Intensive Care Unit Admitting Procedure

1. Guiding Principles

The following document defines the role of the Bunbury Hospital Intensive Care Unit (ICU) in patient management and outlines the pathways to access the unit. The intention is to improve the interdisciplinary communications, management and care of patients requiring admission to ICU.

For the purposes of the following procedure, the term 'ICU' is defined as all beds in the unit, whether utilised for High Dependency level or Intensive Care level care under the College of Intensive Care Medicine Minimum Standard for Intensive Care Units.[1]

The ICU operates as a "closed unit", i.e. patients admitted to ICU are to be primarily under the care of the ICU Duty Consultant assisted by the ICU team. There is good evidence that closed Units are associated with better outcome and better quality of care and it is the accepted Australian standard of care.

2. Procedure

2.1 General Procedural Principles

When any patient is accepted for admission to the ICU at Bunbury Hospital by the ICU Duty Consultant or their delegate, the Duty of Care is to rest with the ICU Duty Consultants for the duration of the patient admission in ICU.

The ICU patient is to be admitted under their Home Unit (Such as Medical, Surgical, Orthopaedics, Urology, Paediatrics, Obstetrics and Gynaecology, Emergency/Toxicology).

While the primary responsibility for patients in ICU is to be with the ICU Duty Consultant, there is a clear benefit in continued input from the home unit. Given the severity of illness necessitating ICU admission input should be appropriately senior. All proposed changes in treatment must be approved by the ICU Duty Consultant.

Upon transfer from the ICU the patient returns to the care of the Home Unit, after appropriate liaison and clinical handover (unless discharged directly or when a different discharge location is more suitable). Patients who are appropriate for discharge home directly from ICU should be reviewed by the home team prior to discharge. The Home Unit team is responsible for discharge planning and follow-up.

The Home Team or Consultant component record on webPAS / Digital Medical Record (DMR) discharge summary is to reflect patient to be under the Home Team. It is important that this occurs for continuity of care in patient's management before admission to ICU and at the time of intra hospital and inter hospital transfers.

In the event that the ICU is full, referrals should still be discussed according to the policies outlined in this document, as transfer of other patients may be considered to facilitate admission to Bunbury ICU. If patients are appropriately referred but cannot be admitted due to insufficient nursing staff or bed availability, their details must be recorded in the 'Patient Refusals' folder in the ICU office.

2.2 Referrals from Emergency Department

Patients referred from Emergency Department (ED) to ICU for possible ICU admission are to be reviewed by the ICU Duty Registrar/ ICU Duty Consultant as soon as possible, and ideally within 30 minutes of referral. In the case of ICU review delay secondary to other workload the ED team is to be informed and is to be responsible for ongoing care until ICU review. The home team is identified in collaboration between ED, ICU and the specialty team at the time the patient is accepted for admission.

Patients requiring tertiary level care (including Intensive Care) are to be referred directly by the ED medical team to the most appropriate tertiary facility. If the patient requires intensive care medical input prior to transfer, ED should consult with the ICU team. In the case of significant delays to inter-hospital transport the patient can be admitted to Bunbury ICU where appropriate capacity exists. If ICU is at capacity, then ED is to refer patients to Perth directly and manage them in ED. ICU Duty Consultant/ Registrar may assist, if possible (ICU would be a full capacity in this instance) but it should primarily be ED responsibility to manage and arrange transfer as described in the Australasian College for Emergency Medicine - P18 Responsibility for Care In Emergency Departments (Section 4.5 Consultation).

If patients referred to the ICU cannot be accommodated due to capacity constraints the issue is to be escalated to the ICU Duty Consultant and ICU Shift coordinator to ensure that all local solutions for patient care have been considered. If it is decided that tertiary referral is the only solution (this is to be made by the ED medical staff) ongoing care of the patient is to then follow the principles outlined above. Patients should not be kept in ED overnight if waiting on an ICU bed but should be transferred out.

