

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

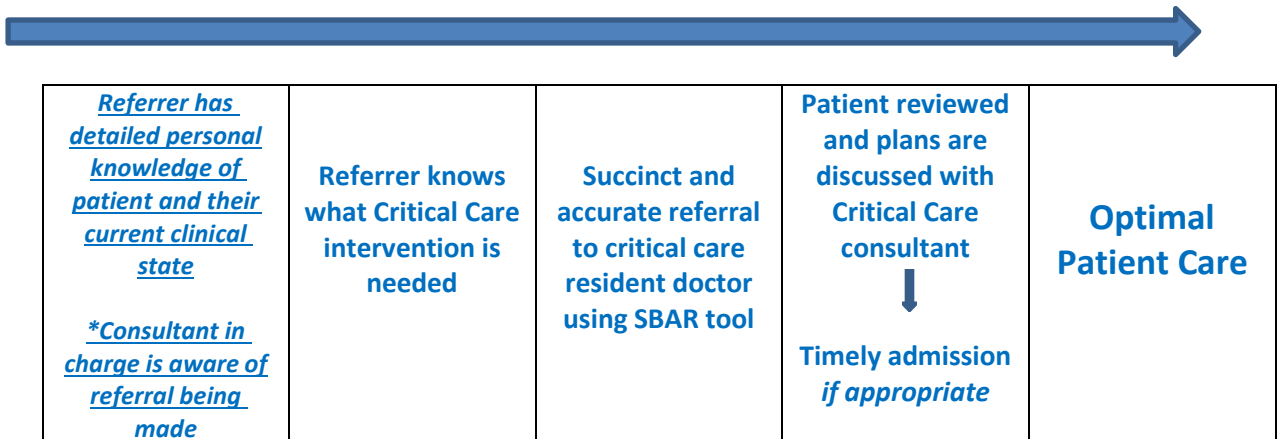
Introduction

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.

- 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 PathwayPolitics 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. 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). If critical care resident busy first on call anaesthetist can be contacted on 511 bleep

- *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

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
S	<ul style="list-style-type: none"> <input type="checkbox"/> (Time and date) <input type="checkbox"/> Drs Name/role. Bleep number. <input type="checkbox"/> Consultant in charge of patient. <input type="checkbox"/> Patient unit number and date of birth. <input type="checkbox"/> Patient location. <input type="checkbox"/> Main concern prompting referral.
B	<ul style="list-style-type: none"> • Date of admission. • Reason for admission. • Primary diagnosis. • Significant past medical history. • Relevant investigations/imaging reports. • MEWS/NEWS score/current observations.
A	<ul style="list-style-type: none"> • What is reversible? • Have senior members of team been involved? • What has been done or treated? • What has been the response to treatment?
R	<ul style="list-style-type: none"> • 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.
- 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.

*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-call 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.

¹In production

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Version / Amendment History	Version	Date	Author		Reason
	2	May 2024	Dr Adilah Miraj		Minor updates to guideline
Intended Recipients: State who the Clinical Guideline is aimed at – staff groups etc.					
Training and Dissemination: How will you implement the Clinical Guideline, cascade the information and address training					
Development of Guideline: Dr Adilah Miraj Job Title: Critical Care Lead					
Consultation with:					
Linked Documents: State the name(s) of any other relevant documents					
Keywords:					
Business Unit Sign Off			Group: (minor changes) Date:		
Divisional Sign Off			Group: Surgery Division (No significant change to content) Date: May 2024		
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Contact for Review			Dr Miraj		