

## Guidelines for when Critical Care Demand Exceeds Capacity

### Introduction

The lack of an ICU (Intensive Care Unit) bed to care for an acutely ill patient is a frequent problem. A plan to care for these patients is therefore of vital importance and is frequently life-saving. Whilst the problem will only be fully addressed by adequate provision of critical care facilities, this document is intended to aid decision making when this situation occurs and provide a framework for managing staff and deciding on the best location for the patient in the short and long term. It is acknowledged that the care provided outside ICU for these patients is not at the same standard as that provided inside ICU.

Whilst these guidelines should be taken as standard operating procedures, senior staff (both nursing and medical) will be expected to exercise judgement in the application. All staff will be expected to take a flexible approach.

The key decisions that need to be made in this situation are whether to transfer the patient to another ICU or manage the patient within the Bradford Royal Infirmary. It must be recognised that non-clinical transfers present a significant risk to the patient, with worse outcomes. If the patient is unsuitable for transfer (e.g. significant cardiovascular instability or urgent need for haemofiltration) there are debatable ethical issues over whether to transfer another patient instead. For these reasons it is necessary to identify other solutions.

### Policy

ICU capacity at Bradford Royal Infirmary consists of 16 beds - 8 level 3 and 8 level 2 beds. This bed base is flexible in that when more than 8 level 3 patients are present, the number of available level 2 beds reduces in a ratio of 2:1. Thus when there are 9 level 3 patients, there are 6 level 2 beds available, necessitating physical closure of a bed. When ICU capacity is exceeded and a bed is closed for this reason, then it may be possible for extra staff to be made available (office, outreach or staff development or in some cases, a recovery nurse). This may only be for a short period of time. If there is no physical bed or no extra staff available and the patient requiring admission is unstable, then he/she must be transferred immediately to the nucleus theatre recovery. However this should be temporary - *less than 6 hours* - until a bed is identified on the main unit or in another hospital. If the patient is unsuitable for Recovery (e.g. requires haemofiltration) then another patient should be transferred to Recovery instead.

When an ICU bed is unavailable due to delayed discharges then the delayed discharge must be moved *immediately* to recovery. Such patients should be level 1/0 and should not need specialist nursing intervention. The patient requiring urgent admission can then be admitted to the main ICU.

When a critically ill patient is admitted to the recovery area, planning should commence for this patient to be transferred to a conventional ICU bed, be it in this

hospital or another. Predicting future availability of a bed on ICU is difficult. When the patient has spent 6 hours in the recovery area and there is no certainty of imminent availability of a bed, then plans should be made for transfer to another ICU.

This guidance is summarised in the decision tree in Appendix 1.

### **Nursing considerations when a critically ill patient is admitted to recovery**

An appropriate bed can be obtained from the Clinical Site Team and should have a pressure-relieving mattress. This can be loaned and available within 4 hours.

Nursing ratio must appropriate for the level of care required. Normally this means a dedicated nurse with additional support when necessary from the other recovery staff.

Monitoring standards are as for ICU using standard ICU charts. Drug and infusion prescriptions are identical to those used on the main ICU. It is not possible to use the Innovian charting system in the recovery area.

The ICU care plan should be used. This includes guidance on pressure sore prevention. Additional paperwork standard for ICU patients such as VTE forms and Waterlow assessments should be used.

### **Medical**

The ICU team has clinical responsibility for critically ill patients admitted to recovery, with the ICU consultant having overall responsibility and control. Advice, prescriptions and procedures are to be provided by the ICU team. The patient should be included in the ward rounds and daily reviews as for all ICU patients. This includes review by the parent specialty, who should be notified of the patient's location at the time of admission.

It is expected however that any available appropriately qualified medical staff (especially anaesthetists working in acutes) will make themselves available to manage the patient. There should be an identified anaesthetist as first point of contact. This should be the trainee on call for ICU or acutes. It is noted that Anaesthetic Departmental policy requires that the trainee on for acutes assist the ICU team when not working in theatre. Every effort should be made to maintain an anaesthetic presence in nucleus theatres excepting overriding clinical need.

In an emergency (e.g. cardiac arrest, unplanned extubation) medical staff in the theatre area will be expected to assist.

All ICU patients cared for in recovery should be reviewed at least 6 hourly by the ICU medical staff and at least 12 hourly by the ICU consultant. This should include consideration of transfer to another ICU. This review should be documented in the patient record as usual.

### **Limitations**

Complex procedures or those requiring extra input, such as haemofiltration, will not be possible. Weaning from ventilation with a potentially unco-operative patient has the attendant risks of unplanned extubation in an environment where additional help may not be immediately forthcoming.

### **Patient's relatives**

Visiting should be facilitated whenever possible, but it is recognised that the recovery is a restricted area where other patients are managed. Relative interviews should ideally take place on ICU.

### **Infection control**

Patients who are an infection risk who would normally require a sideroom should be discussed with infection control. A risk assessment should be made. It may be possible to 'isolate' such patients by managing them in theatre.

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## Appendix 1

Decision tree for the management of critically ill patients when demand exceeds capacity

