NHS
Maidstone and Tunbridge Wells
NHS Trust

Ref: FOI/GS/ID 6685

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29 April 2021

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 triage protocol for ICU.

You asked:

I would like to see any triage protocols for ICU (which specified who would be admitted and who would be denied care) that were in use between March 2020 and to date.

Trust response:

Admission protocols to the Intensive Care Units has remained unchanged - see the following Critical Care SOP (particularly page 25) and Admission process.

Operational policy and procedure for the Critical Care Units (CCU)

at Maidstone and Tunbridge Wells Hospitals

Target audience:	All Trust clinical staff who have or are likely to have contact with Critical Care
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Owner:	Medical Director
Division:	Medicines & Emergency Care
Directorate:	Critical Care
Specialty:	Intensive Care
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Approved by:	Clinical Operations & Delivery Committee, 14th February 2020
Ratified by:	Policy Ratification Committee, 14th May 2020
Review date:	May 2024

This policy has been written for implementation during periods of standard functioning within the Trust. Outside of those periods (such as major incidents or national emergencies) other 'emergency' policies may be written to supersede or run alongside this policy.

Disclaimer: Printed copies of this document may not be the most recent version.
The master copy is held on Q-Pulse: Organisational Wide Documentation database
This copy – REV2.0

Document history

Requirement for document:	• Operational policy required as a revision to previous policy.
Cross references (external):	1. Intensive Care Society(ICS), Faculty of Intensive Care Medicine (FICM), Royal College of Nursing (RCN), British Association of Critical Care Nurses (BACCN) et al *Core Standards for Intensive Care Units 2013* 2. BACCN Visiting Guidelines 2012 3. FICM, ICS, RCN, BACCN et al *Guidelines for the Provision of Intensive care services 2016* 4. NHS Improvement*, (The NHS Patient Safety Strategy)* 5. *NHS England 27 March 2015 Serious Incident Framework* *http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf* 6. Royal College of Anaesthetists (RCOA) *Care of The Critically Ill Woman in Childbirth; Enhanced Maternal Care 2018* 7. South East Coast Critical Care network (SECCCN) *Transfer of the Critically Ill patient – Standards and Guidelines for intra and inter hospital transfer* April 2015 8. National Institute for Health and Care Excellence (NICE) (2009) *'Rehabilitation after critical illness in adults' Guideline 83.* 9. National Outreach Forum (NoRF) (2012) *'Operational Standards and Competencies for Critical Care Outreach Services'.* 10. Intensive Care Society (ICS) version 2 (2018) *'Guidelines for Provision of Intensive Care Services'.* 11. Paediatric Intensive Care Society Quality Standards for the Care of Critically Ill Children 12. Paediatric Critical Care Child Ventilated in Adult ITU Evelina Children's Hospitals Clinical Guidance 2017
Associated documents (internal):	• Aseptic non touch technique (ANTT) policy and procedure [RWF-OPPPCSS-C-PATH5] • Blood sample collection policy and procedure [RWF-OPPPCSS-C-PATH38] • Care and management of central venous access devices [RWF-OPPPPS-C-TIO6] • Control and management of Carbapenemase-producing Enterobacteriaceae (CPE) and Carbapenemase-resistant Enterobacteriaceae (CRE) [RWF-OPPPCSS-C-PATH41] • Control and management of multi-resistant organisms (excluding MRSA and CRE) [RWF-OPPPCSS-C-PATH23] • Decontamination policy and procedure [RWF-OPPPCSS-C-PATH19] • Decontamination procedure for flexible endoscopes [RWF-OWP-APP260] • Dress, uniform and identification badge policy and procedure [RWF-OPPPCS-NC-WF26] • Environmental disinfection policy and procedure [RWF-OPPPCSS-

	C-PATH11] • Escalation plan for increase in ICU capacity at Maidstone for major incident/mass casualties [S: Drive mtwdfsv01/dept/criticalcare] • Escalation plan for increase in ICU capacity at TWH for major incident/mass casualties [S: Drive mtwdfsv01/dept/criticalcare] • Fire safety policy and procedure [RWF-OPPPCS-NC-CG4] • Hand hygiene policy and procedure [RWF-OPPPCSS-C-PATH13] • Healthcare records policy and procedure [RWF-OPPCS-NC-TM31] • Helicopter operations policy and procedure [RWF-OPPCS-NC-TM28] • ICU business continuity plans [local document] • Information governance policy and procedure [RWF-OPPCS-NC-TM9] • Interpreting and translation policy and procedure [RWF-GQU-GOV-POL-1] • Isolation policy and procedure [RWF-OPPPCSS-C-PATH16] • Major Incident Action Card 34. Maidstone Hospital: ICU [Appendix 5.34 Major Incident Plan] [RWF-OPPM-CORP270] • Major Incident Action Card 34. Tunbridge Wells Hospital: ICU [Appendix 4.34 Major Incident Plan] [RWF-OPPM-CORP234] • Major Incident Plan [RWF-OPPP-CS-NC1] • Management & prevention of sharps / splash injuries policy and procedure (incorporating bloodborne virus exposure) [RWF-OPPPCS-C-WF5] • Materials handling / supply / storage and distribution [local document] • Medicines policy and procedure [RWF-OPPPCSS-C-PHAR1] • MRSA - Control and management of Meticillin resistant Staphylococcus Aureus including screening and de-colonisation [RWF-OPPPCSS-C-PATH21] • Operational discharge policy and procedure [RWF-OPPPES-C-AEM6] • Patient property policy and procedure [RWF-OPPPCS-NC-NUR1] • Patient transfer policy and procedure [RWF-OPPPCS-C-TM3] • Peripheral venous cannulation policy and procedure [RWF-OPPPCSS-C-PATH3] • Policy and procedure for the admission of young persons (16 and 17 year olds) to acute adult services wards [RWF-PAE-POL-3] • Policy and procedure for the assessment of patients presenting with diarrhoea [RWF-OPPPCSS-C-PATH10] • Policy and procedure for the control and management of Clostridium difficile [RWF-OPPPCSS-C-PATH8] • Policy and procedure for the management of healthcare waste [RWF-OPPPCS-NC-FH6] • Policy and procedure for the management of violence and aggression [RWF-OPPPCS-NC-FH8] • Policy and procedure on being open / Duty of candour [RWF-OPPPCS-NC-CG2]

	• Protocol for the decontamination of nasendoscopes [RWF-OWP-APP261] • Risk management policy and procedure [RWF-OPPPCS-NC-CG13] • Safeguarding adults at risk policy and procedure [RWF-OPPPCS-C-NUR5] • Smoke-free policy and procedure [RWF-OPPCS-NC-TM37] • Use of cameras, video and audio recorders (including the use of smart phone and other mobile devices with recording functionality) on Trust premises policy and procedure [RWF-OPPPCS-NC-CG8] • Wells Suite, operational policy and procedure [RWF-OPPP-PP-NC1]

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	Outreach	NEWS2	Deteriorating
	Stabilisation		

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Issue:	**Description of changes:**	**Date:**
1.0	New policy / procedure	September 2015
1.1	Addition of new appendix (9): SOP for the Critical Care Outreach Service at Maidstone and Tunbridge Wells Hospitals	December 2016
2.0	Revised policy and added new appendices (10): Standard Operating Procedure (SOP) for Paediatrics in Critical Care, (11): SOP for paediatric transfer in Critical Care and (12): SOP for Obstetric patients in Critical Care.	May 2020

Summary for

Operational policy and procedure for the Critical Care Units at Maidstone and Tunbridge Wells Hospitals

This document is to facilitate effective management and understanding of the Critical Care Units and should be used to understand the critically ill patient’s pathway. The operational policies for the Acute and Emergency Medicine, Surgery, Cancer and Haematology, Diagnostics, Therapies and Pharmacy, Obstetrics, Gynaecology and Sexual health, Private Patients and Trauma and Orthopaedics directorates should be used in conjunction with this policy where applicable.

