

GUIDELINES FOR STEP-DOWN TRANSFER OF PATIENTS FROM THE INTENSIVE CARE UNIT (ICU)

Key Document code:	WAHT-KD-022
Approved by:	<i>Intensive Care Forum</i>
Date of Approval:	14 th October 2019
Date of review:	14 th October 2021

Key Amendments

Date	Amendment	Approved by
5 th June 2018	NEWS2 chart included	ICM Forum
9 th January 2019	Updated SBAR form	ICM Forum
14 th October 2019	No amendments made	ICM Forum

INTRODUCTION

Most patients who require critical care do so either because they require monitoring post major surgery, or because they have been critically ill, requiring support for one or more system failure, e.g. acute respiratory failure. When the patient is deemed fit enough to be transferred out of the Intensive Care Unit, by their very nature they will remain vulnerable and require careful monitoring in the new area.

The step-down transfer of patients out of the Intensive Care Unit is a process that has been associated with some of the following;

- Miscommunication
- Relocation anxiety for patients and their relatives
- Stress for ward staff
- Readmission to critical care (9-16% of discharges will require readmission to Intensive Care) [Goldhill and Sumner 1998]
- Lack of information / planning
- Pain control issues
- Resource / equipment problems

This guideline has been developed to assist in providing a consistent and standardised critical care transfer process, in-order to reduce the incidence of the above.

GUIDELINE

There are four identified stages to the transfer process;

1. Pre-admission (Elective)
2. Transfer planning in Intensive care
3. Step-down Transfer
4. Care in the receiving area

1. Pre-admission (Elective)

Many patients who require elective major surgery are identified pre-operatively as requiring an Intensive Care bed post-operatively. Fear and anxiety about the critical care phase of their stay, may be reduced in some patients and their relatives if they are provided with information.

- A patient information leaflet explaining about being nursed in an Intensive Care area is to be designed to be provided, at pre-operative assessment clinic if possible, or on admission to the ward area. The leaflet outlines that critical care is only a part of their journey and outlines the 'positive step' of transfer back to the ward afterwards.
- Where possible patients should be offered the opportunity to be shown the relevant Intensive care unit during the day of their admission to the ward.

2. Transfer planning in Intensive care

Transfer planning has been shown to be an essential element in reducing the effect of psychological stress for the patient and their family on discharge from ICU [Whittaker and Ball 2000]. Where possible, the preparation of both patient and documentation should begin 2-4 days prior to discharge [Choate and Stewart 2002]. This is particularly important if the patient has an altered airway.

When the patient is nearing transfer, discuss this with the patients Parent Team &/ or Anaesthetist and the Nurse in charge and consider the following;

- Always inform the patient in advance of transfer.
- Discontinuation of non-essential monitoring e.g. Cardiac monitoring; and reduce the frequency of observations where possible [Cutler and Garner 1995].
- If patient is to be transferred to a ward area continue on ICU chart but record NEWS. Commence a ward NEWS 2 chart immediately prior to the transfer with an exit NEWS recorded.
- Reduce the nurse presence around the patient's bed space [Jenkins and Rogers 1995]. Preparation for the change of nurse to patient ratio on step-down area/ ward.
- Give the patient the 'Moving on' leaflet. Ensure that they can understand/ read it and discuss if necessary.
- Before transfer commence 'in reach' process by introducing the patient to the Critical Care Outreach Nurse on duty. Critical Care Outreach provides a follow up visit/s to all patients who have recently stepped-down from the Intensive Care Unit within the Trust.
- If the patient has an altered airway ensure that Outreach is available to support ward staff and that the patient is transferred with bed head sign, care pathway and tracheostomy/laryngectomy box. Ensure patient is transferred between 8am-5pm to designated wards only – Head and Neck, Laurel 2 or MHC. If the patient is transferred after 5pm this should be identified as an adverse event and a DATIX should be completed.
- If applicable/ possible, introduce a ward nurse to patient.
- Commence Intensive Care Transfer/SBAR Form
- Rehabilitation needs: make any necessary referrals e.g. Occupational Therapy. Document on SBAR form prior to transfer.
- Consider nutritional needs: the patient may require prescription from the dietician for naso-gastric (NG) feeding on ward charts. Parenteral nutrition (TPN) prescriptions that have already been initiated should be transferred with the patient. Contact the Intensive Care Pharmacist between 8am-4pm to inform them of the transfer. AH Pharmacist bleep 0303. WRH Pharmacist bleep 463.

