TRUST POLICY FOR CONSULTANT RESPONSIBILITY FOR PATIENTS ON THE INTENSIVE CARE UNIT (ICU)

DERBY SITE ONLY

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Executive Lead Signature	Executive Medical Director
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TRUST POLICY FOR CONSULTANT RESPONSIBILITY FOR PATIENTS ON THE INTENSIVE CARE UNIT (ICU)

1. Introduction

The decision to admit a patient to ICU should be made at consultant level. In practice this means that the decision to refer should be discussed with the admitting team's consultant prior to referral. Patient, relatives and clinician should all be involved in this decision if possible. All referrals will be discussed with the consultant intensivist and he / she will be responsible for making the final decision on whether a patient is accepted.

2. Purpose and Outcomes

To recognise the multidisciplinary care that patients require whilst on ICU and to clarify the differing roles and responsibilities of the clinicians involved.

To enable patients requiring admission to the ICU to benefit from the expertise that they require whilst on ICU and to ensure seamless continuity of care following discharge.

This Policy applies to all clinicians involved in the referral and on-going management of patients admitted to the ICU.

3. Definitions Used

ICU: Intensive Care Unit.

Admitting team: The team responsible for patient care prior to the patient being referred to ICU.

Parent team: The team with whom the ICU doctors will primarily liaise with about ongoing clinical management decisions. This will initially be the admitting team but may become a more appropriate team depending on the requirements of the patient. The parent team will be responsible for patient care when the patient is discharged from ICU.

Speciality consultation: A speciality consultation requested by the ICU doctors will not change the parent team unless agreed by the parent team. It is the responsibility of the admitting team to negotiate a change of parent team if this is seen as being in the patient's interests and to document this in the medical notes.

Consultant Intensivist:	The consultant Intensivist accepting the referral and thereafter the consultant Intensivist responsible for the ongoing management of the patient.
ICU Team:	The consultant Intensivist, junior medical staff and nursing staff.

4. Key Responsibilities/Duties

Acutely Unwell Patient Advisory Group

This group will monitor the implementation of the Policy and refer relevant issues as appropriate.

Admitting Team

The admitting team are responsible for the care of a patient prior to their referral to ICU following negotiation with the consultant Intensivist.

Parent Team

The parent team are responsible for liaising with the ICU doctors about ongoing clinical management decisions and for reviewing the patient in an appropriate timescale. The admitting team must also negotiate a change of parent team if this is seen as being in the patient's interests and will be responsible for the patient's care following discharge from ICU.

Consultant Intensivist

The consultant Intensivist will negotiate referrals with the admitting team and will be responsible for the ongoing management of the patient.

ICU Team

The ICU Team are responsible for the care and management of the patient admitted to ICU and for liaison with relatives and carers.

5. Implementation of the Policy for Consultant responsibility for Patients on ICU

5.1 Category A Patients - Patients admitted acutely through the Emergency Department (ED) or via Medical Assessment Unit (MAU) / Surgical Assessment Unit (SAU).

- The consultant on-call for Medicine / Surgery or ED should be involved in the referral process. The clinical urgency of the patient should be paramount - so in some cases transfer to ICU will occur rapidly without the admitting team's consultant being informed
- The on call Medical consultant for general cases will be the point of call for all unallocated cases if a general medical opinion is required. Patients will otherwise be assigned to the appropriate medical specialities

- If the patient remains a general medical case with no particularly appropriate speciality then they will remain under the ICU team until they are ready for discharge

- If a medical opinion is required for a general medical patient that has been admitted to ICU then the Medical consultant that is on call on that day will be contacted

- When patients are referred to the ICU urgently, ED staff should inform the relevant Medical or Surgical Registrar either before, at the same time as, or immediately after the transfer, so they are aware of the need to review the patient **promptly** and inform their consultant. This team will be nominated as the admitting team and will continue to act as the parent team unless the patient is referred onwards to another speciality

- On arrival on the ICU, the ICU team will document who the admitting team are and ensure that the Registrar is made aware of the need to review the patient in an appropriate timescale. This will be part of the admission process

- Post-take ward rounds should include ICU as a routine – it is the responsibility of the admitting team's Registrar to inform his / her consultant if he / she is aware of any patients admitted to the ICU that day

- It may be appropriate for the admitting team to refer onwards to a more relevant speciality to take over as the parent team. This is the responsibility of the admitting team to negotiate. This should be documented in the medical notes and clearly communicated to the ICU team.