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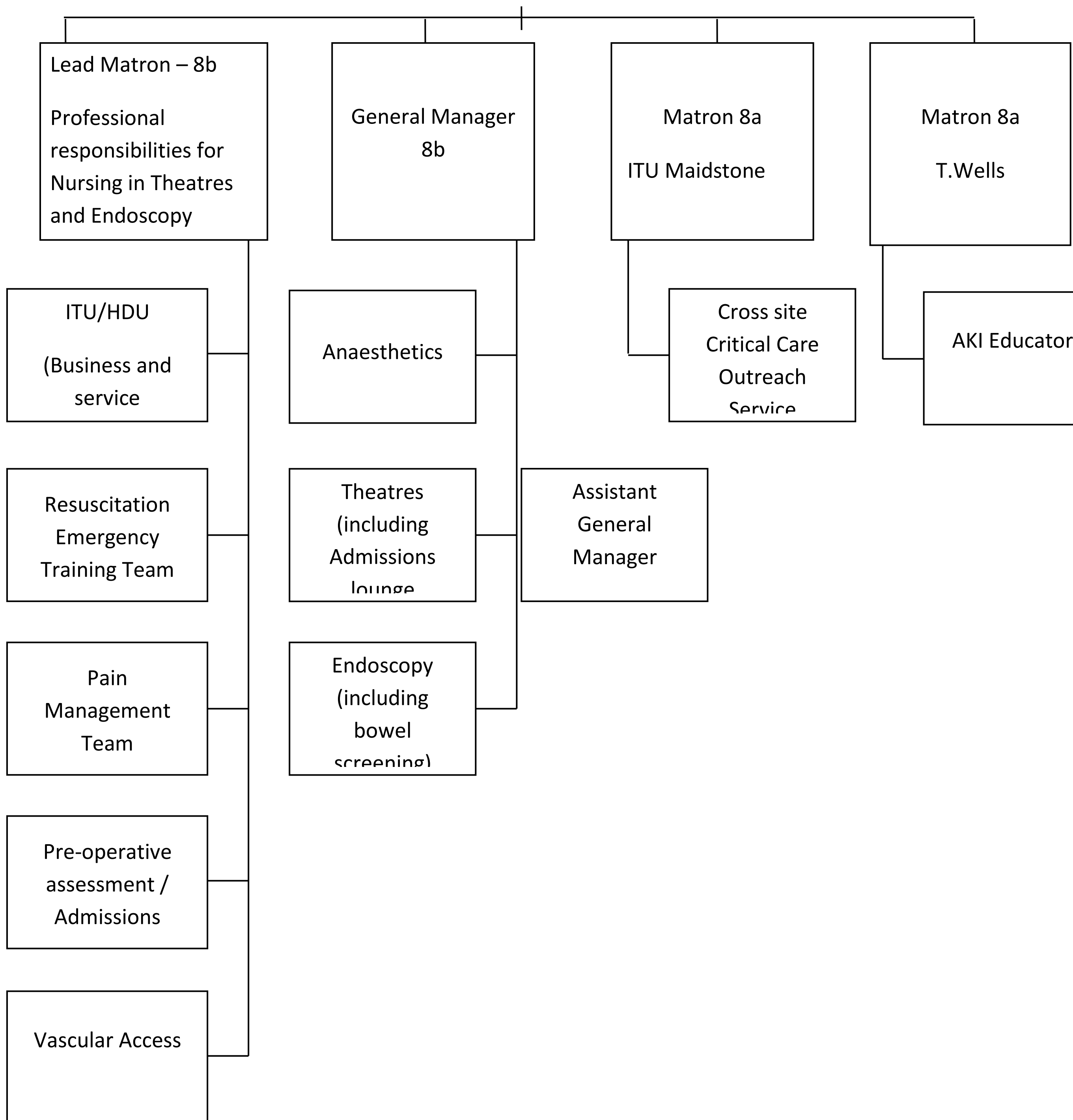
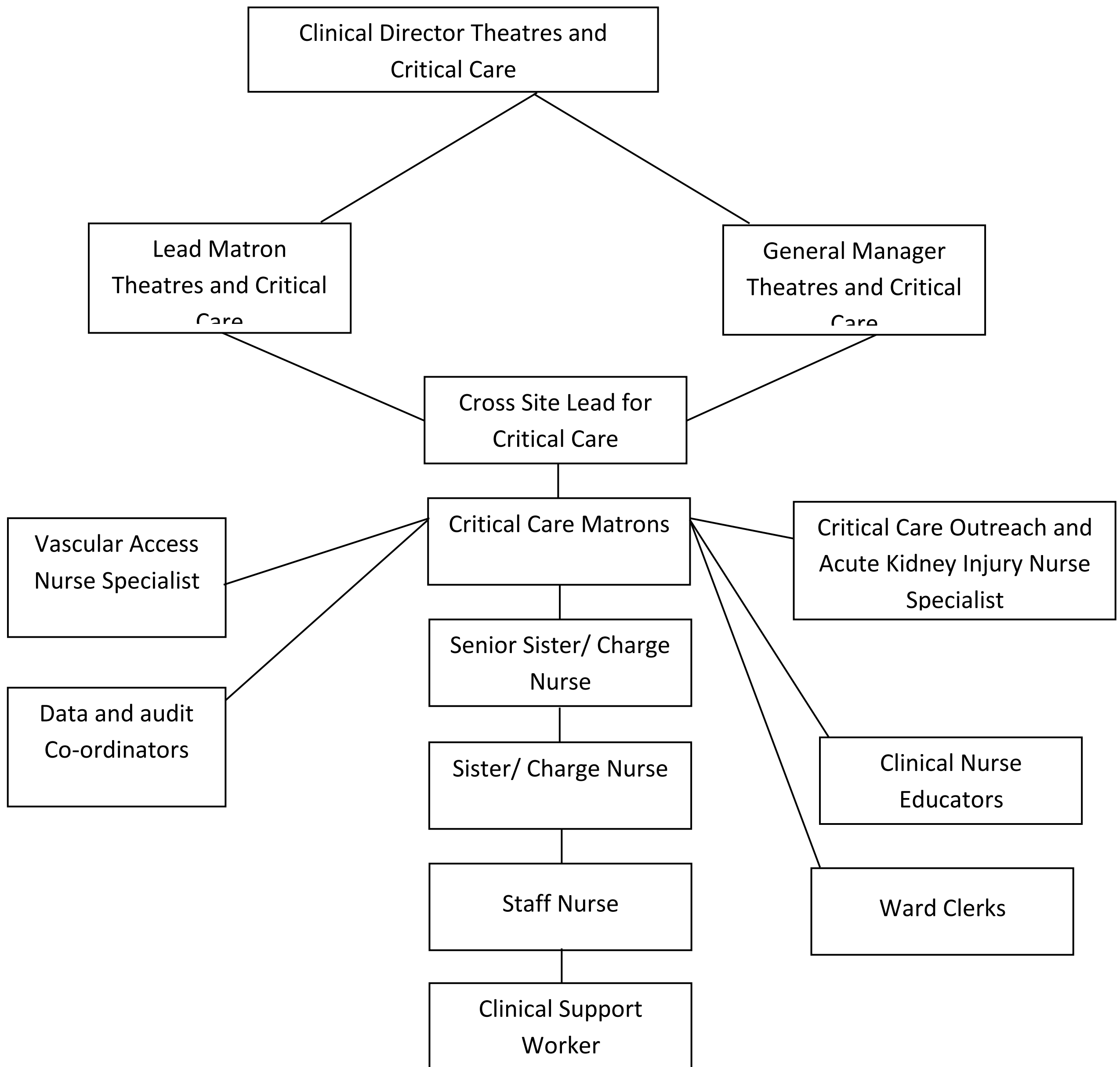
Critical Care Directorate structure

Clinical Director



Lead Matron – 8b
Professional responsibilities for Nursing in Theatres and Endoscopy
General Manager 8b
Matron 8a
ITU Maidstone
Matron 8a
T.Wells
ITU/HDU
(Business and service
Anaesthetics
Cross site Critical Care Outreach Service
AKI Educator
Resuscitation Emergency Training Team
Theatres (including Admissions lounge
Assistant General Manager
Pain Management Team
Endoscopy (including bowel screening)
Pre-operative assessment / Admissions
Vascular Access

Critical Care management structure



1.0 Introduction, purpose and scope

The Trust's Critical Care units provide a spectrum of care encompassing Intensive Care Units (ICU) and High Dependency Units (HDU). The units are comprised of nine single bedded rooms at Tunbridge Wells Hospital (TWH) and 14 beds in three areas, including two single rooms at Maidstone Hospital (MGH). Each unit is staffed to care for a fixed dependency of patients. The Units are managed within the Critical Care Directorate. They provide care for critically ill adults requiring level 2 or level 3 care across the Trust (see **Appendix 4**). Both units are currently staffed to a patient dependency of 7 (assuming a nurse to patient ratio of 1:1 for ICU and 1:2 for HDU).

