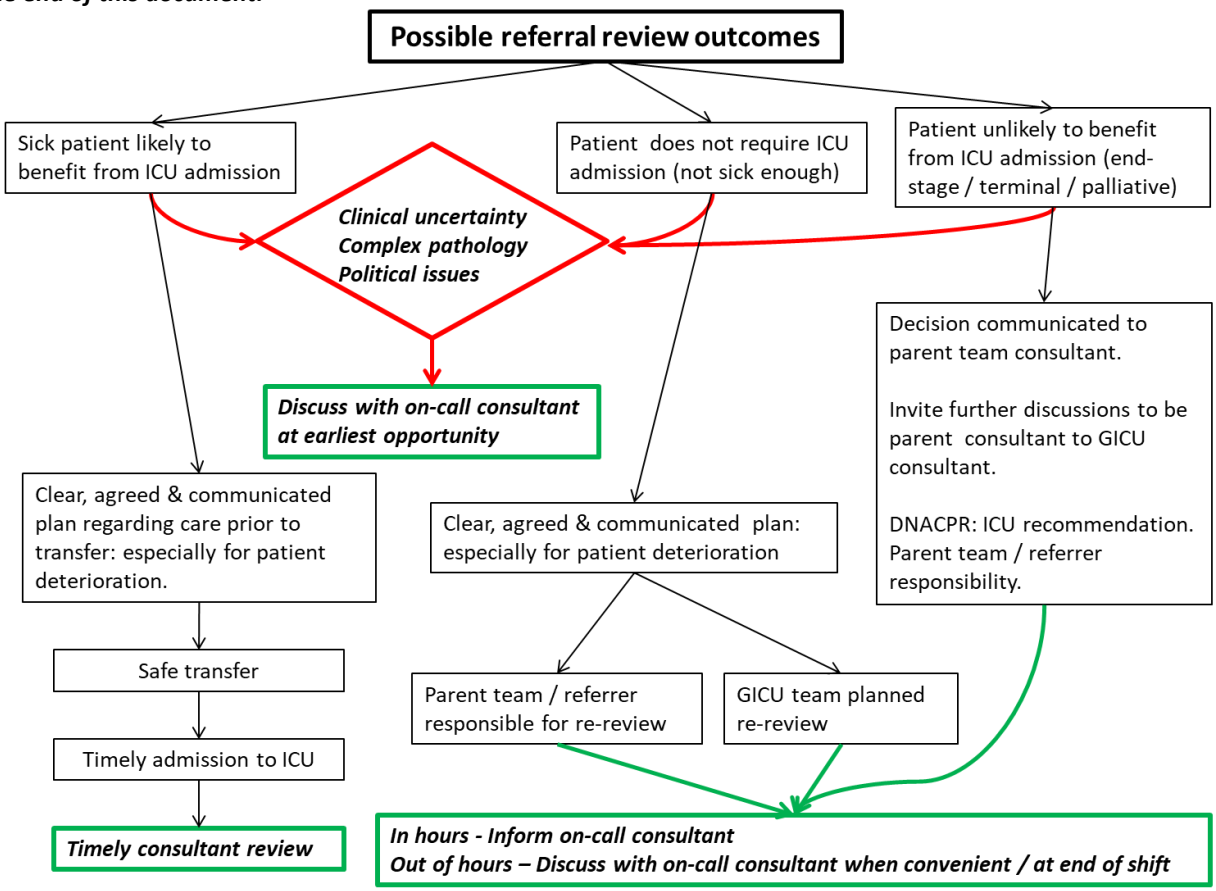
Admission of Emergency Patients Referred to GICU

On receiving a referral that might require admission, the GICU SpR should:

- Enter patient's initials and medical record number (MRN) onto a new message in the "GICU today" WhatsApp group. This informs all the senior decision makers of the possibility of an admission and acts as a time stamp for the referral for audit purposes. In addition, at the earliest opportunity, the SpR should add the patient to the "GICU referrals" patient list in Cerner.
- The Nurse in Charge (NiC) should identify a potential bed space to admit the patient to. If GICU is full, is there a bed on CTICU or Neuro that could be used? The NiC should ensure that the identified space is prepared to take a patient (even if a nurse is not immediately available).
- If equipment is likely to be needed to stabilise and transfer the patient, ***consider*** taking it with you (***but*** travel light, scoop & run rather than take ICU with you and stay & play).
- Review the patient within our agreed auditable standards
    - between 8am-6pm Monday to Friday - 90% seen within 15 minutes;
    - out of hours - 90% seen within 30 minutes
    - if the patient sounds as if they need immediate attention ask the caller to put out an arrest call via switchboard by dialling 2222. Follow this up either by phone or in person as soon as practical
- The primary purpose of the review should be to decide if the patient will benefit from transfer to ICU. Ideally, this should take less than 20 minutes. If you cannot make a decision in this timeframe please discuss the case with the on-call consultant. [***Especially at night, the SpR should minimise their time off the unit. Better to admit a patient who doesn't benefit from the transfer than fail to transfer one who will***.]
- When reviewing the patient, use the following decision tree (available on the referral record and audit form template in Cerner Documents) - ***for intubated patients in the emergency Department see the specific policy at the end of this document.***



- As soon as possible send a message to the "GICU today" WhatsApp group confirming the decision. If the patient requires transfer to ICU include the urgency as either:
    - **Immediate** - the patient ***CANNOT*** be safely managed in their current environment ***OR*** is at significant risk of physiological deterioration / decompensation in the next 30-60 minutes
    - **Urgent** - the patient ***CAN*** be safely managed in their current environment ***AND*** is at low risk of physiological deterioration / decompensation in the next 30-60 minutes

- Auditable standards for the time taken from the decision to transfer to ICU to the patient's arrival on ICU
  - Patients classified as requiring **Immediate** transfer in less than **30 minutes**
  - Patients classified as requiring **Urgent** transfer in less than **60 minutes**