5.2 Category B - Patients referred to ITU from general wards.

- All patients should be assessed by a Registrar or consultant prior to referral to ICU

- The decision to refer should be discussed with the referring consultant but this should not delay vital patient treatment.

5.3 Category C – Interhospital Transfers

- Occasionally it is necessary to transfer a patient from one ICU to another. This may be for a clinical reason or because of lack of capacity. It is the responsibility of the ICU team to ensure that the parent medical team at the referring hospital are aware of the transfer. When accepting a patient as a transfer the ICU team will nominate a new parent team of a relevant speciality. These discussions will take place at Registrar level or above. The ICU team will endeavour to avoid non-clinical transfer. The consultant Intensivist will make the final decision on which patient to transfer, taking into account the patient's condition and requirements.

5.4 Consultant Responsibility for Patient Whilst on ICU

- The responsibility for making decisions to admit a patient to ICU, the on-going day- to-day management and the decision to discharge a patient ultimately rests with the consultant Intensivists

- Frequent communication with the parent team is encouraged and speciality consultations may be requested. The amount of input from the parent team will vary depending on whether the patient is medical or surgical and also on the patients' diagnosis

- When admitted under a surgical parent team then the surgical aspects of the patients care will remain the responsibility of the surgeon. The patient will benefit from the multidisciplinary input and clear lines of accountability

- In the event that the medical or surgical teams wish to re-assign the patient to another team, then it is their responsibility to communicate this change to both the new parent team and ICU

- In the event that a patient dies whilst on ICU, the ICU team will inform the parent team, liaise with the Coroner and issue the death certificate if appropriate. The ICU team will deal with all documentation – occasionally the parent team may wish to take on this role, especially after surgical deaths. The ICU team will send a discharge summary to the General Practitioner and will offer counselling to the patient's relatives if appropriate.

5.5 Discharge from ICU

- Patients will usually be discharged to the care of the existing parent team. In particular where patients have received speciality care this will need to be continued after discharge from ICU and the patient must be discharged direct to the correct speciality ward. Similarly where patients are admitted from a ward, (rather than ED or MAU) they will be returned to that ward unless taken over by a new parent team

- Where a patient has been admitted to ICU from MAU / ED with a general medical problem, an appropriate available bed on a ward will be identified by the flow team. The medical team on the ward will be contacted by the ICU team and informed that the patient will be discharged to their ward. The consultant on call for that ward at that time will become the parent consultant and the new parent team will take over responsibility for the patient. In the event that a bed cannot be found and a patient is fit enough to be discharged home directly from ICU then the on call general medical team will be contacted to discharge them and arrange any appropriate follow up

- It is the responsibility of the ICU team to ensure that the medical team responsible for taking over responsibility for the patient is aware of the patient's discharge. This may involve a "consultant to consultant" telephone call for some complex patients. The discharge should be planned to occur during the daytime and a detailed written discharge summary will accompany the patient

- It is the responsibility of the parent team to review the discharge summary and medications. All patients discharged from ICU must be reviewed in a timely fashion. Any queries should be raised with the ICU team.

6. Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trust monitoring template:

Monitoring Requirement :	To ensure compliance with the agreed process for consultant responsibility for patients on ICU.
Monitoring Method:	Audit
Report Prepared by:	Consultant Intensivist
Monitoring Report presented to:	Acutely Unwell Patient Advisory Group.
Frequency of Report	Six Monthly