Patients can be admitted from any hospital areas such as the Emergency Departments (EDs), operating theatres, and the wards, as well as from external hospitals via the Emergency Bed Service (EBS) and from private sector hospitals.

Clinical cover for the critical care units is provided by Consultant Intensivists. Care is provided on a "Closed Unit" model evidenced to provide optimum patient care. On site junior doctor cover is provided by a mixture of trainees and staff grades from the Anaesthetic and Medical training rotas. There is normally cover from an Anaesthetic trainee or staff grade 24 hours per day for each site.

Staffing and budgetary control falls within the Critical Care Directorate.

Standard wording- This policy covers business as usual. In exceptional circumstances other policies need to be followed.

2.0 Definitions/glossary

Term	Definition
CCU	Critical Care Unit
Child	Those individuals under 16 years of age (up to 18 for safeguarding reasons)
Closed unit	Patients are admitted to the ICU and responsibility for their treatment is transferred to the Consultant Intensivist until they are ready for discharge
ICU	Intensive Care Unit
ICU/ITU	Interchangeable meanings
ITU	Intensive Therapy Unit
Levels of care	Described in **Appendix 4**
Obstetric patient	A person who is pregnant, giving birth or immediately post-partum.
Parent team	The medical/surgical/specialist team that the patient is admitted under, and is determined by the name of the Consultant leading that team
Young person	Those individuals aged between 16 and 18 years of age.

3.0 Duties

Duties are embedded within specific sections of the procedures below.

4.0 Training / competency requirements

All staff will receive Trust and departmental induction training. Induction booklets are available for all medical staff on joining the units.

Training of Critical Care nursing staff will be co-ordinated, documented and supervised by the Units' Clinical Educators. There will be 1.0 Whole Time Equivalent (WTE) Band 7 Education Nurse for each unit.

For induction competencies, all staff working on the units will complete medical device competencies and specific specialist training. All nursing staff without Critical Care experience will undertake the Foundations of Nursing the Critically ill Course. The Units will support suitable staff to undertake post registration Intensive Care Nursing degree modules. Both units will aim for a minimum of 50% of all staff to have undertaken post graduate specialist Intensive Care Nursing courses *(GPICS 2016).*

On-going training will be part of the CCU's training programme and will include participation in weekly Multidisciplinary Team (MDT) meetings, staff meetings, updates from the Clinical Educators and attendance at speciality specific study days. All staff will undertake training in organ donation. All staff will maintain compliance with statutory and mandatory training.

Medical staff must be up to date with all relevant Trust Mandatory Training. All trainees' must be part of a Training programme and all staff on the Registrar rota must have undergone Transfer Training. All staff must be competent in the procedures that they are expected to undertake.

5.0 Philosophy of care

The units provide and maintain the highest quality of patient centred care to all patients regardless of age, sex, race, religion, or personal beliefs.

Both units are intended to provide adult critical care, for individuals over 16 years (for information regarding the critical care of adolescent and paediatric patients see **Appendix 10**).

The units facilitate and support an effective recovery where possible, and, where recovery is not possible, providing a sympathetic, caring, dignified and holistic approach to the end of life care.

The units continually pursue the safety of their patients and staff in their delivery of care.

The units ensure that patients, their relatives and significant others:

- Understand their right to individuality and their rights regarding respect for their privacy and dignity.
- Are regularly informed of care and progress in a courteous and appropriate manner, with honesty, openness, and transparency. This will include disclosure about hazards, risks and complications.

- Are informed in a courteous, honest, open and transparent manner about any failures in our care if they occur with an explanation of how we will prevent such failings in the future.
- Are actively involved in decisions about their care, and are invited to be involved in that care.
- Are encouraged to give us feedback to enable improvements in practice.

Staff have the right:

- To feel supported and developed and have their individual contribution to care valued.
- To be treated with respect, with a commitment that disruptive, disrespectful, or unprofessional behaviour is not tolerated.
- To work within a collaborative and supportive team, where all staff involved listen and respond effectively to each other to foster teamwork and dialogue across all disciplines for the betterment of smooth, safe, respectful and efficient patient care.
- To promote evidence based practice and support its development through education and research as well as lessons learned from sub-optimal care.
- To have a questioning attitude to all aspects of practice in order to achieve the best possible patient outcomes.

6.0 Mission and aims

Our mission is to provide excellence in Critical Care services.

Critical Care staff aim to:

- Support and foster the highest quality of care to all patients and their families.
- Train individuals who are passionate about adult critical care and who will become academic and clinical leaders in this field.
- Foster an academic, diverse, educational environment that encourages on-going professional development, evaluation and constructive feedback.
- Lead the field of critical care nursing and medicine.
- Advocate on behalf of patients and their families, emphasising prevention, treatment and research relating to adult critical illness.

7.0 Functional relationships

The two Critical Care Units work cooperatively to ensure the standardisation of practice, and to ensure appropriate, safe, cost effective staffing and levels of care. Critical Care staff will work cross-site when necessary.

The MDTs consist of nurses, doctors, physiotherapists, occupational therapists, speech and language therapists, pharmacists, clerical staff, specialist nurses and dieticians.

The Trust's Critical Care Units work closely with the South East Coast Operational Delivery Group, via staff attending Network meetings and participating in developments in care.

8.0 Hours of operation and predicted workload

The units operate 24 hours a day, seven days a week, every day of the year.

8.1 Medical ward rounds

There are at least twice daily reviews of all patients by a Consultant Intensivist. This includes weekends and Bank Holidays. This should include liaison with other members of the MDT such as the Pharmacists, Physiotherapists, Dieticians, Speech and Language Therapists and Consultant Microbiologist as required.

8.2 MDT meetings

The Critical Care team should meet daily with other members of the MDT including a Consultant Microbiologist, who should attend the ICU every Monday to Friday. The Consultant Microbiologist will be available for advice at all times (contact via switchboard). Parent teams are expected to visit daily to discuss their patients with the Critical Care team.

8.3 Patient visiting

The units operate an open visiting policy, with rest periods determined on an individual patient basis. The units encourage only two visitors at a time to each patient due to limitations of space around the patients. However, all aspects of this visiting guidance can be varied depending upon individual patient and relative circumstances (BACCN Visiting Guidelines 2012).

9.0 Staffing configuration

9.1 Nursing

Early		Late		Night	
Nurse (RN)	Clinical Support Worker (CSW)	RN	CSW	RN	CSW
9	1	9	1		1

The nursing teams will include a Band 8a Matron who will be rostered for a minimum of two clinical shifts per month. Each shift will have a supernumerary shift leader who is a Band 7 or Band 6 Sister/Charge Nurse who has an Intensive Care Nursing Post Registration qualification *(GPICS 2016).* Normally there will be a second Band 7 or Band 6 on as backup. Any concerns with nursing staff levels should be escalated through the Matron and/or clinical site manager.

Each unit will employ a 0.5 WTE Data and Audit Co-ordinator who will be an experienced Critical Care nurse.

9.2 Medical

Patients admitted to the CCU have their day to day care managed by a Consultant Intensivist. Each unit has a covering Consultant Intensivist who, during working hours, will be on site and immediately available. Thereafter each unit is covered by on-call intensivist who should be available to attend within thirty minutes; this may be the same intensivist or a different intensivist. All patients will be seen by a Consultant Intensivist within 12 hours of admission, and thereafter twice daily as part of the Critical Care ward rounds.