- Ensure as far as possible that any patient anxieties (particularly regarding the transfer) have been addressed.

3. Step-down Transfer

To reduce the likelihood of transfer problems ensure the following

Documentation

- If the receiving area is a ward ensure that the notes are filed prior to transfer. Every participant in Whittaker & Balls study in 2000 mentioned problems with the notes, e.g. 'there are pieces of paper everywhere and things go missing'. Un-filed notes could lead to the patient not getting the care or treatment they require.
- Complete Intensive Care Transfer/SBAR Form. Documentation should include a summary of the patients critical care stay including diagnosis and treatment, infection status and any agreed limitations of treatment [NICE 2007].
- Changes to oral medication should be noted and a plan for rehabilitation documented.
- Include an assessment of the patient's physical abilities in the transfer documentation. Muscle weakness is a common debilitating feature of recovery from critical illness [Griffiths and Jones 2002].
- Ensure prescriptions are complete for fluids, drug infusions, etc.
- The form should be checked and signed by the Critical Care Outreach Nurse on duty to facilitate communication between the teams and provide continuity of care for the patient. If Outreach are not available then the Nurse in Charge on ICU should check and sign the form.

Pain control

- Assess and document the patient's pain score prior to transfer. Transferring patients should be scoring 1 or less.
- If an epidural is in progress perform a block check and document. Continue the epidural for the duration of the transfer.
- Patient Controlled Analgesia (PCA) may need to be organised, as continuous morphine infusions are not recommended in ward areas.
- Whenever possible arrange for the bed to come from the receiving area in advance. Transfer the patient onto this bed at the earliest opportunity and allow the patient to recover, ideally for at least 30 minutes before setting off.

Medications (Pharmacy related issues).

- Intensive Care team and Pharmacist to review medications on ward round when patient is ready for transfer to ensure Intensive Care specific medications are discontinued or weaned on leaving Intensive Care e.g. melatonin, medication for delirium.
- Nursing staff to transfer non-stock medications (except ward controlled drugs) and patient's own medications with the patient.
- This may also include transferring Parenteral Nutrition (TPN) supplies if the patient is transferred outside of the hours of Monday to Friday 8am – 4pm.
- This may include transferring patient's own controlled drugs by two nurses signing them out of the CD register stating which ward the patient is being transferred to. The receiving ward nurse must take possession of these CD's so that they can sign them into the new ward's CD register.

- During handover go through the Prescription chart with the receiving nurse. This will reduce patients missing drugs that were due around the time of the transfer.
- Any queries should be directed to the Intensive Care Pharmacist. AH bleep 0303, WRH bleep 463.

General

- National Early Warning Score - NEWS should be recorded on the Intensive care transfer form. If the score is 5 or more the patient may not be suitable for transfer. Inform the patients Parent Team/ Intensive Care Medical Team and document any decision.
- Ensure that the receiving area is made aware of any equipment that will be required by the patient e.g. NG feed pump, so arrangements can be made.
- Avoid step down transfer overnight (between 19.30hrs and 07.30hrs). Patients that have been transferred out of Intensive Care Units at night have been found to fare significantly worse than those transferred during the day [Goldfrad and Rowan 2000 ,NICE 2007] If the transfer does occur overnight this should be documented as an adverse incident. A referral should be made to the OOHNP (Out of Hours Nurse Practitioner) when patients are discharged after 19.30hrs and a DATIX must be completed.
- It is important that the Parent Team and patients relatives are informed of the transfer as both transfer team and receiving ward team should take shared responsibility for the care of the patient being transferred [NICE 2007].
- To ensure the safety of level 2 patients during transfer, they should be attached to monitoring when being stepped-down from ICU to a High Care area bed. (See appendix for 1 levels of care information).

4. Care in the Receiving area

General

- Receiving nurse to sign the Intensive Care Transfer Form.
- Transferring nurse ensures that they assist with setting up of infusions/monitoring (if applicable), and that patient left safely in receiving area.