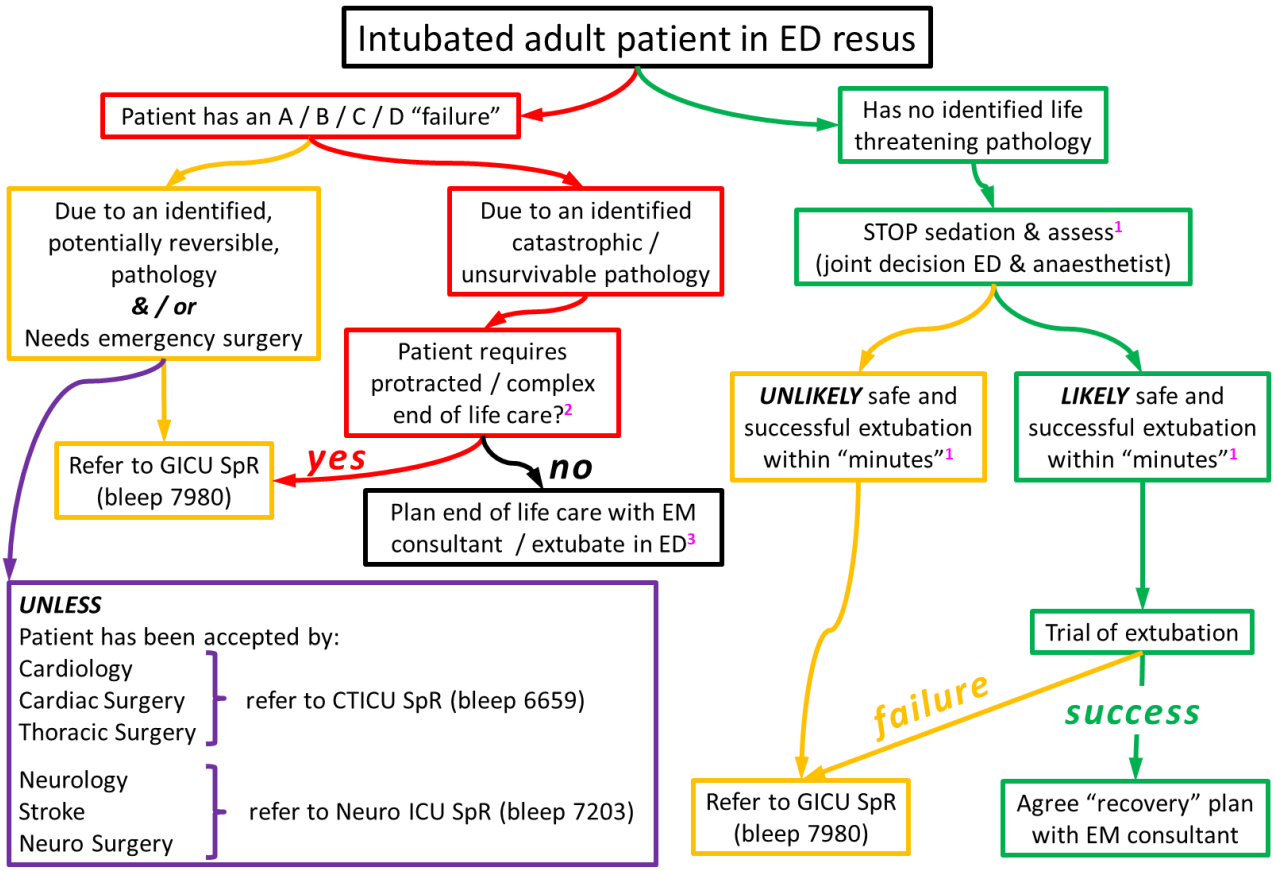
The transfer plan options

<table>
<tr><th>Plan</th><th>ICU bed status</th><th>Immediate</th><th>Urgent</th></tr>
<tr><td>A</td><td>GICU bed available</td><td colspan="2">• Transfer patient to GICU.
• If additional equipment / staff required, call GICU and request help +/- porters +/- Anaesthetic SpR on bleep 6111 (or 7647)</td></tr>
<tr><td>B</td><td>GICU bed will be available within 30-60 mins</td><td>Discuss the following options with the GICU NiC / on-call consultant:
• Ask the Anaesthetic SpR on bleep 6111 (or 7647) to help you / to temporarily look after the patient
• Consider taking the patient to an available ICU bed on CTICU or Neuro ICU to start treating them
• Consider transferring the patient to an Anaesthetic room in St James's Theatres
• Stay with the patient yourself</td><td>• Agree a plan with the referring team for foreseeable patient deterioration in the interim.
• Return to GICU
• Maintain regular contact with the ward team
As soon as the bed is available:
• Ask the ward team to transfer the patient to GICU.
• Consider assisting the ward team with the transfer to minimise any further delays
OR
• ask the Anaesthetic SpR on bleep 6111 (or 7647) to assist with the transfer.</td></tr>
<tr><td>C</td><td>No GICU bed available within 30-60 mins, BUT capacity on CTICU / Neuro ICU (immediately or within 30-60 mins)</td><td colspan="2">• GICU SpR OR GICU on-call consultant liaises directly with the other units and arranges transfer to them; either short term for initiation of treatment (whilst GICU bed created) OR definitive
• If accepted for transfer to CTICU / Neuro ICU BUT there will be a 30-60 minute delay, the responsibility for the patient remains with the GICU team as neither CTICU nor Neuro ICU have medical personnel to retrieve a patient
• Follow / adapt Plan B depending upon the urgency of the transfer</td></tr>
<tr><td rowspan="2">D</td><td rowspan="2">No ICU bed available within 60 minutes</td><td colspan="2">Unless already done
• GICU SpR to inform GICU on-call consultant
• GICU NiC to inform SG591
• Open an escalation area and transfer the most suitable patient(s) into that area
• Transfer the emergency patient to a suitable location</td></tr>
<tr><td>SHORT TERM
• Consider transferring the patient to an Anaesthetic room in St James's Theatres or an alternative short term place of safety
• Ask the Anaesthetic SpR on bleep 6111 (or 7647) to temporarily look after the patient where they are</td><td>SHORT TERM
• Agree a plan with the referral team for foreseeable patient deterioration in the interim.
• Return to GICU
• Maintain regular contact with the ward team
• Have low threshold for re-reviewing the patient in person</td></tr>
</table>