Whenever there is a change of Consultant Intensivist for a unit a structured handover using the 'Critical Care handover framework' (see **Appendix 13**) must occur between the two Consultant Intensivists. While they both need to actively participate in this process it is the outgoing intensivist's responsibility to ensure they have handed over to the incoming intensivist.

There will be a resident Critical Care Staff Grade/Registrar who will also attend Cardiac arrests in the rest of the hospitals if they are available. Whenever there is a change of Critical Care Staff Grade/Registrar for a unit, a structured handover must occur between the two CCU Staff grades/Registrars, while they both need to actively participate in this process it is the outgoing intensivist's responsibility to ensure they have handed over to the incoming Staff grade/Registrar.

Whilst being cared for in the CCU patients remain nominally under the care of their parent Consultant team who should visit them daily as part of the multidisciplinary team contributing to their care. As a 'Closed Unit' the visiting parent team should discuss any suggested medical or surgical interventions with the CCU team and document these in the patient's healthcare records but must not adjust or change any medications or other managements themselves without the expressed approval of the CCU team

The Critical Care Units will have Consultants undertaking the following lead roles:

- Cross site Lead Consultant for Critical Care
- Critical Care Outreach Lead Consultant
- Critical Care Transfer Lead Consultant
- Critical Care Obstetric Lead Consultant

For further information see job descriptions for these roles.

9.3 Administrative

Each unit will have a Ward Co-ordinator (1 WTE) who will work Monday to Friday from 08:30 to 16:30, and will undertake clerical and administrative duties.

- **MDT**

The MDT provides highly specialised services to support and enable the care and rehabilitation of critically ill patients requiring organ support and intensive monitoring. As well as nursing and medical staff the team consists of:

- **Physiotherapy** –present on the unit Monday to Friday, from 8:30am onwards. Physiotherapists will undertake a respiratory assessment and an assessment of rehabilitation needs within 24 hours of admission and prior to discharge. A minimum of 45 minutes of active therapy will be offered for all patients receiving rehabilitation five days a week. At weekends respiratory physiotherapy will continue for all patients and rehabilitation provided according to patient need.
- **Out of Hours Respiratory Physiotherapy** – on call physiotherapists are available for respiratory care 24 hours per day including weekends and bank holidays. All patients will be routinely seen from 08:30 onwards at weekends and on bank holidays
- **Speech and Language Therapy** – Available on request on the Unit Monday to Friday from 08:30 to 16:30 as required. SLTs will undertake communication and swallowing needs assessments for all patients with tracheostomies.
- **Dietetics** – a Critical Care Lead Dietician will visit the Units daily during the week to assess, implement and manage appropriate nutritional support as required.
- **Pharmacists** – A Critical Care trained Pharmacist will be available on each unit from Monday to Friday, between 08:30 and 17:00, and should attend the MDT ward round.
- **Clinical Psychologist** – A referral pathway is available if needed (see **Appendix 8**).
- **Specialist Nurse Services** – will provide advice regarding tissue viability issues, stoma care, diabetes management and other specialists as required.
- **Matron for Safeguarding Adults –** the Matron will provide advice regarding the issues surrounding adult protection, best interests, mental capacity and deprivation of liberties as required.
- **Chaplaincy Services** – The Trust's Chaplains will provide an on-call service and can be contacted via switchboard.
- **Critical Care Outreach Team (CCOT) –** CCOT will follow up patients after discharge to the wards. They will visit the units each morning to discuss patients discharged over the past 24 hours. The Critical Care Outreach Team will liaise with the Critical Care Units regarding any high risk patients on the wards that they are concerned about. They will facilitate transfers to the units and, when appropriate, to specialist units (see **Appendix 9**).

10.0 Infection control

This will be led by the Trust's Infection Prevention and Control Team. Critical Care staff will abide by the Trust's policies and patients will be treated in accordance with this.

Please refer to the Trust 'Isolation policy and procedure'.

10.1 Patients with infections which are transmissible via direct contact (e.g. MRSA, ESBLs, GRE etc.)

The Trust's Isolation Policy and Procedure requires these patients to be nursed using contact precautions. At MGH CCU this will be achieved using isolation in single rooms if available. Where this is not possible patients will be risk assessed and barrier nursing precautions at the patient's bedside will be used. Advice will be sought from the Trust's Infection Prevention and Control team.

10.2 Patients with infections which are transmissible via the faecal / oral route (e.g. patients with diarrhoea identified as Pathway 1, CDT, norovirus etc.)

When patients have infections which are transmissible via the faecal oral route barrier nursing signs will be displayed, either outside their room or at the end of the bed space as per policy. Doors to single rooms must remain closed when patients are being barrier nursed unless risk assessed to remain open.

These patients will need to be nursed using enteric precautions ideally in a single room. Discussion and or risk assessment must take place with the Infection Prevention and Control team as to the best option for both the patient and clinical areas.

At CCU cohorting patients with proven non-infective diarrhoea is an option if single rooms are not available.

All patients admitted from hospitals outside the Trust will be nursed initially in isolation, in single rooms whenever available, and specimens sent for CRE where appropriate until advised otherwise by Infection Prevention and Control.

11.0 Support services

11.1 Emergency Departments (EDs)

Critical Care patients can be admitted directly from the EDs. Transfer will be by trolley with appropriate equipment. A parent team must be identified from medicine and or surgery with which liaison for later ward care and treatment can occur. A link Intensive Care Consultant will work with the ED consultants to try and ensure that all appropriate and necessary drugs and equipment are available within the EDs.

11.2 Catering

There is no provision for catering within the Critical Care Unit for patients at MGH other than for the provision of hot and cold drinks and snacks. Patients that are able to eat will make use of the menu cards and catering from the catering department.

Within TWH a selection of frozen meals, snacks and nutritional supplements are available as well as meals from the main kitchen on request, this flexibility allows for patients to eat at a time suitable to them.

11.3 Cleaning

Cleaning is performed as per domestic schedule, with a dedicated cleaner from Monday to Sunday with minimal cover out of hours (6pm to 8am). Facilities for level 3 cleaning of all bed spaces is available out of hours.

The CCU is considered a ‘high risk’ area and as such cleaning will be audited on a weekly basis with the domestic supervisor or team leader and the Ward Manager or deputy, a score of 95% or above is required from the cleaning audit and appropriate escalation to the domestic supervisor if this is not achieved.

11.4 Chaplaincy

There is a requirement for access to spiritual care for patients, relatives and staff which is inter-denominational and is available through the Trust Chaplaincy Service

11.5 Chemical Pathology

All Critical Care patients will require input from chemical pathology as required by their clinical condition. This service is needed out of hours every day of the year. Blood samples will need to be sent from the units to the laboratory via the vacuum transfer system or the portering service.

11.6 Clinical supplies

Supplies are replenished by the hospital Materials Management service on a regular basis, and stores located in the designated store-rooms provided.

11.7 Communication

Telephone extensions as follows:

Maidstone Hospital ICU

Nurse stations Side A Ext. 22025 or 22028
Nurse stations Side B Ext. 24398 or 24401
Side room 1 Ext. 24812
Side room 2 Ext. 24813
ICU Ward Manager Ext. 24726
Clinical Educator Ext. 22033
Audit Co-ordinator Ext.24488

Tunbridge Wells Hospital ICU

Nurse stations; Ext. 35446 or 35598
ICU Ward Manager Ext. 35019 or 35757
Critical Care Audit Ext. 35844

The Trust has a mobile telephone policy and procedure (this covers Use of cameras, video and audio recorders (including the use of smart phone and other mobile devices with recording functionality) on Trust premises).

11.8 Dietetics

The dietician is available on the unit during the daily ward round on week days and provides advice and support for the nutritional needs of the critically-ill patients.