The ICU medical team are responsible for the care of patients once they have been reviewed and accepted for admission to the ICU (irrespective of their location within the hospital). If there are delays in admitting patients to the ICU the responsibility of ongoing care of the patient still rests with the ICU team. The Emergency Department team should only become involved in an emergency situation or after discussion with the ICU team. There should be clear communication between ICU and ED regarding care of patients. The ED medical staff is to assist in the care of any ICU patients in ED when the ICU workload prevents prompt attendance by the ICU Duty Registrar.

2.3 Planned ICU Admission Post Elective Surgery

The Duty Anaesthetist or Surgeon is to contact the ICU Shift Coordinator on extension 1217 and the ICU Duty Consultant at least 24 hours prior to the planned admission and provide relevant details on the ICU Elective Bed Booking Form, e.g. patient identification, clinical indications and potential length of stay

Anaesthetic and surgical team is to consider pre-operative elective booking for high risk surgical cases for ICU admission. All high-risk patients, including patients with multiple

comorbidities and having a complex procedure are to be considered and discussed with ICU team for elective ICU admission. A Request for ICU Elective Bed Booking Form is to be completed and sent to ICU. The form is available on WACHS SW Forms Guide. Any potential ICU admission post elective surgery should be discussed with Patient and family at the pre-anaesthetic appointment.

On the day of the planned admission to ICU the Anaesthetist is to contact the ICU Shift Co-ordinator on extension 1217 to confirm bed availability prior to the commencement of the anaesthetic.

If admission to ICU is not possible due to occupancy/ acuity the procedure may need to be postponed.

ICU elective bookings are recorded on the Enterprise Bed Management system (EBM).

2.4 Unplanned/Emergency Admissions Post Elective Surgery/ Emergency Surgery

The ICU Duty Consultant/ICU Duty Registrar and the ICU Shift Co-ordinator are to be contacted in the first instance to confirm bed availability and appropriate clinical resource. The timing of the transfer from recovery is to be in full consultation with the ICU Shift Coordinator (contactable on extension 1217) to ensure a smooth transfer of care while maintaining comprehensive monitoring and interventions as clinically appropriate.

A comprehensive handover is to be provided by the patient's Home Unit Registrar to the ICU team and documented in the medical record as per the WACHS Policy on Medical handover.

The Anaesthetist/ Surgical Team is to contact the ICU registrar (contactable on extension 2217) and inform about the possible ICU admission. If the request is for high dependency level care, the ICU Duty Consultant reserves the option for patient to be reviewed in recovery for possible ICU admission, for reasons of appropriate critical care resource allocation. In this instance the case is to be reviewed by the ICU Duty Registrar who is to discuss with the ICU Duty Consultant who is to make a decision regarding ICU admission. This decision is to be documented and communicated to the Anaesthetist and Home Team. If the ICU Duty Consultant does not agree with need for admission to ICU, Anaesthetic Consultant and ICU Consultant must make direct contact and discuss the case and come to a clinical agreement

In cases, where patient needs emergency unplanned admission to ICU, it is expected that Anaesthetist looking after the patient is to liaise with the ICU Duty registrar and request an ICU bed. ICU Duty registrar is to discuss with ICU Duty consultant and ICU Nurse Coordinator and accepts the ICU admission. If the bed is available, patient to be transferred to ICU in a timely fashion with minimal possible delay. If a bed is not available in ICU, then, the patient to be managed in recovery by the anaesthetist looking after the patient and the recovery nurses till the bed is available in ICU. All efforts are to be made to expedite the process of acceptance of the patient in ICU.

2.5 Emergency Transfers (including post Medical Emergency Response [MER/MET] events)

Unplanned admissions/transfers from other clinical areas across the South West Health Campus to ICU must be referred to ICU Duty Consultant/ICU Duty Registrar in the first instance by the Home Unit.

The ICU Duty Registrar/MER Nurse are to advise the ICU Shift Coordinator (contactable on extension 1217) of a pending admission /transfer and to confirm availability of a bed.

Resuscitation or admission to the Unit must not be delayed in imminently life-threatening cases, unless specific advanced directives exist and are clearly documented.