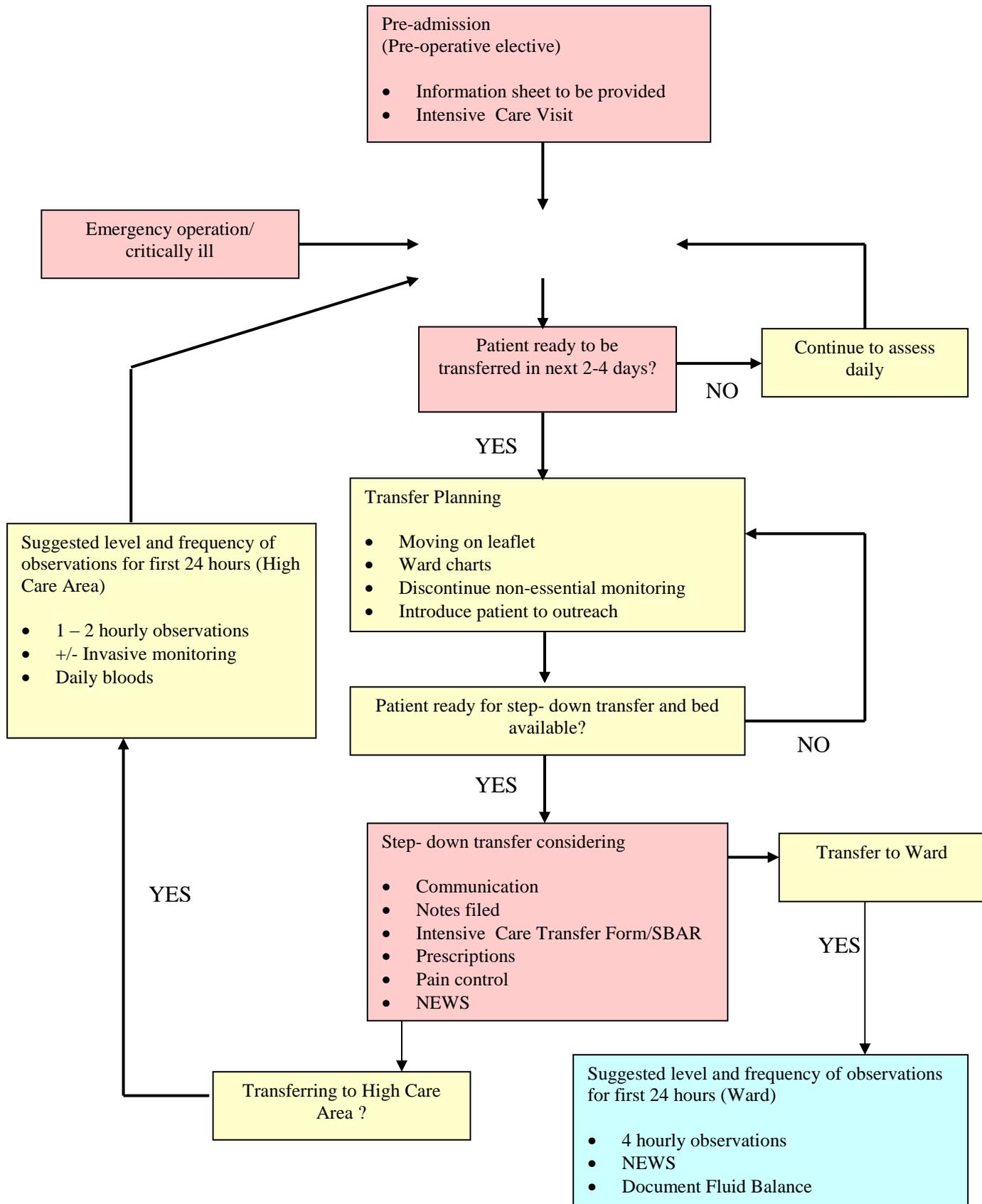
Handover

- Use the Intensive Care Transfer Form to structure handover. This will ensure all-important areas are discussed.
- Give advice on the level of observation required for the first 24 hours post transfer. Patients are at risk of deteriorating post transfer.
- Caution required regarding choice of terminology/ phrases used by Intensive Care staff during handover as this may be open to misinterpretation e.g. this patient has done really well, may indicate that the patient may no longer require close observation (Hall Smith et al 1997).

Suggested level and frequency of observations for first 24 hours

- High Care Area; 1-2 hourly observations, with or without invasive monitoring, daily bloods etc.
- Ward: 4 hourly observations, including NEWS and strict fluid balance

APPENDIX 1: STEP- DOWN TRANSFER FLOWCHART



APPENDIX 2: LEVELS OF DEPENDENCY

- LEVEL 0 Patients whose needs can be met through normal ward care in an acute hospital

- LEVEL 1 Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with added advice and support from Intensive Care Team.