11.9 Electro-medical engineering (EME)

All Critical Care patients will require equipment serviced and supported by the EME service. This service needs to be available every day of the year, 24/7. The service will advise on purchasing and commissioning of new equipment, and be responsible for service contracts both internally and with external companies. Where possible, servicing of equipment will be undertaken on site.

11.10 Endoscopy

There will be a need for use of endoscopes and bronchoscopes for the carrying out of endoscopy, bronchoscopy and tracheostomy. The Critical Care units have their own bronchoscopes. At MGH they are kept in the Endoscopy Unit. During working hours these are prepared and cleaned by endoscopy staff. At TWH an on-call service operates within endoscopy and scopes can be accessed via the scope cabinet in main theatres.

Disposable bronchoscopes (A Scopes) are available as part of the difficult airway trolleys on both critical care units and elsewhere within the Trust. These can be used for elective procedures, out of hours and for emergencies

11.11 Point of care testing

Each Critical Care unit has blood gas analysers for use by Critical Care staff who have been appropriately trained. The blood gas analyser is maintained by Critical Care staff with input from Clinical Chemistry and EME.
Other departments may request that samples from outside the units may be processed on these blood gas analysers which trained nursing staff can do for them, or they can receive training on how to process these samples for themselves. However the Critical Care units are not funded to provide this service. There is a vacuum transfer system at both hospital sites for transport of specimens with access located within each Critical Care unit.

11.12 Inpatient wards

Inpatients may require Critical Care during their hospital stay necessitating transfer from general wards, this may be facilitated by Outreach Staff and the clinical site management team who will coordinate hospital bed use.

11.13 Imaging

All Critical Care patients may require radiological investigations. The frequency of this will depend on their medical condition and progress. Portable X-ray will be needed for CCU patients. Usual precautions will be adopted when in use.

A suitable PC with access to the Picture Archiving and Communication System (PACS) and suitable monitor for reviewing radiography will be available on each Critical Care unit and staff trained in its use.

Access to CT scanner is frequently required. As Critical Care patients are often bedbound on multiple organ supports appropriate transfer equipment is required. The transfer must be documented and observations recorded during the transfer. Suitably trained escorts (medical and/or nursing) will accompany the patient

The need for imaging must be clearly documented in the healthcare records.

Currently the units do not routinely support MRI scanning for ventilated patients.

11.14 Linen

Supplies of linen are replenished daily.

Supplies of disposable curtains are held by domestic services and changed as per policy (yearly / when visibly soiled / after a level 4 clean for Clostridium difficile or clostridium difficile carriage)

11.15 Medical gases and suction

Medical gases and suction are needed at every bed space. All outlets to be fully functional, any faults must be reported immediately. Oxygen and air supply and equipment is checked as part of the bedside nurse checks at handover and maintained by EME.

11.16 Healthcare records

The Trust's 'Information governance policy and procedure' will be followed. Patient's paper healthcare records will be returned to Health Records as soon as no longer required. The Ward Coordinator will ensure paper healthcare records are not retained on the wards when patients have been discharged.

All patient paper records must be booked out to the Critical Care Units if retained on the units. Access to electronic records must be available in every bed space, either by computer or tablet.

11.17 Microbiology and infection control

All Critical Care patients will require the input of a Consultant Microbiologist. A Consultant Microbiologist visits the Unit on a daily basis (weekdays) to advise on antibiotic regimes and infection issues, and is available 24/7 for telephone advice.

Members of the MDT will liaise with members of the Infection Prevention and Control Team for all patients with infective diarrhoea or resistant organisms to ensure best infection prevention practices are being performed.

All entrances will be provided with hand-gel (which is the responsibility of the nursing staff to replenish). All visitors and health professionals will be expected to wash their hands or decontaminate them with gel on entering the Unit, or a bed space and in accordance with the WHO 5 moments of hand hygiene. In addition staff must wear a disposable apron when in a bed-space

or in contact with blood and body fluids. Additional precautions may be required with some patients.

All staff and visitors must take appropriate precautions to avoid cross contamination.

The Critical Care Units will undertake Department of Health (DH) Saving Lives audits and these results are reported through the Directorate and through the Infection Prevention and Control Committee.

11.18 Critical Care Outreach Team (CCOT)

Close links will be maintained with the CCOT. The Outreach team will visit the units on a daily basis in order to determine those patients in need of follow up upon ward discharge and to advise on any possible admissions to the Critical Care units from the wards. Outreach currently operates a 24 hour service (see **Appendix 9**).

11.19 Pharmacy

The pharmacist will visit the unit daily during the week, attend the multidisciplinary ward round and review all patient medication charts. Top-up will be made twice a week and delivered via the pharmacy portering service and contained in a locked box.

Refer to ‘Medicines policy and procedure’ for administering patient drugs.

11.20 Physiotherapy

Physiotherapists will be required to visit the unit once in the morning, and where clinically indicated will return to the unit later in the day and on request.

Physiotherapists will be responsible for assessing respiratory function and contributing to the treatment of respiratory problems and liaising with nursing staff in the development of weaning plans for patients. The physiotherapist will formulate plans for on-going rehabilitation as appropriate and ensure outcome measures are used to quantify rehabilitation goals.

11.21 Phlebotomy

Is undertaken by Critical Care staff as per the Trust’s ‘Blood sample collection policy and procedure’.

11.22 Acute Pain Team

The Acute Pain Team will visit all patients undergoing analgesia via the epidural route and via patient controlled analgesia (PCA) and will advise as necessary on pain control issues. They will be informed when these patients are discharged to the wards.

11.23 Patient information leaflets

Patient information leaflets are available to all relatives and patients (information rack in visitors waiting area). All patients must receive a copy of the ICUsteps information leaflet upon ward discharge.

11.24 Policies

All unit local policies will be held in the unit's policy folder and stored on the Trust computer network. Trust-wide policies are held on the Organisation-wide documentation Q-Pulse database, accessed via the Trust intranet.

All unit guidelines and protocols will be available on the Trust intranet via the ICU-elink pages.

11.25 Portering

There is a requirement for an active portering service 24 hours per day seven days per week.

11.26 Post

All post is delivered and collected from the designated areas within the unit by the portering staff (there is no Sunday service).

11.27 Theatres

Critical Care patients may be admitted following a surgical procedure, or may need surgical intervention during their stay. Patients may or may not come to the Critical Care unit via recovery depending upon their individual circumstances.

11.28 Patient transport

All patient transport is provided by South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and ordered via telephone or electronically following contractor's processes. See **Appendix 7** for the exact process.

11.29 Specimens

If not able to be sent via the vacuum pod, these will be placed for collection in the designated area within the unit.

11.30 Waste management

Clinical waste – all clinical waste must be segregated at source and be placed in appropriate coloured coded bag, sealed and placed in the designated ward waste area for collection. Clinical waste will be removed by the porters.

Sharps disposal – all staff must adhere to the Trust policy for the disposal of sharps (Management & prevention of sharps / splash injuries policy and procedure (incorporating bloodborne virus exposure)).

Non-clinical waste – must be segregated at source and be placed in appropriate bags, sealed and placed in the designated ward waste area for collection by portering staff

Please refer to the Trust 'Policy and procedure for the management of healthcare waste' for further information.

11.31 Research and development

The units are research active departments and maintain close contact with the trust Research and Development department. The Critical Care Research Team facilitates studies within the units in accordance with Trust Clinical Governance arrangements and good clinical practice.

12.0 Other considerations

12.1 Patients' valuables

The Trust does not accept liability of loss or damage to patients' own property. Patients must be informed not to bring in valuable items or money (in accordance with Trust policy). Any valuables handed in for safe keeping are to be stored in the hospital safe. A notice informing patients and relatives of the Trust policy will be displayed at the entrance to each unit.

12.2 Waiting areas

Waiting areas are available at both Critical Care units with facilities for relatives to obtain refreshments.

12.3 Smoking

The Trust operates a no smoking policy ('Smoke-free policy and procedure').

12.4 Staff dress code

There are facilities for staff changing, with limited locker space, at each unit. Nursing staff will have the use of a locker. Locker keys will be the responsibility of the locker users. All staff will adhere to the Trust's uniform policy and will have responsibility for their own personal property ('Dress, uniform and identification badge policy and procedure'). The Trust does not accept liability for the loss or damage to the personal property of staff.