Management of patients post MER events needing ICU care is the responsibility of ICU team. A patient should be transferred to ICU as soon as feasible. However, if ICU does not have the capacity to accept the patient, it is the responsibility of ICU Duty Consultant to decide about disposition. If there is a delay in transfer and there is a need for resuscitation or close monitoring, the patient is to be transferred to Emergency Department for further care. Ongoing care of the patient in ED is to follow as mentioned in Section 2.

In rare situations, where both ICU and ED do not have the capacity to accept patients care, the next appropriate place where patient could be safely managed/monitored should be considered after discussions with the respective ward coordinators e.g., recovery and the Coronary Care Unit (CCU).

2.6 Paediatric Admissions

The Bunbury Intensive Care Unit is an adult ICU and does not routinely admit Paediatric patients. All requests for admission to ICU are to be managed on a case by case basis and require review by the Head of ICU (or delegate), sufficient capacity of the ICU staff to safely manage the clinical and other needs of the patient and an agreed management plan with the paediatric consultant.

In general, requests to admit younger (e.g. less than 14yrs) and smaller (e.g. less than 40kg) children are not routinely supported except in emergency situations, and patients must be transferred to a Paediatric ICU as soon as safely possible.

Whenever a child is admitted to ICU every effort must be undertaken to provide a clinically safe environment that complies with relevant regulations and current guidelines, along with support from specialist teams involved in the patients care.

2.7 Direct Admissions

Patients requiring ICU level care from outside Bunbury hospital must be referred to the ICU duty consultant/ICU Duty registrar in the first instance by the current hospital to determine suitability for admission. ICU registrar to confirm suitable for admission and discuss bed capacity with ICU Shift Co-ordinator. Patient is only to be accepted once discussed with ICU shift co-ordinator to ensure resources available to accept

admission. Once the admission is confirmed then the sending hospital is to make transport arrangements and enter request onto the EBM (refer to Appendix 1: Bunbury Hospital Direct ICU Admission Pathway).

Direct admissions must have a nurse and/or Doctor escort. Transferred patients enter through Ambulance entry in the ED but do not require Triage unless urgent medical treatment is required. ICU registrar to be present on patient arrival to ICU to receive clinician to clinician handover.

3. Definitions

HDU	High Dependency Unit level of care within the Intensive Care Unit
EBM	Enterprise Bed Management is an application to streamline and standardise bed allocation and the management of patient transfers across the state
ICU Team	Comprises ICU Duty Consultant, ICU Duty Registrar, ICU Duty RMO and ICU Duty Nursing staff
Home Team	Provide specialist advice and ultimately receive care of the patient upon discharge from ICU. Allocated at admission.

4. Roles and Responsibilities

The Home Unit Consultant (or acting on their behalf, the home unit Duty Registrar) responsible for the patient requiring admission to ICU is to contact the ICU Duty Consultant or the ICU Duty Registrar, via Bunbury Hospital switchboard, to discuss the patient's requirement for ICU care. If the referral is made to the duty ICU registrar, they must then refer the request for admission to ICU (including the HDU beds) with the Duty Intensivist. **Only patients who have been accepted by the Duty Intensivist for intensive care management may be admitted to ICU.**

However, in the occasional instance that the ICU negative pressure room (Room 1) is required by the general medical team and the patient does not require intensive care management then this is the only circumstance for which there is a general medical outlier in ICU. The primary responsibility for the care of this patient rests with the general medical team.

This procedure applies to all sources of referral, whether they are from the Emergency Department, an inpatient ward, the operating theatres or St John of God Hospital Bunbury.

The ICU Duty Consultant or ICU Duty Registrar is to liaise with the ICU Shift Co-ordinator on 1217 regarding unit capacity and bed availability prior to finalising acceptance of the patient and prior to the transfer of the patient to ICU.

The Home Unit Registrar for the patient is to liaise with the ICU Duty Registrar and provide a comprehensive handover including written documentation of continuing care requirements as per the WACHS Inter-hospital Clinical Handover Form Procedure.

