload of theatres ie. how many emergency theatres are actually running and the workload/dependancy of the patients that the CCOT nurse is looking after.

7.0 Monitoring and audit

- All applicable Critical Care patients admitted to the Emergency Recovery Unit awaiting a Critical care Bed will trigger the collection of a Critical Care Minimum Data Set (**CCMDS**)
- Once the patient is entered onto the Ward Watcher System they are no longer considered a delayed admission for audit purposes as they are then triggering funding for ICU Care.
- The frequency of the utilisation of a Critical Care Bed in the Emergency Recovery Unit will be audited 3 monthly and the outcomes to be discussed as a an integral part of Critical Care Directorate meetings.

APPENDIX ONE

Process requirements

*The following three sections are **compulsory** and should always be located in Appendix One:*

1.0 Implementation and awareness

- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- Circulation to all Consultants via Clinical Directors
- All Theatre and Recovery Coordinators, Clinical Site Management Team, Critical Care Outreach team and ICU Teams to be informed by Relevant Directorate Matrons.

2.0 Review

This Policy and procedure will be reviewed every 2 years or following any significant changes.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: The Management and Delivery of Critical Care in the Emergency Recovery Unit

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Job title: <i>List staff to be included in the consultation. See Section 5.5 of the "Production, Approval and Implementation of Policies and Procedures" policy and procedure for guidance.</i>	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff MUST be included in ALL consultations:				
Local Counter Fraud Specialist				
Clinical Governance Assistant				
Chief Pharmacist (if pharmacy/prescribing issues are included in the document)	N/A			
Please list key staff whose reply is compulsory before approval can be granted:				
CD Critical Care Directorate	10/11/15	12/01/16	Y	Y
Critical Care Directorate Matron	01/10/15	28/10/15	Y	Y
Matron ITU TWH	01/10/15	12/01/16	Y	Y
Clinical Co-ordinator Theatres TWH	03/12/15	12/01/15		
GM Critical Care				
ADNS Emergency Services	03/12/15			
ADNS Cancer, Surgery & Critical Care	01/10/15			
Clinical Lead Intensive Care	01/10/15	1/11/15	Y	Y
Clinical Lead Critical Care Outreach	01/10/15			
Matron Maidstone ITU and Critical Care Outreach*	01/10/15	10/10/15	Y	Y
Matron Site Management Team	10/11/15	01/02/16	Y	Y
Please list other staff to be included in the consultation but whose reply is not compulsory:				
Chief Nurse	14/1/16	14/1/16	Y	Y
Chief Operating Officer				
Deputy Chief Nurse				
*Involved in writing				
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the				

development of the policy.

The following list of staff is **not compulsory** but simply intended to act as an aide-memoir. You may wish to consider selecting staff from the following list as appropriate:

Directors, Director of Infection Control, Divisional Directors, Associate Director Operations, Deputy Director Nursing, General Managers, Divisional Risk Lead, Clinical Governance Leads, Senior Nurses Clinical Governance, Head of Estates, Director of Facilities, Corporate Business Manager, Head of Quality and Governance, Risk Manager, Quality and Patient Safety Manager, Audit & Research Manager
Staff Side chair, Director of ICT, Associate Director of ICT, Pembury New Build, Head of Policy and Information, HR Communications Manager

APPENDIX THREE [Compulsory]

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of policy or practice	
What are the aims of the policy or practice?	
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Males or Females	
People of different ages	
People of different ethnic groups	
People of different religious beliefs	
People who do not speak English as a first language	
People who have a physical disability	
People who have a mental disability	
Women who are pregnant or on maternity leave	
Single parent families	
People with different sexual orientations	
People with different work patterns (part time, full time, job share, short	