- LEVEL 2 Patients requiring more detailed observations including support for a single failing organ system or post-operative care, and those stepping down from higher levels of care.

- LEVEL 3 Patients requiring advanced respiratory support alone or basic respiratory support together with support for at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

Appendix 4: NATIONAL EARLY WARNING SCORE CHART

Attach Patient Label here or record

NAME: _____

NHS NO:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

HOSP NO:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

D.O.B:

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 MALE FEMALE

NEWS 2
National Early Warning Score



	DATE	TIME																					
A+B Respirations Breaths/min	≥25																			3			
	21-24																				2		
	18-20																						
	15-17																						
	12-14																						
	9-11																					1	
≤8																					3		
A+B SpO ₂ Scale 1 Oxygen saturation (%)	≥96																					1	
	94-95																					2	
	92-93																					3	
	≤91																					3	
SpO₂ Scale 2¹ Oxygen saturation (%) Use Scale 2 if target range is 93-95% in hypercapnic respiratory failure ¹ ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O ₂																					3	
	95-96 on O ₂																					2	
	93-94 on O ₂																					1	
	≥93 on air																						
	88-92																						
	86-87																					1	
	84-85																					2	
≤83%																					3		
Air or oxygen?	A=Air																					2	
	O ₂ L/Min																						
	Device																						
C Blood Pressure mmHg Score uses systolic BP only	≥220																						3
	201-219																						
	181-200																						
	161-180																						
	141-160																						
	121-140																						
	111-120																						
	101-110																						1
	91-100																						2
	81-90																						
	71-80																						
	61-70																						3
	51-60																						
≤50																						3	
C Pulse Beats/min	≥131																						3
	121-130																						
	111-120																						
	101-110																						
	91-100																						1
	81-90																						
	71-80																						
	61-70																						
51-60																							
41-50																							
31-40																							
≤30																						3	
D Consciousness Score for NEWS omit if confusion (no score if chemix)	Alert																						
	Confusion																						
	V																						3
	P																						
E Temperature °C	≥39.1 ¹																						2
	38.1-39.0 ²																						1
	37.1-38.0 ²																						
	36.1-37.0 ²																						
	35.1-36.0 ²																						1
≤35.0 ²																							3
NEWS TOTAL																							
Urine output >/<																							
Monitoring frequency																							
Escalation of care Y/N																							
Initials																							



Situation Background Assessment Recommendation

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Please note that the key documents are not designed to be printed, but to be used on-line. This is to ensure that the correct and most up-to-date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours and should be read in conjunction with the key document supporting information and/or Key Document intranet page, which will provide approval and review information.

Affix Patient Label here or record

NAME:

NHS NO:

HOSP NO:

D.O.B: / / MALE FEMALE

WARD:.....CONS:.....

NEW Score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	<ul style="list-style-type: none"> Continue routine NEWS monitoring
Total 1-4	Minimum 4-6 hourly	<ul style="list-style-type: none"> Inform registered nurse, who must assess patient Registered nurse decides whether increase frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	<ul style="list-style-type: none"> Registered nurse to inform medical team for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	<ul style="list-style-type: none"> Registered nurse to immediately inform medical team caring for the patient Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients Provide clinical care in an environment with monitoring facilities

If NEWS is 5 or more use Sepsis Screening Tool. Rescreen in 24hours if no improvement or condition worsens

Date screened: _____ Date screened: _____ Date screened: _____

Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	<ul style="list-style-type: none"> Registered nurse to immediately inform medical team caring for the patient - this should be at least at specialist registrar level Emergency assessment by a team with core care competencies, including practitioners with advanced airway management skills Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency ward or ICU Clinical care in an environment with monitoring facilities
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Codes for recording oxygen delivery on the NEWS2 observations chart

A (Breathing air)	NRB (Non Re-Breath Mask)
N (Nasal cannula)	TM (Tracheostomy mask) eg. TM28
SM (Simple mask)	CP (CPAP mask) eg. CP35
V (Venturi mask and percentage) eg. V24, V28, V35, V40, V80	H (Humidified oxygen and percentage) eg. H28, H35, H40, H60
NIV (Patient on NIV system)	OTH (Other, specify _____)



Situation Background Assessment Recommendation

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