12.5 Staff room

There is a staff rest-room where staff can take their breaks and facilities to make tea and coffee and eat their lunch with access to a microwave and toaster.

12.6 Telephone enquiries

Will be answered by a healthcare professional or a ward Co-ordinator, and the call usually passed onto the nurse providing direct care for the patient.

12.7 Visitors

An open visiting policy is in operation (with a rest period encouraged between 13:00 and 15:00 hours. This is, however, done on an individual patient basis (see 8.3). No more than two visitors at a time are allowed – unless in exceptional circumstances and agreed by nurse in charge.

Each hospital site has restaurant facilities available for visitors use during normal working hours.

12.8 Visitors' room

A limited number of visitors rooms located near the Critical Care units are available for the relatives of Critical Care patients only. Arrangements for visitors to stay overnight must be made with the unit's nurse in charge (see 14.3).

13.0 Client and patient flow

13.1 Physical access to the units

The Critical Care units should be secure areas with controlled access. Staff should have access via their ID cards or security passes. Visitors will need to request entrance via an intercom system and then enter via the main department entrances as soon as it is convenient.

Patient entry and exit will be via the Critical Care units main department entrance at MGH and via Non-Elective Recovery or the patient corridor at TWH. Critical Care staff should be made aware of impending arrivals so that they can ensure that the security doors are open to prevent delays.

13.2 Private patients (See Trust's 'Wells Suite, operational policy and procedure')

Private patients who are booked for elective surgery and require the use of a Critical Care unit must have the appropriate paperwork completed in order for an invoice to be generated. This is managed by the Unit Coordinator and the relevant admitting Consultant's secretary and the Private Patients Unit at TWH.

At TWH patients are referred to the Critical Care Unit via The Wells Suite. Charging for staffing of the HDU/ICU bed is cross charged to the Wells Suite and a daily fee is also charged. Bed availability cannot be guaranteed. Beds will be allocated according to clinical need as per the admissions policy.

If patients have deteriorated while in a local private hospital they may be transferred as an emergency admission and may or may not be charged as private depending on their insurance arrangements. The relevant details should be relayed to the Private

Patient's Officer/ Wells Suite as soon as possible in order to confirm this.

Whilst every effort will be made to accommodate external emergency referrals, there can be no guarantee of a bed and it is the responsibility of the referring hospital to find suitable alternative care if no beds are available within MTW.

In order to facilitate timely, accurate and appropriate invoicing to the private hospital concerned the following principles apply:

- If a private patient deteriorates or becomes an emergency and changes to NHS status, it must be documented and signed in the health care records by one of the doctors of either the referring or receiving teams.
- When a private elective patient is admitted to a Critical Care unit, this must be documented in the health care records. On discharge the date is then easily identifiable for the purposes of invoicing.
- If a patient changes status from private to NHS they cannot **in the same episode** electively return to private care.
- Liaison must be made through the bed managers when requiring a bed.
- G4S and SECAmb will not provide transport for private patients. If a patient needs to travel cross site or to or from a private facility either the patient will need to fund the transport themselves or payment should be negotiated with their insurance company.

14.0 Accommodation

14.1 Patient bed spaces

14 beds spaces including two side rooms are available at Maidstone and nine single rooms at TWH for the care of critically ill patients. All bed spaces have vital signs monitoring and space for integrated infusion pump and stands, a ventilator and a haemofiltration machine. A computer or electronic tablet should be present in each bed space and single room for accessing pathology results, electronic patient records, electronic observations and patient administration systems. Electronic tablets must be cleaned in accordance with the Trust policy.

14.2 Nurses stations

Nurses' workstations are positioned within the units with computer access, central monitoring system and telephones.

14.3 Relatives areas

At MGH there are two relatives rooms, one on each side of the unit to allow relatives of the critically ill to stay on site. One doubles as a quiet room. There are however no shower facilities available for relatives.

At TWH there is one en-suite relatives rooms, equipped for disabled visitors.

14.4 Equipment stores
For CCU use, to store critical care equipment.

14.5 Clean storerooms
For CCU use, to store disposables, sterile supplies.

14.6 Point of care laboratory
For blood gas machine.

14.7 Dirty utility
For CCU use, containing macerator, sluice hopper, clinical and domestic bins, skips for dirty laundry, commodes and storage of cardboard macerator products.

14.8 Cleaners' cupboard
For use by CCU domestic staff. Sink and drainage.

14.9 Staff restroom
For use by CCU staff during breaks, therefore nearby in case of emergency, also it is difficult to allow time to change clothing to access canteen during refreshment breaks.

14.10 Shower / WC
Patient shower room available on both sites.
Patient toilets available on both sites.
Separate staff toilet and shower available.

14.11 Quiet room
A private room is available on both sites to allow privacy for distressed relatives and for updating/giving news in relation to patients' conditions.

14.12 Staff changing rooms
Male and female staff changing facilities are available on both units.

15.0 The units' local patient admission, transfer and discharge policy

15.1 Admissions (see Appendix 5).

- Admission to the CCU may be appropriate for patients reaching Level 2 to 3 care requirements according to the modified levels of care from Comprehensive Critical Care 2000. Single organ support may be more appropriate elsewhere e.g. Coronary Care Unit for single inotropes, Canterbury or Guys Renal Unit for renal failure, non-invasive ventilation (NIV) care on respiratory wards, unless the complexity of the patients care makes care within the CCU more appropriate.
- Requests for elective admissions for post-operative care can be made on the basis of the clinical merits and risks of the individual patients. Such requests should ideally be made at least 72 hours in advance to allow for bed and staffing planning. Such patients' critical care requirements should then be routinely re-reviewed as their clinical course develops prior to admission.

- Request for an intensive care review of a patient should be made as a Consultant to Consultant referral in view of the high burden of treatment and risks associated with advanced organ support. However, delays in getting Consultant involvement must not delay urgent intervention. If the intensive care team feels admission is appropriate, this should be arranged and enacted as swiftly as possible (within four hours).
- Critical Care admission necessitates a Consultant to Consultant discussion. If the referring team Consultant was not involved in the initial referral process, they, or the nominal on call Consultant for the speciality, must discuss the admission with the Critical Care Consultant at the time of the admission, so that both parties are aware of the patients' condition, management plan and prognosis. If it has not proved possible for the Critical Care Consultant to have a Consultant to Consultant discussion about the admission this should be reported as an incident.
- If a patient's admission to Critical Care is going to be delayed, consideration should be given to accommodating them temporarily elsewhere where suitable facilities exist e.g. Theatre Recovery.
- All admissions must be agreed with the Consultant responsible for the Critical Care Unit.
- All patients must be seen by a Critical Care Consultant within 12 hours of admission. The time of decision to admit to CCU and the time seen by the Consultant should be documented in the patient's healthcare records.
- All referrals should be considered on their individual merits, including weighing up of the potential risks, benefits, and the burden of treatment and long term sequelae of advanced organ support. In view of these burdens and risks admission would normally only be appropriate if there is a reversible element to the patients' clinical deterioration.
- In certain circumstances it may be appropriate to admit patients requiring level 1 care, but this will need to be on the merits of the individual case following Consultant to Consultant discussions.
- Referrals from outside the Trust should be considered on their individual merits, including weighing up of the potential risks, benefits, and the burden of treatment and long term sequelae of advanced organ support. In addition referrals from outside the trust need to be agreed with a parent team (i.e. a medical or surgical team) who must then provide a named Consultant for the patient. Only once a parent team has accepted the patient can a Critical Care transfer occur. Repatriation of local residents from other Trusts and from abroad should be accommodated if at all possible.
- MTW should aim to accept patients who had initially come from this Trust but were then sent to specialist centres within 24 hours of request for repatriation.