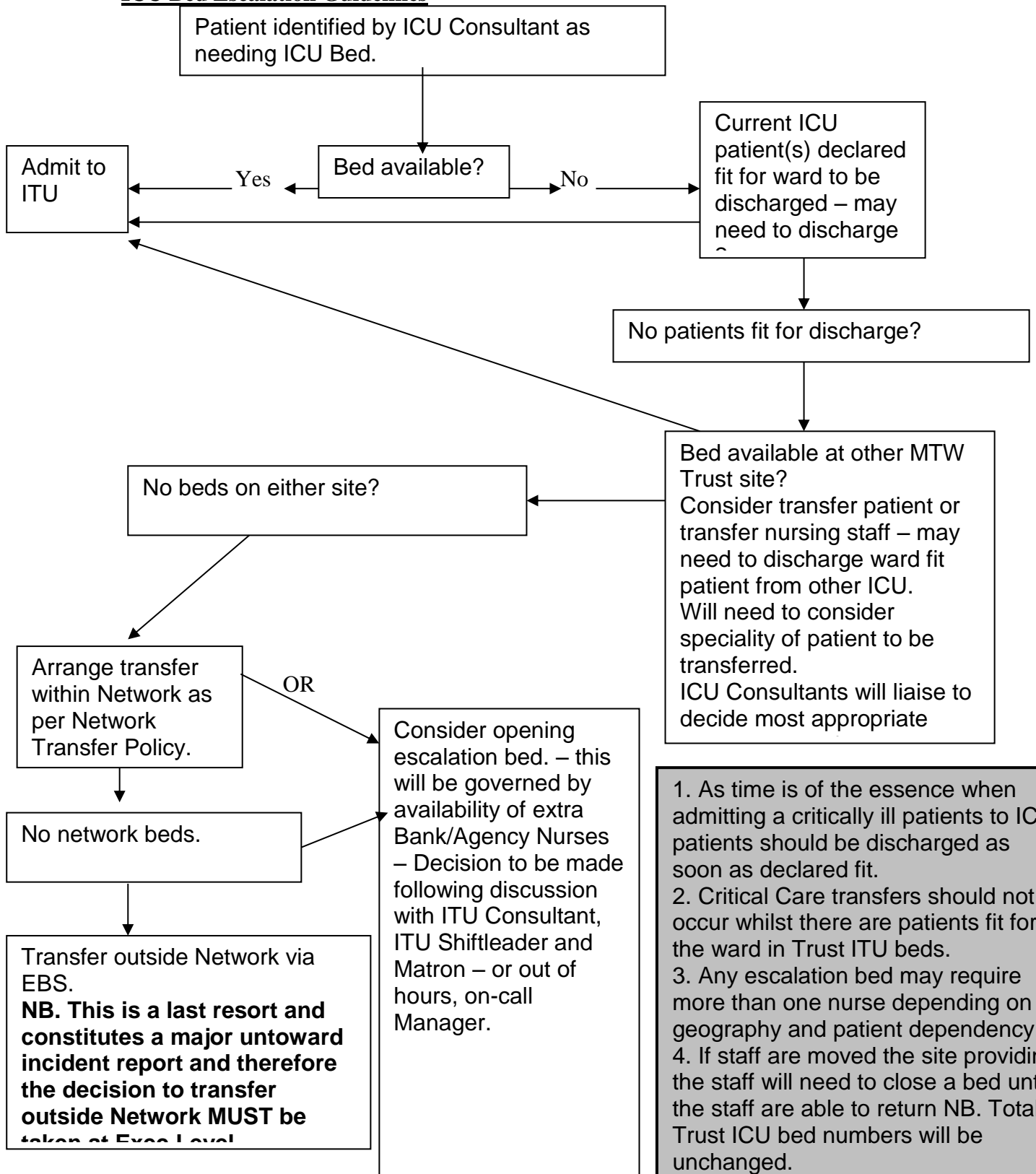
term contractors, employed, unemployed)	
People in deprived areas and people from different socio-economic groups	
Asylum seekers and refugees	
Prisoners and people confined to closed institutions, community offenders	
Carers	
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
3	Critical Care Outreach Team Recovery Flow chart	
4	TWH ICU Escalation Plan	
5	Maidstone ICU Escalation Plan	
6	Critical Care Bed escalation Guidelines Flowchart	

ICU Bed Escalation Guidelines



1. As time is of the essence when admitting a critically ill patients to ICU patients should be discharged as soon as declared fit.
2. Critical Care transfers should not occur whilst there are patients fit for the ward in Trust ITU beds.
3. Any escalation bed may require more than one nurse depending on geography and patient dependency.
4. If staff are moved the site providing the staff will need to close a bed until the staff are able to return NB. Total Trust ICU bed numbers will be unchanged.
5. The impact on electives for the next day will need to be assessed when moving staff across site.

