University Hospitals of Derby and Burton
NHS Foundation Trust

# Suggested Pathway of Referral to Critical Care- Pathway - Burton Sites Only

CG-ICU/2020/3537

## Introduction

The following is a recommendation of matters to consider and a procedure to follow when referring a patient to Critical Care (bleep 510). This is intended to make the process more streamlined, to provoke a response to treating a deteriorating patient in a more structured fashion and to ensure the correct people are aware at the right time and have input into the process.

Not all contacts with Critical Care are for potential admission to the Unit (the referral for admission guideline below is for that purpose). Requests for assistance (with line insertions, treatment or medicines advice etc.) do not routinely require consultant discussion and should be treated sympathetically.

Offers to help should only follow assurance that appropriately senior members of the referring team have been involved *before* the critical care resident doctor is called.

## Things to remember (as stipulated in the Mid Trent Critical Care Network (MTCCN) Admission and Operational Policy http://www.midtrentccn.nhs.uk/images/MTCCN%20Admission%20and%20Operational%20Policy%20March%202012%20-Final%20version%207.pdf

- Patients are admitted to critical care areas for life support or for monitoring, investigation and care which is only available in such Units. Admission to critical care beds or ward based critical care services may also be required to prevent anticipated deterioration in patients to the extent that they require invasive therapy.

- Patients should have a reasonable prospect of final cure or of a recovery, which would be better than could be achieved without admission. Patients should not be admitted to critical care against their previously stated and appropriately documented wishes.

- The criteria for acceptance to critical care services are clinical need and the urgency of that need. Clinical guidelines for admission and discharge are summarised in the Department of Health document EL (96) 202. Patients may require critical care support at ward based or HDU level or in exceptional circumstances, transfer to another critical care resource within the Network as indicated by their Unique Transfer Group.

- The nurse-in-charge will be consulted with, prior to accepting a referral, to ensure that adequate numbers of nursing staff are available to care for a new admission.

**Optimal Pathway**

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| ***Referrer has detailed personal knowledge of patient and their current clinical state***<br><br>****Consultant in charge is aware of referral being made*** | **Referrer knows what Critical Care intervention is needed** | **Succinct and accurate referral to critical care resident doctor using SBAR tool** | **Patient reviewed and plans are discussed with Critical Care consultant**<br>↓<br>**Timely admission *if appropriate*** | **Optimal Patient Care** |

## Politics of referral

We would hope to be able to help with any ward-based patient who may require Critical Care support. Is it Critical Care that you need the advice of – or can someone more senior in your team help? (*The Consultant in charge of that patient should be contacted for advice first in all cases where possible) **NB – the Critical Care resident may be relatively junior (e.g. CT1) and *not an anaesthetist***.

Note: we cannot admit patients for standard monitoring which can be provided at ward level.

**If the patient is in cardiac arrest (or is so ill that arrest is imminent) call the cardiac arrest team on 2222 first.**

- Any consultant, or appropriate member of their team, may refer a patient to critical care. I take 'appropriate member of their team' to mean the most senior member of the referring team that is resident *and* able to review the patient (Mid Trent Critical Care Network Admissions and Operational Policy version 8.2, November 2014). The referring doctor *must* have personally reviewed the patient.

- All referrals should follow the SBAR (validated) methodology as set out below.

- The critical care resident doctor may not unilaterally refuse to see any referred patient (MTCCN operational policy)

- All referrals for opinions regarding potential admission to critical care must be discussed with the duty critical care consultant (MTCCN operational policy)

- *The request to see a patient on the ward or in ED should be sanctioned by the consultant in charge of the patient care ***unless the request is very urgent*** (i.e. patient 'crashing'), in which case the patient must **always** be reviewed by critical care as soon as is possible (i.e. *immediately* unless the on-call critical care resident is clinically engaged on ICU/elsewhere and unable to leave).

- *The referring team should make the consultant in charge of the patient aware of the referral to critical care *as soon as is possible* – if this is not done before the referral is made.

- There *does not* need to be consultant to consultant referral for an ITU opinion to be sought. Consultant to consultant discussion may be required if there is disagreement as to whether admission to critical care is appropriate (rarely, a second opinion may need to be sought if this disagreement is not resolved).

## Definitions of levels of care

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| **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 additional advice and support from the critical care team. |
| **Level 2** | Patients requiring more detailed observation or intervention 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 of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure. |

## What information does Critical Care want?

## SBAR tool (Patient Safety First - 2008)

| Modified SBAR | Questions/Considerations |
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| S | (Time and date)<br>Drs Name/role. Bleep number.<br>Consultant in charge of patient.<br>Patient unit number and date of birth.<br>Patient location.<br>Main concern prompting referral. |
| B | • Date of admission.<br>• Reason for admission.<br>• Primary diagnosis.<br>• Significant past medical history.<br>• Relevant investigations/imaging reports.<br>• MEWS/NEWS score/current observations. |
| A | • What is reversible?<br>• Have senior members of team been involved?<br>• What has been done or treated?<br>• What has been the response to treatment? |
| R | • What would you like Critical Care to do? |

# Other Referrals

## Referrals for Venous Access

Firstly, please consider carefully what access the patient really requires and discuss this with the Consultant in charge of the patient's care if in doubt. *Not all solutions to difficult venous access require a central line*.

- Clotting and platelet levels require measuring (and correcting if necessary) prior to any centrally-inserted lines being considered.

- Peripheral, short and intermediate-term venous access may be provided by the Midline Team from theatre (Monday-Friday in office hours) – bleep 584.

http://bhftintranet.burtonft.nhs.uk/Policies/Vascular%20Access%20Service%20Policy.pdf

- If you are certain that the patient requires temporary central venous access (central line) the first port of call should be the **anaesthetic first-on (bleep 511)** who will ask some questions regarding the indication for insertion. If CVC insertion is felt appropriate by them, they will co-ordinate with theatre a convenient time to perform this procedure. In the event that the first-on anaesthetist cannot assist, it may be appropriate that the Critical Care resident assists if they are able to.

- Long-term, tunnelled central venous catheters (the lines used here are correctly termed Groshong rather than 'Hickman' lines) are inserted and removed in the operating theatres on a formal operating list which is co-ordinated by the ITU Office (extension 4099 - 9-5 Mon to Fri only). **Please note this *is not* an out-of-hours service and may not be available every week.**

*Critical Care does not *routinely* offer technical help with other procedures – seek advice from your teams.

## Transfer

If airway compromise has occurred or is likely, call the anaesthetic team for assistance (511). Call the Critical Care resident if the first-on anaesthetist is not available for any reason.

The anaesthetic on-all team will also assist with transfer of the ventilated/sedated patient to another provider (e.g. for neurosurgery etc.).

*Critical Care does not offer a transfer service for non-critical care patients. If cardiac arrest during transfer is likely, an ALS-provider escort or a paramedic crew ambulance is required (see transfer ambulance guidelines)[1].

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**May 2015**

**Reviewed October 2019.**
**Extended until Feb 2024**

[1] In production