CRITICAL CARE ESCALATION POLICY, DEFINITIONS AND STANDARD OPERATING PROCEDURES

Document reference

Authors	Anne Palmer, Head of Nursing for Adult Critical Care Dr Maurizio Cecconi, Clinical Director for Adult Critical Care Ruth Leighton, General Manager for Adult Critical Care
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	NATIONAL DEFINITION	LOCAL DEFINITIONS	ACTIONS - ESCALATIONS
CRITCON 0 ***NORMAL*** ***Managing within capacity***	• Normal, able to meet all critical care needs, without impact on other services. • Normal winter levels of non-clinical transfer and other 'overflow' activity.	• Timely admissions and discharges • No refusal of referrals	• ICU Bleep Holder (SG591) attends morning escalation meetings (Mon to Fri) or provides reports to escalation meeting as agreed.
CRITCON 1 **LOW SURGE** ***Capacity available if patients discharged***	• Critical care capacity full	• Pressure on elective admissions • Movement of staff & or patients to accommodate maximal use of resources. • Delayed transfers of care (DToC) of patients creating occasional use of recovery to house elective patients for a short period. • Elective admissions prioritised by the specialities in discussion with the individual units. • Rare elective cancellations of lower priority cases.	• SG 591 to attend all escalation meetings • Critcon 1 reported • On-call Consultants and SG 591 bleep holder co-ordinate capacity and staff. • DToC posing a risk of cancellation of electives reported at escalation meeting. • Ad hoc cancellations agreed between relevant consultants
CRITCON 2 ***MEDIUM SURGE*** ***High acuity and high demand***	• Critical care capacity full • Non-clinical transfers within units • Overflow into quasi-critical care areas (theatre recovery, other acute care areas)	• All critical care beds full with high acuity patients • Low discharge rate due to acuity • Planned staffing of recovery or other quasi-critical care areas • Routine cancelation of elective surgical cases.	• SG 591 to attend all escalation meetings (24/7) • Critcon 2 reported to escalation meetings. • Management of next day elective care required • Head of Operations/COO to co-ordinate

	NATIONAL DEFINITION	LOCAL DEFINITIONS	ACTIONS - ESCALATIONS
CRITCON 3 ***HIGH SURGE*** ***Planned move into other areas***	• Expansion into non-critical care areas, and/or use of adult facilities for paediatric critical care.	• Critical Care Capacity full with high acuity patients • High demand for emergency • Planned move into other non-critical care areas	• SG 591 to attend all escalation meetings • Critcon 3 reported to escalation meetings • Cancelation of all elective operations • Critical Care (Consultant and SG 591) report status to Head of Operations, Divisional Chair, DDO & COO • Head of Operation or GM On-Call pulls 'Business Continuity Plan' • Divert to other units in sector/area if required
CRITCON 4 ***Triage*** ***Sector overwhelmed***	• Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation) • This level only defined by the SHA – must be reviewed every 12 hours	• All possible non critical care areas opened. • High demand for emergency beds that cannot be provided within extended critical care bed numbers.	**In Collaboration with the NHSE (London)** • Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation) • ***NO TRUST TO BEGIN TRIAGE UNLESS ALL OTHER TRUSTS are at CritCon 3***.

Operational Procedure for Opening of Escalation Areas:

Definitions of Critical Care Areas and Escalation Areas according to time and day of the week

Critical Care Areas Open from Monday 10:30 am to Saturday 12:30 pm

- General Intensive Care Unit: Area on First Floor St James Wing plus 3 beds Holdsworth HDU
- Cardiothoracic Intensive Care Unit: Main Area on first floor Atkinson Morley Wing plus 6 beds in former Coronary Care area (CTICUA) adjacent to main unit on the same floor.
- NeuroIntensive Care Unit: Main Area on Second Floor Atkinson Morley Wing plus 4 beds in Mckissock HDU

Escalation Areas:

- St James' Recovery beds

Procedure

The decision of opening St James' Recovery beds should be made collaboratively and involve the shift leaders and on call consultants on all 3 units. This should be considered when the capacity among the three units is not able to match the demand or is unlikely to match the demand based on the current and predicted activity. After consultation with the three units the Bleep Holder SG591 activates the process to open the area. Patients in this area, apart from exceptional circumstances should be under the care of the General Intensive Care Consultant.