The Ward/ ED Shift Co-ordinator is to liaise with the ICU Shift Co-ordinator (1217) prior to initiation of patient transfer for patient accepted by the ICU medical team, including written documentation of continuing care requirements as per the WACHS Inter-hospital Clinical Handover Form Procedure.

Any perceived issues around access are to be discussed between the ICU NUM, ICU, CNS, the Home Unit Consultant and the ICU Duty Consultant if required.

While the primary responsibility for patients in ICU is to be with the ICU Duty Consultant, members of the Home Unit may provide consultation, however all changes in treatment must be approved by the ICU Duty Consultant.

The ICU Duty Consultant is responsible for the decision making for the Admission/Transfer process of all the patients admitted and transferred to the ward from ICU. The ICU Team is to provide outreach support (if required) for patient care after transfer to the wards from ICU. If there are any concerns regarding the patient's condition or care after ICU transfer, it is expected that the Home Team Registrar/Consultant is to directly discuss with ICU Duty Consultant or ICU Duty Registrar.

When a patient is ready to be transferred from ICU, the ICU Duty Registrar is to inform the Home Team Registrar about the transfer. ICU Duty Registrar is expected to give a detailed hand over along with the Progress Summary in the patients file.

When there is access block for ICU transfers to the ward, the Home Team should review the patient daily, and assist with ongoing care and discharge planning.

Patients referred to ICU for possible ICU admission from ED and other wards are to be reviewed by ICU Team in a timely fashion. The decision to admit or refuse admission to ICU is entirely with ICU team (ICU Consultant on Call) the decision to be documented and communicated to the primary team. The ICU Duty Consultant is to make the decision for admission/transfer of patients to and from ICU. In case of disagreement, it is expected that a Consultant to Consultant discussion occurs in the best interests of the patient.

The decision to affect an unanticipated, out of hours transfer of a patient from the ICU to a general ward is to be made by the ICU Duty Consultant in conjunction with the Home Unit Consultant managing that patient (or their registrar acting on their behalf where they may delegate this function). An appropriate level of care must be maintained.

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors

for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy

7. Evaluation

Evaluation, audit and feedback processes are to be in place to monitor compliance. This is the responsibility of the Bunbury ICU Head of Department, every five years using the following means or tools:

- Review with key stakeholders
- Local audits of compliance with this policy

8. Standards

National Safety and Quality Health Service Standards – 1.5,1.6, 2.6, 5.7. 5.13, 8.1, 8.4, 8.5, 8.8, 8.9, 8.10, 8.11, 8.13

National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration

9. Legislation

Health Services Act 2016 (WA)
Carers Recognition Act 2004 (WA)
Disability Services Act 1993 (WA)
Guardianship and Administration Act 1990 (WA)
Health Practitioner Regulation National Law (WA) Act 2010
Mental Health Act 2014 (WA)
Medicines and Poisons Act 2014 (WA)
Medicines and Poisons Regulations 2016 (WA)
State Records Act 2000 (WA)

10. References

1. IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf
2. Evidence supports the superiority of closed ICUs for patients and families: Yes
3. Australasian College for Emergency Medicine - P18 Responsibility for Care In Emergency Departments
4. Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for recognising and responding to acute physiological deterioration (second edition) Canberra Australia. January 2017

11. Related Forms

MR 184 WACHS Inter-hospital Clinical Handover

12. Related Policy Documents

WACHS Inter-hospital Clinical Handover Form Procedure
WACHS Recognising and Responding to Acute Deterioration (RRAD) Policy
WACHS Recognising and Responding to Acute Deterioration (RRAD) Procedure

13. Related WA Health System Policies

WA Health Consent to Treatment Policy
MP0095 Clinical Handover Policy
MP0122/19 Clinical Incident Management Policy 2019
MP0067/17 Information Security Policy
MP0171/22 Recognising and Responding to Acute Deterioration Policy

14. Policy Framework

Clinical Governance, Safety and Quality Policy Framework

15. Appendix

Appendix 1: Bunbury Hospital Direct ICU Admission Pathway

This document can be made available in alternative formats on request for a person with a disability

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Appendix 1: Bunbury Hospital Direct ICU Admission Pathway