Worcestershire Acute Hospitals NHS Trust

Critical Care Unit Discharge Policy
Worcestershire Acute Hospitals NHS Trust

Policy for the discharge of patients from the critical care units to the ward

Key Document code:	WAHT-KD-022
Key Document Owner:	Dr Ed Mitchell
Approved by:	*Intensive Care Forum*
Date of Approval:	*21ST February 2018*
Date of review:	*20th September 2020*

Key Amendments

Date	Amendment	Approved by
20th March 2020	Document extended for 6 months during current COVID-19 pandemic	Dr Burtenshaw

INTRODUCTION

Discharging patients from the critical care area to the general ward involves the handover of an often complex episode of care. This is often a time of uncertainty and anxiety for patients who have survived a serious illness, but who do not yet feel fully recovered. There have often been many changes to the patient's chronic medication, and other care processes, such as rehabilitation, physiotherapy and psychological support need to continue in a seamless manner.

The patient remains at the centre of care, and discharge processes should cause the minimum of disruption to on-going medical care (both acute and chronically). The patient should also feel supported and reassured throughout.

Structured, formalised, handover remains the gold standard (NICE, Royal College of Physicians, Faculty of Intensive Care Medicine), and it is the responsibility of both the discharging team and the receiving team that this handover occurs (NICE CG50). Handover and discharge processes have been identified as an area where patients may come to harm if effective transfer of care does not occur, and is being monitored nationally as a quality standard.

DETAILS OF GUIDELINE

Scope of the policy

This policy covers all critically ill inpatients on critical care units throughout the Worcestershire Acute Hospitals NHS Trust.

Definitions

Duties and Responsibilities

Board of Directors
Be aware of the policy as it feeds into the Trust Quality Assurance Procedures.

Medical Director
Be aware of the policy.

Divisional Director
Be aware of the policy
Support the implementation of the policy by helping co-ordinate inter-divisional processes.

Lead Clinician
Be aware of the policy.
Support the implementation of effective processes to facilitate the policy e.g. improved paperwork.

Consultant on duty covering the intensive care unit
Be aware of the policy.
Ensure timely decisions are made regarding discharge.
Communicate decision to discharge to the patient and/or family.
Ensure discharge paperwork completed to satisfactory standard.
Liaise with senior critical care nursing staff to make sure it is clear what patient's ongoing medical needs are.
Liaise with receiving team consultant/nursing staff where appropriate.
Complete incident reports where discharge processes do not run smoothly.

Junior Medical staff
Be aware of policy.
Complete discharge paperwork 'SBAR form' before patient leaves unit
Ensure contact is made with receiving medical team.

Senior nursing staff on the intensive care unit
Be aware of policy.
Liaise with bed management team to find appropriate bed to meet patient's needs.
Ensure discharge paperwork is satisfactory and patient does not leave unit until process is complete.

Nursing staff on the intensive care unit
Complete 'SBAR form' paperwork in timely fashion before patient leaves unit.

Dieticians
Ensure forward plan for nutrition documented in clinical notes.

Pharmacists
Ensure changes to chronic medication are documented on drug chart.

Physiotherapists
Ensure documented Physiotherapy goals and plans are up to date on discharge
Ensure any issues around suitability of discharge destination from a Physiotherapy/ Rehabilitation perspective are raised in a timely manner.
Give verbal handover to physiotherapist on receiving ward.

Equality statement
Worcestershire Acute Hospitals NHS Trust is committed to maintaining equality & diversity for the benefit of all users and patients as well as the whole organisation.

Policy detail
Discharge decisions
Decisions should be made as early as possible to facilitate safe transfer of the patient within normal working hours (NICE 50).
The consultant on duty for the intensive care unit should identify any patient needs that affect the type of bed, or the destination to which the patient might most safely be discharged to e.g. coronary care unit, surgical high dependency unit.
Identifying the correct bed and level, provision and location of care often requires the input of the parent medical/surgical team, and these teams should be involved in the discharge decision and planning process

It is recognised that preparing patients for discharge is a process that may occur over days and weeks before the actual decision to discharge is made. Parent medical and surgical teams MUST be part of this process (NICE CG50), and ideally this should happen at consultant level (GPICS)
The patient should be discharged to the ward within 4 hours of the decision to discharge from the critical care area (GPICS).
The decision to discharge the patient should be communicated to the patient and/or their relatives when it is made, and their views sought. If the patient has any concerns these should be sensitively addressed.
Patients should no longer be requiring level 3 critical care input at the point of decision to discharge. If the patient still requires level 1 or 2 input e.g. NIV, cardiac rhythm monitoring, this should be clearly documented.
If there are any concerns about whether or not a patient's care needs may be met on a particular ward, the ward staff and/or medical team should be invited to review the patient on the critical care unit and help plan care. (NICE 50)
If the patient is being discharged to facilitate end of life care, this should also be clearly documented, and the relevant care pathways completed.