- Patients on the Critical Care Units will be under the care of the Critical Care team but will remain nominally under the care of their parent Consultant team who should visit them daily as part of the MDT contributing to their care (see 9.2).
- Every effort should be made to gain and document consent for Critical Care from the patient prior to admission. If this is not possible the patient should be treated in their best interests.
- Both Critical Care Units will participate in the National Emergency Bed Service and offer available beds to other units who have insufficient capacity if requested. Both units also participate in the National NHS Directory of Services (DOS) online Critical Care bed capacity system updating their capacity at least twice daily.
- An incident report will be completed for all delays in admission over four hours.
- For the admission and management of a critically unwell obstetric patient, please see **Appendix 12**.

15.2 Discharges (See **Appendix 6**)

- The decision to discharge a patient from Critical Care will be made by the Critical Care Consultant.
- The Unit Shift Leader will negotiate the most appropriate ward bed with the Site Manager.
- Patients should be discharged to general surgical and medical wards within four hours of the decision to discharge.
- The parent team will be informed of their patient's discharge by a Critical Care Junior Doctor.
- A comprehensive nursing and medical discharge summary (electronic discharge notification - eDN) and the patient's paper prescription chart must accompany the patient to the ward. The prescription chart should be checked for any prescriptions that are inappropriate for ward based care and these removed prior to discharge. The receiving wards junior doctors are responsible for transcribing all appropriate prescriptions onto a ward electronic prescription system if and when such a system is in use.
- Critical Care Outreach must be informed of all patient discharges to the ward so that they can carry out a follow-up visit.
- If the patient has an epidural the Acute Pain Specialist Nurse must also be informed of the discharge.
- Patients with epidurals must only be discharged to appropriate wards (Pye Oliver and Cornwallis NB Ward will change to Peale and Cornwallis at MGH and Ward 10 at TWH)
- A CCU Nurse must accompany the patient to the ward to handover care.
- Patients should not be discharged to general wards during the hours of 22:00 and 07:00 unless capacity is needed for an urgent admission.

- Every effort must be made to ensure there is a critical care bed available for an urgent admission. Shift leaders must ensure site managers are aware if there is no capacity **and** there are ward fit patients on the unit before 15:00 each day so that a plan to create capacity for the night can be formulated.
- An incident form must be completed for all discharges delayed over 24 hours and out of hours.
- On occasions it may be appropriate to discharge a patient home directly from the Critical Care unit *(*see 'Operational discharge policy and procedure').
- Patients should be given a copy of the ICU Steps information leaflet on discharge from the unit and this should be documented on the discharge checklist.

15.3 Transfers *(*See Kent & Medway Critical Care Network Guidance for Critical Care Transfers and **Appendix 7***))*

- On occasions it may be necessary to transfer critically ill patients to other Critical Care facilities. This may be for specialist treatment not available at MTW or capacity reasons.
- Every effort should be made to avoid transfer for capacity reasons (see local 'ICU escalation policy')
- The decision as to whether a patient is fit for transfer and which patient should be transferred lies with the Critical Care Consultant.
- All ventilated patients will be accompanied by an appropriately trained Anaesthetist and a Critical Care nurse who has undertaken transfer training. There is a requirement for all medical and nursing staff to undertake training in the transfer of the critically ill. This will be available as multidisciplinary training.
- HDU patients can be transferred solely by a Critical care Nurse at the discretion of the Critical Care Consultant after discussion with the Nurse-in-charge.
- Patients from Critical Care, even if fit for the ward, must not be transferred without a nurse escort.
- All Critical Care patients undergoing transfer must have a network transfer observation chart completed and observations carried out and documented on route. A copy of this is to be retained for audit purposes.
- A comprehensive nursing and discharge summary and photocopies of all healthcare records for the current admission or a compact disk of their electronic records must accompany patients transferred outside of the Trust. Thought should also be given to ensuring all relevant imaging gets transferred to the receiving hospital either by image linking or by Compact Disc. If the patient is transferred within the Trust the original Healthcare Records should accompany them.
- All level 2 and level 3 patients are transferred by SECAmb
- For information regarding the transfer of paediatric patients, please see **Appendix 11**.

- Level 1 patients can be transferred by G4S.
- Transfer by helicopter will be considered for appropriate patients. See ‘Helicopter operations policy and procedure’ (RWF-OPPCS-NC-TM28).
- An incident report must be generated for all non-clinical transfers even if transferred within the Trust.

16.0 Patient safety

16.1 The units will always strive to ensure they do not utilise more than 20% of registered nurses from bank/agency on any one shift who are not their own staff.

16.2 There will be a Critical Care pharmacist for the Critical Care Unit.

16.3 Critical Care facilities should comply with national standards.

16.4 All equipment will conform to the relevant safety standards and be regularly serviced.

16.5 All staff will be appropriately trained, competent and familiar with the use of equipment.

16.7 The units will hold multi-professional clinical governance meetings, including analysis of mortality and morbidity.

16.8 A risk register and associated audit calendar will be maintained.

16.9 Staff will be provided with team training in human factors and non-technical skills.

16.10 There will be standardised clinical handover of all patients at shift changes, and on admission to and discharge from Critical Care. Handover should take place after essential tasks are completed, and should follow a locally agreed verbal structure.

16.11 There will be a structured, locally-agreed bedside ward-round, including daily safety concerns and treatment goals. This will be documented, with audited evidence of compliance.

16.12 In addition to existing best-practice strategies and care bundles (e.g. CVC bundle, VAP bundle), the CCUs will systematically implement recognised error-reduction protocols where these are available and approved by recognised bodies e.g. NICE, NCEPOD.

16.13 There will be demonstrable measures in place to protect staff from the inherent risks of critical care. These include: psychological stress, injuries from manual handling; sharps injuries; slips, trips and falls; and risks from managing delirious patients.

16.14 There will be a robust system for critical incident monitoring, with all reports regularly reviewed, supplemented by information from morbidity and mortality reviews and global trigger tools. Trends in reported incidents will be monitored.

16.15 Feedback will be obtained from staff, and systems will be in place to allow serious concerns to be raised in order to pre-empt risks.

16.16 Systems will be in place to escalate safety concerns raised via complaints or comments from patients or visitors, and feedback will be actively solicited through questionnaires and at follow-up.

16.17 There will be a locally agreed standard response to serious incidents in the CCU, including ‘hot’ (immediate) and ‘cold’ (planned) debriefing, immediate steps to prevent recurrence, open disclosure to patient and family, and support measures for the ‘second victim’ (staff who were involved and affected).

16.18 There will be a risk register that is relevant and specific to the CCU and its practice. The risk register, together with lessons learned from critical incident reports and staff and patient feedback, will be regularly disseminated and easily available to staff.

Appendix 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the policy database on the intranet, under ‘Policies & guidelines’.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under ‘Policies & guidelines’. 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.

2.0 Monitoring compliance with this document

- The Critical Care Units will participate in the national database for adult Critical Care (Intensive care National Audit and Research Centre - ICNARC). This facilitates benchmarking against similar Units, provides quality reports on quality indicators and mortality scoring.
- Both units will participate in monthly multi-professional clinical governance meetings including analysis of mortality and morbidity. Minutes will be taken and sharing of learning disseminated.
- Cross site senior staff meetings should be held regularly with multidisciplinary representation to provide an additional forum for discussion of governance issues and service development (see ‘Cross site senior staff terms of reference’).
- The Critical Care team will engage, contribute and participate in the South East Coast Operational Delivery Network which includes audit activity and regular peer review

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every four years.