Useful numbers

- General Intensive Care Unit (GICU), 1st Floor St James's Wing, Ext 1307 / 3294 / 3295.
  - SpR bleep 7980 Step down and follow nurse (also available to assist with transfers) bleep 7400
- Neuro Intensive Care Unit (NICU), 2nd Floor Atkinson Morley Wing, Ext 4195 / 4196
- Cardiothoracic Intensive Care Unit (CTICU), 1st Floor Atkinson Morley Wing, Ext 1495 / 1504 / 1507
- Adult Critical Care senior nurse on call (for Critical Care bed and staffing issues) - SG591 (24/7)

Intubated patient in ED Resus patient pathway guideline



Note: SpR, StR and "ST4 and above" are all interchangeable terms.

Notes

Key personnel in the decision making process

- EM consultant in charge of Resus (bleep 8021) in collaboration with lead ED nurse for Resus - Primarily responsible for patient care
- Anaesthetic SpR (bleeps 6111 or 7647) in collaboration with the Duty Floor Anaesthetist (bleep 8011) or the general anaesthetic consultant on call
- GICU SpR (bleep 7980) in collaboration with the GICU consultant. [The GICU SpR is usually best placed to act as the single point of contact for Adult Critical Care].

Admissions to CTICU and Neuro ICU from ED

- These are dependent upon the patient having been accepted by the relevant specialty team
- If the patient has not been accepted by one of these teams then the referral pathway is to GICU in the first instance. It is for the on call consultants for the 3 ICUs to determine the best ICU to admit the patient to and this is dependent upon both the patient's needs and the bed state of the Adult Critical Care service.

1. For patients who have no identified life threatening pathology: Sedation holds for assessment and planned extubation in ED within "minutes"

- As soon as safe and practical, a sedation hold should be performed to facilitate re-assessment. The decision to perform a sedation hold should be agreed by the ED and Anaesthetic key personnel.
- If it seems likely that the patient can be safely and successfully extubated within "60 minutes" then this should be undertaken in ED.
- The EM consultant in Resus, the senior nurse in Resus and the anaesthetist should agree a plan for the patient, including "stand down" criteria for the anaesthetist.

2. Patient requires protracted / complex end of life care?

- It may be appropriate to admit a patient to an ICU bed for end of life care.
- As each situation is unique, it is highly desirable if the EM consultant discusses the case with the GICU consultant.
- One reason might be active management whilst the potential for organ donation is considered.
    - For more information see http://www.gicu.sgul.ac.uk/resources-for-current-staff/organ-donation-including-brainstem-death-testing

3. Please refer to ED guideline on End of Life Care for Adults

Communication

- In the event of uncertainties or problems consultant to consultant discussions invariably result in the fastest possible resolution.

Considerations prior to ICU transfer

- Is there a clearly documented list of acute problems / diagnoses / injuries with a plan for each?
- Which specialty teams are actively involved in the patient's on-going care? Are their contact details clearly documented?
- Has a nasogastric (or orogastric) tube been inserted and the stomach been effectively decompressed?
- Has a urinary catheter been inserted and urine drained?
- Has all necessary imaging been completed and reviewed (including repeat x-rays of lines / tubes etc)?
- If pertinent, has the spinal clearance form been completed and all unnecessary immobilisation removed?
- Have all wounds been cleaned, sutured and dressed, ***OR*** is there a documented plan to go to theatre for this including the surgical team responsible?
- If there is going to be a delay in transfer whilst the ICU bed is cleared / cleaned / prepared, what could usefully be done for the patient during this time? [E.g. sedation hold; wean to spontaneous mode of ventilatory support; central line & / or vascath insertion; etc etc].
- Please contact the GICU team for advice regarding any aspect of critical care whilst the patient is being managed in ED.

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