Discharge process
Once the decision to discharge has been made, a bed should be identified by senior nurses liaising with the bed manager.
In normal working hours admitting medical team should be informed of the decision to discharge the patient from the intensive care unit. This should ordinarily be to the registrar or consultant of the admitting team. They should be given the opportunity to review the patient on the intensive care unit.
For discharges occurring out of normal working hours, the duty medical or surgical registrar should be informed.
Discharges between 2200h and 0700h should be avoided as this group of patients suffer an increased rate of adverse events and mortality. Any patient discharged from the critical care areas in this time frame should have this event recorded as a serious adverse incident. (NICE 50, GPICS)

Recording discharge processes
Patients should receive a standardised handover process to minimise variation and error
Patients should have at least two pieces of discharge specific paperwork

The 'SBAR' form (Appendix 1)
This tool is completed by the ITU nursing and medical staff and is a real-time tool to ensure a comprehensive discharge plan is made and communicated.
It includes:
A summary of critical care stay, including diagnosis, treatments and changes to chronic treatment
A monitoring and investigation plan
A plan for ongoing treatment, nutrition and infection status
A PARS score, which is clearly communicated to the receiving team
This form **MUST** be completed prior to discharge from the critical care area as it provides evidence of the handover process occurring.

The Bluespier discharge document
The Bluespier ITU discharge document provides a means of communicating with the patient's GP and ensuring that the critical care consultant has had an opportunity to review the patient's case at the point of discharge. It provides a clear overview of the patient's journey, and is invaluable in helping decision making in the future for particular patients.
This document should be completed within 24 hours of the patient's discharge from the critical care unit.

Follow up of discharged patients
All patients discharged by the critical care units will be followed up by the critical care outreach service within 24 hours of discharge.

Critical care outreach will continue to support patients and ward staff if there are any continuing issues related to the critical care stay (e.g. management of tracheostomies, central venous catheters) in accordance with trust policy.
Unexpected deterioration of patients who have been discharged from the critical care unit should prompt re-referral to the critical care medical team.
Patients who are discharged to either the surgical or vascular high dependency area will routinely be reviewed by the ITU second on call consultant the following day

Appendix 1:
Discharge tool 'SBAR' document

Affix Patient Label here or record
NAME:
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

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CRITICAL CARE DISCHARGE PLAN & TRANSFER DOCUMENTATION

Date of unit admission: _____ Date and time of Transfer: _____
Consultant: _____ Transferred to: _____
Informed of discharge: _____ DNACPR Status: _____

Situation Reason for admission. Current concerns	
Background PMH Operation/Procedure Investigations History of ITU stay	Changes to chronic therapy:

Assessment				
AIRWAY				
Tracheostomy:	YES	NO	Date of Insertion:	Shiley / Portex Size:
Ventilated:	YES	NO	Date of Extubation:	Tracheostomy boxes:
BREATHING				
Oxygen % via:			Resp rate: Record resps..... hourly	Aim pO_2: Aim Sats: .....%
CIRCULATION				
Arterial line:	YES	NO	Date of insertion:	Site:
CVC Line:	YES	NO	Date of insertion:	Site:
No of PVD'S: ..... Form completed:	YES	NO	Heart Rate: BP:	CVP: Temp:
Infusion type			**Rate**	**Prescribed:**
1. _____				
2. _____				
Urine output> 1/2 ml/kg/hr ☐			Measure: .....hrly	Catheter: Yes ☐ No ☐ Date of insertion: ...../...../.....
DISABILITY				
Neuro Status			GCS: A V P U	**Epidural:** Motor Block
Sedation Score: Pain Score:				Rate: .....mls/hr
Nausea Score:				Sensory Block: Left ☐ Right ☐

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REFERENCES

Guidelines for Provision of Intensive Care Services (GPICS). Faculty of Intensive Care Medicine and Intensive Care Society. 2015

Clinical Guideline 50. Acutely ill patients in hospital. National Institute for Health and Care Excellence (NICE). 2007

Clinical Guideline 83. Rehabilitation after critical care. National Institute for Health and Care Excellence (NICE). 2010