4.0 Archiving

The policy database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

Appendix 2

CONSULTATION ON: Operational policy and procedure for the Critical Care Units at Maidstone and Tunbridge Wells Hospitals

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

Please return comments to: Matron ITU

By date: 05/07/19

Job title:	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:				
Corporate Governance Assistant	11/04/19 26/06/19	17/04/19 18/07/19	Y Y	Y Y
Counter Fraud Specialist Manager (tiaa)	26/06/19	27/06/19	N	N
Energy and Sustainability Manager	10/07/19	N		
Chief Pharmacist and Formulary Pharmacist	11/04/19 26/06/19	N		
Formulary Pharmacist	26/06/19	N		
Staff-Side Chair	26/06/19	N		
Complaints & PALS Manager	26/06/19	N		
Emergency Planning Team	26/06/19	26/06/19	Y	Y
Head of Staff Engagement and Equality	26/06/19	N		
Health Records Manager	26/06/19	N		
All individuals listed on the front page	11/04/19			
The relevant lead for the local Q-Pulse database		N		
All members of the approving committee (Clinical Operations Committee)	01/02/20	14/02/20	N	
Other individuals the author believes should be consulted				
Cross Site ITU lead	26/06/19	N		
Critical Care Matron MGH	26/06/19	N		
Lead Matron for Critical Care	26/06/19	28/06/19	Y	Y
Chief Operating Officer	11/04/19	N		

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Chief Nurse	11/04/19	N		
ADNS for Planned Care	11/04/19	N		
ADNS for Acute & Emergency Services	11/04/19	N		
ICU Consultant (Safety Lead)	11/04/19	N		
ICU Consultant	11/04/19	16/04/19	Y	YN
ICU Consultant	11/04/19	N		
ICU Consultant	11/04/19	N		
Lead Speech and Language Therapist	11/04/19	N		
Lead Dietician	11/04/19	N		
Matron for Vulnerable Adults	11/04/19	N		
GM Critical Care Directorate	11/04/19	N		
Lead Pharmacist for Critical Care	11/04/19	N		
Consultant Nurse Infection Control	11/04/19	N		
Head of EME	11/04/19	N		
Senior Nurse Organ Donation	11/04/19	N		
GM for Radiology	11/04/19	N		
Estates & Facilities	11/04/19	N		
CD for path/radiology	11/04/19	N		
Lead Physiotherapist for Critical Care	11/04/19	18/04/19	N	N
Matron for Private Patients Unit	11/04/19	N		
C D for Emergency Services	11/04/19	N		
Clinical Director for Surgery	11/04/19	N		
CD for Oncology & Haematology	11/04/19	N		
CD for Trauma & Orthopaedics	11/04/19	N		
CD for Obstetrics & Gynaecology	11/04/19	12/04/19	N	N
Women's and children's Matron	11/04/19	N		
Paediatric Matron	11/04/19	N		
The following staff have given consent for their names to be included in this policy and its appendices:				

Appendix 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Operational policy and procedure for the Critical Care Units at Maidstone and Tunbridge Wells Hospitals
What are the aims of the policy?	To guide and inform people of the procedures for this Service
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
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.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	Yes - Refer to Trust's 'Interpreting and translation policy and procedure'
People who have a physical or mental disability or care for people with disabilities	Yes - Refer to Trust's 'Equality and diversity policy and procedure'.
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Yes
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

Further appendices

The following appendices are published as related links to the main policy/procedure on the policy database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Levels of care (Critical Care Units)	RWF-OPG-PS13	This policy
5	Admission processes (Critical Care Units)	RWF-OPPM-PS14	This policy
6	Discharge process (Critical Care Units)	RWF-OPPM-PS15	This policy
7	Critical Care transfers	RWF-OPPM-PS16	This policy
8	Referral for psychology pathway (Critical Care Units)	RWF-OPPM-PS17	This policy
9	SOP for the Critical Care Outreach Service at Maidstone and Tunbridge Wells Hospitals	RWF-THT-IC-GUI-1	This policy
10	Critical Care Unit standard operating procedure for care of paediatric patients on the adult Critical Care Units	RWF-THT-IC-GUI-3	This policy
11	Critical Care Unit standard operating procedure for stabilisation and transfer of critically ill paediatric patients	RWF-THT-IC-GUI-2	This policy
12	Critical Care Unit standard operating procedure for the care of obstetric patients on the adult Critical Care Units	RWF-THT-IC-GUI-4	This policy
13	Critical Care handover framework	RWF-THT-IC-APP-1	

Admission processes (Critical Care Units)

Emergency / urgent admissions:

1. Critical Care review of a patient may be initiated by referral to the on call outreach nurse, the Anaesthetic trainees on call, the Critical Care trainee on call, or to the Critical Care Consultant. However in view of the high burden of treatment and risks associated with advanced organ support this should be done as a consultant to Consultant referral and **must** prompt a Consultant to Consultant discussion. If this is not possible this should be raised as an incident.
2. As the decision to admit rests with the Critical Care Consultant, all cases must be discussed with them.
3. All referrals should be considered on their individual merits, including weighing up of the potential risks, benefits, and the burden of treatment and long term sequelae of advanced organ support. In view of these burdens and risks admission would normally only be appropriate if there is a reversible element to the patients' clinical deterioration.
4. Every effort should be made to gain and document consent for Critical Care treatment from the patient prior to admission. If this is not possible the patient should be treated in their best interests.
5. Once a decision is made to admit a patient the time of this decision must be documented in the notes.
6. Ongoing care, resuscitation and treatment of the patient should occur in parallel with measures to organise the patients transfer to the Critical Care Unit. Depending on the patients stability this may include initiation of Critical Care treatments in their current location.
7. The Nurse in charge (NIC) of the Critical Care Unit should be contacted by the Critical Care Consultant to ensure a bed is available for the patient.
8. If no bed is immediately available the Critical Care Consultant in association with the NIC should follow the bed escalation policy to ensure a Critical Care bed is made available as rapidly as possible. The NIC should contact the site practitioner / bed manager as part of this process.
9. Delays from decision to admit to Critical Care admission of greater than four hours should be recorded as a critical incident.
10. Once the NIC has made a bed available they should contact the Critical Care practitioner looking after the patient and the nursing staff at the patient's current location to initiate their transfer.
11. The medical staff with the patient should contact the portering team if required to help facilitate the transfer.
12. Safe transfer of the patient for admission may require initiation of organ supports and enhanced monitoring if appropriate.
13. Upon arrival in the Critical Care unit any further treatments required should be initiated as soon as possible.
14. As soon as possible the admitting Critical Care physician should complete the admission paperwork with completion of a full admission clerking, writing a fresh drug chart with review of all current medication, and prescription of Critical Care IV fluids and infusions as required.
15. Once admitted the patient should be reviewed within 12 hours by a Consultant in Critical Care. The time of this review must be documented in

the medical notes. If a Critical Care Consultant review does not occur within 12 hours this should be recorded as a critical incident.

Elective admissions

1. Requests for elective admissions for post-operative care can be made on the basis of the clinical merits and risks of the individual patients. Such requests should ideally be made at least 72 hours in advance to allow for bed and staffing planning. Such patients' Critical Care requirements should then be routinely re-reviewed as their clinical course develops prior to admission.
2. The request should be submitted to the Critical Care NIC, Consultant or ward clerk by the surgical team, planned care, medical team or anaesthetist with an explanation of the predicted level of care required and the reasons why Critical Care is appropriate.
3. Any query as to the appropriateness of admission should result in a Consultant to Consultant discussion.
4. For elective admissions the availability of the Critical Care bed must be confirmed on the day to ensure an appropriate bed is available and that it has not been used for emergency patients. Occasionally admission and possibly theatre for the patient may need to be delayed while bed availability is explored.

External admissions

1. Referrals from outside the Trust should be considered on their individual merits, including weighing up of the potential risks, benefits, and the burden of treatment and long term sequelae of advanced organ support.
2. Referrals from outside the Trust need to be agreed with a parent team (i.e. a medical or surgical team) who must then provide a named Consultant for the patient. Only once a parent team has accepted the patient can a Critical Care transfer occur.
3. Repatriation of local residents from other Trusts and from abroad should be accommodated if at all possible. MTW should accept patients initially from MTW who were referred to specialist centres as soon as possible after request for repatriation.
4. Repatriations from abroad should only be accepted when a bed is available and in view of the high risks of such transfer, and the long timescales involved the bed must be occupied virtually from the point of the patient's departure until they arrive in the Trust.
5. All external transfers should be initially isolated in a single room and barrier nursed until microbiology and infection control have collated enough evidence to suggest it is safe not to do so.
6. All invasive lines in a patient received from an external organisation must be changed within 24 hours of admission.