Critical Care Areas Open from Saturday 12:30 pm to Monday 10:30 am

- General Intensive Care Unit (GICU): Area on First Floor St James Wing
- Cardiothoracic Intensive Care Unit (CTICU): Main Area on first floor Atkinson Morley Wing plus 3 beds in former Coronary Care area (CTICUA) adjacent to main unit on the same floor
- NeuroIntensive Care Unit: Main Area on Second Floor Atkinson Morley Wing

Escalation Areas:

- Remaining 3 beds former Coronary Care area (CTICUA)
- St James' area (St James Recovery or Holdsworth HDU)
- Mckissock HDU

Procedure for Routing Closure of the above areas at weekend or extended opening

If any of the 3 areas is unable to close by 12:30pm on Saturday due to delayed discharge either because:

- transfer delays of wardable patients (fit for discharge)
- a lack of ICU beds on parent units for patients unfit for step down

The default escalation plan should be to keep the area open and the patients in that area should remain in that area. Communication about these delays to the site team should happen early and from the nurse in charge of the Main Intensive Care Unit. These delays should be escalated at the same time to the bleep holder SG591.

Consideration should be given to the pros and cons of cohorting these patients into 1 or 2 of the 3 areas and closing the remainder. Any such plans should be made collaboratively and involve the shift leaders and on call consultants on all 3 units. The bleep holder should coordinate this process in conjunction with the on call consultants and the nurses in charge.

Opening of the escalation areas at weekend

If critical care capacity is full it's important to evaluate the CRITCON status and especially discriminate between CRITCON 1 (ie full also because of delayed discharges) and CRITCON 2 and above (full because of acuity).

CRITCON monitoring and relevant actions should be followed and active communication with the site management team should occur to facilitate the creation of Critical care capacity and minimise delayed discharges.

- As a standard operating procedure there should be attendance at the Friday Huddle at 8:30 am by the bleep holder SG591 where the forecasted CRITCON status for the weekend should be discussed
- An initial consultation with the consultants in charge and nurses in charge for the three units should occur in order to decide if escalation areas are likely to be used and staff can be organised.

In the event that an escalation area is needed during the weekend to accommodate urgent or emergency admissions within the critical care units, the following procedures should be applied in sequential order:

- CTICUA 3 beds will be opened – this will be run by General Intensive Care (in place of re-opening Holdsworth HDU, and with nursing staff from CTICU).
- If necessary, one or more patients will be decanted from Holdsworth HDU to facilitate this.
- Any General Intensive Care patients cared for on CTICUA should be managed with GICU processes i.e. paper drug charts etc. Preferentially, the patients with the lowest acuity and highest likelihood of step down to ward level care should be transferred to CTICUA.

- If additional escalation beds are required to accommodate urgent or emergency admissions within the critical care units, GICU will open beds in a St James's escalation area.

- The decision to open either Holdsworth HDU or St James's recovery will be made by the GICU consultant in charge in conjunction with the GICU nurse in charge and the bleep holder SG591 and based on patients' acuity and available resources.

- The GICU team must not operate with patients in both St James's escalation areas (Recovery or Holdsworth HDU) and in CTICUA. Hence, if the GICU team have 1-3 patients in CTICUA and have to open a St James's escalation area the GICU team will handover to the CTICU team who will take over the care of the GICU patients on CTICUA.

- In the event that the units cannot admit urgent or emergency patients due to delayed discharges, McKissock beds should remain open / be re-opened and the lowest acuity delayed discharges from any of the units decanted into McKissock to facilitate emergency admissions to the most appropriate unit.

- Should the situation arise whereby GICU has 18 patients in the unit and 3 patients in St James's escalation area, CTICU has 15 + 6 patients; and Neuro ICU has 14 +/- 4 patients on McKissock awaiting step down, AND further emergency critical care capacity is required, the expansion into other areas (other recovery areas for instance) should be considered. This is likely to be CRITCON 2 and 3 (see above) and all relevant actions should be taken (see table and below):

CRITCON 2

- SG 591 to attend all escalation meetings (24/7)
- Critcon 2 reported to escalation meetings.
- Management of next day elective care required
- Head of Operations/COO to co-ordinate

CRITCON 3

- SG 591 to attend all escalation meetings
- Critcon 3 reported to escalation meetings
- Cancelation of all elective operations
- Critical Care (Consultant and SG 591) report status to Head of Operations, Divisional Chair, DDO & COO

Dr Maurizio Cecconi (Clinical Director Adult Critical Care Directorate) Signature……Date:……	**Dr Frank Schroder (Care Group Lead, Cardiothoracic Intensive Care Unit)** Signature……Date:……
Dr Jonathan Ball (Care Group Lead, General Intensive Care Unit) Signature……Date:……	**Dr Neil Burgess (Care Group Lead, Neurological Intensive Care Unit)** Signature……Date:……